PacifiCare
5701 Katella Avenue
P.O. Box 6006
Cypress, California 90630

Customer Service:
800-624-8822
800-442-8833 (TDHI)

Visit our Web site @ www.pacificare.com

Sales Information:
800-610-2660
800-387-1074 (TDHI)
6:00 a.m. to 6:00 p.m., weekdays

PacifiCare®
A UnitedHealthcare Company

12/06
PCA185103-003

University of California 2007 Combined Evidence of Coverage and Disclosure Form

PacifiCare®
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CALIFORNIA

University of California
2007 Combined Evidence of Coverage and Disclosure Form

Introducing PacifiCare's HMO Plan

Since 1978, we've been providing health care coverage in the state. This publication will help you become more familiar with your health care benefits. It will also introduce you to our health care community.

PacifiCare® provides health care coverage to Members who have properly enrolled in our plan and meet our eligibility requirements. To learn more about these requirements, see **Section 8. Member Eligibility**.

What is this publication?

This publication is called a *Combined Evidence of Coverage and Disclosure Form*. It is a legal document that explains your health care plan and should answer many important questions about your benefits. Many of the words and terms are capitalized because they have special meanings. To better understand these terms, please see **Section 11. Definitions**.

Whether you are the Subscriber of this coverage or enrolled as a Family Member, your *Combined Evidence of Coverage and Disclosure Form* is key to making the most of your membership. You'll learn about important topics like how to select a Primary Care Physician and what to do if you need hospitalization.

What else should I read to understand my benefits?

Along with reading this publication, be sure to review your *Schedule of Benefits* and any benefit materials. Your *Schedule of Benefits* provides the details of your particular Health Plan, including any Copayments that you may have to pay when using a health care service. Together, these documents explain your coverage.

What if I still need help?

After you become familiar with your benefits, you may still need assistance. Please don't hesitate to call our Customer Service department at **1-800-624-8822** or **1-800-442-8833 (TDHI)**. **NOTE:** Your *Combined Evidence of Coverage and Disclosure Form* and *Schedule of Benefits* provides the terms and conditions of your coverage with PacifiCare, and all applicants have a right to view these documents prior to enrollment. The *Combined Evidence of Coverage and Disclosure Form* should be read completely and carefully. Individuals with special health needs should pay special attention to those sections that apply to them.

You may correspond with PacifiCare at the following address:

PacifiCare of California
5701 Katella Avenue
P.O. Box 6006
Cypress, California 90630
www.pacificare.com

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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Section 1. Getting Started: Your Primary Care Physician

- **What is a Primary Care Physician?**
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- **What is a Participating Medical Group?**
- **Your *Provider Directory***
- **Choosing Your Primary Care Physician**
- **Continuity of Care**

One of the first things you do when joining PacifiCare is to select a Primary Care Physician. This is the doctor in charge of overseeing your care through PacifiCare. This section explains the role of the Primary Care Physician, as well as how to make your choice. You'll also learn about your Participating Medical Group and how to use your *Provider Directory*.

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

Introduction

Now that you're a PacifiCare Member, it's important to become familiar with the details of your coverage. Reading this publication will help you go a long way toward understanding your coverage and health care benefits. It's written for all our Members receiving this plan, whether you're the Subscriber or an enrolled Family Member.

Please read this *Combined Evidence of Coverage and Disclosure Form* along with any supplements you may have with this coverage. You should also read and become familiar with your *Schedule of Benefits*, which lists the benefits and costs unique to your plan.

What is a Primary Care Physician?

When you become a Member of PacifiCare, one of the first things you do is choose a doctor to be your Primary Care Physician. This is a doctor who is contracted with PacifiCare and who is primarily responsible for the coordination of your health care services. A Primary Care Physician is trained in internal medicine, general practice, family practice, pediatrics or obstetrics/gynecology.

Unless you need Emergency or Urgently Needed care, your Primary Care Physician is your first stop for using these medical benefits. Your Primary Care Physician will also seek authorization for any referrals, as well as initiate and coordinate any necessary Hospital Services. All Members of PacifiCare are required to have a Primary Care Physician. If you don't select one when you enroll, PacifiCare will choose one for you. Except in an urgent or emergency situation, if you see another health care Provider without the approval of either your Primary Care Physician, Participating Medical Group or PacifiCare, the costs for these services will not be covered.

What is the difference between a Subscriber and an enrolled Family Member?

While both are Members of PacifiCare, there's a difference between a Subscriber and an enrolled Family Member. A Subscriber is the Member who enrolls through his or her employment after meeting the eligibility requirements of the University of California and PacifiCare. A Subscriber may also contribute toward a portion of the Premiums paid to PacifiCare for his or her health care coverage for himself or herself and any enrolled Family Members. An enrolled Family Member is someone such as a Spouse or child whose dependent status with the Subscriber allows him or her to be a Member of PacifiCare. Why point out the difference? Because Subscribers often have special responsibilities, including sharing benefit updates with any enrolled Family Members. Subscribers also have special responsibilities that are noted throughout this publication. If you're a Subscriber, please pay attention to any instructions given specifically for you.

- For a more detailed explanation of any terms, see the "Definitions" section of this publication.

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 Primary Care Physician

When choosing a Primary Care Physician, you should always make certain your doctor meets the following criteria:

- Your doctor is selected from the list of Primary Care Physicians in PacifiCare's *Provider Directory*.
- Your doctor is located within 30 miles of either your Primary Residence or Primary Workplace.

You'll find a list of our participating Primary Care Physicians in the *Provider Directory*. It's also a source for other valuable information. (**NOTE:** If you are pregnant, please read the section below, "If You Are Pregnant," to learn how to choose a Primary Care Physician for your newborn.)

What is a Participating Medical Group?

When you select a Primary Care Physician, you are also selecting a Participating Medical Group. This is the group that's affiliated with both your doctor and PacifiCare. If you need a referral to a specialist, you will generally be referred to a doctor or service within this group. Only if a specialist or service is unavailable will you be referred to a health care Provider outside your medical group.

To learn more about a particular Participating Medical Group, look in your *Provider Directory*. Along with addresses and phone numbers, you'll find other important information, including Hospital affiliations, additional services and any restrictions about the availability of Providers.

Your *Provider Directory* – Choice of Physicians and Hospitals (Facilities)

Along with listing our participating Physicians, your *Provider Directory* has detailed information about our Participating Medical Groups and other Providers. This includes a QUALITY INDEX® for helping you become familiar with our Participating Medical Groups. Every Subscriber should receive a *Provider Directory*. If you need a copy or would like assistance picking your Primary Care Physician, please call our Customer Service department. You can also find an online version of the *Provider Directory* at **www.pacificare.com**.

NOTE: If you are seeing a Participating Provider who is not a part of a Medical Group, your doctor will coordinate services directly with PacifiCare.

Choosing a Primary Care Physician for Each Enrolled Family Member

Every PacifiCare Member must have a Primary Care Physician; however, the Subscriber and any enrolled Family Members don't need to choose the same doctor. Each PacifiCare Member can choose his or her own Primary Care Physician, so long as the doctor is selected from PacifiCare's list of Primary Care Physicians and the doctor is located within 30 miles of either the Member's Primary Residence or Primary Workplace.

If a Family Member doesn't make a selection during enrollment, PacifiCare will choose the Member's Primary Care Physician. (**NOTE:** If an enrolled Family Member is pregnant, please read below to learn how to choose a Primary Care Physician for the newborn.)

Continuity of Care for New Members at the Time of Enrollment

Under certain circumstances, as a new Member of PacifiCare, you may be able to continue receiving services from a Non-Participating Provider to allow for the completion of Covered Services provided by a Non-Participating Provider, if you were receiving services from that Provider at the time your coverage became effective, for one of the Continuity of Care Conditions as limited and described in **Section 11. Definitions**.

This Continuity of Care assistance is intended to facilitate the smooth transition in medical care across health care delivery systems for new Members who are undergoing a course of treatment when the Member or the Member's employer changes Health Plans during open enrollment.

For a Member to continue receiving care from a Non-Participating Provider, the following conditions must be met:

1. Continuity of Care services from Non-Participating Provider must be Preauthorized by PacifiCare or the Member assigned Participating Provider;
2. The requested treatment must be a Covered Service under this Plan;
3. The Non-Participating Provider must agree in writing to meet the same contractual terms and conditions that are imposed upon PacifiCare's Participating Providers, including location within PacifiCare's Service Area, payment methodologies and rates of payment.

Covered Services for the Continuity of Care Condition under treatment by the Non-Participating Provider will be considered complete when:

1. The Member's Continuity of Care Condition under treatment is medically stable; and
2. There are no clinical contraindications that would prevent a medically safe transfer to a Participating Provider as determined by a PacifiCare Medical

Director in consultation with the Member, the Non-Participating Provider and, as applicable, the newly enrolled Member's assigned Participating Provider.

Continuity of Care also applies to those new PacifiCare Members who are receiving Mental Health care services from a Non-Participating Mental Health Provider at the time their coverage becomes effective. Members eligible for continuity of mental health care services may continue to receive mental health services from a Non-Participating Provider for a reasonable period of time to safely transition care to a Mental Health Participating Provider. Please refer to "Medical Benefits" and "Exclusions and Limitations" in **Section 5. Your Medical Benefits** of the PacifiCare *Combined Evidence of Coverage and Disclosure Form*, and the *Schedule of Benefits* for supplemental mental health care coverage information, if any. For a description of coverage of mental health care services for the diagnosis and treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED), please refer to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form*. A Non-Participating Mental Health Provider means a psychiatrist, licensed psychologist, licensed marriage and family therapist or licensed clinical social worker who has not entered into a written agreement with the network of Providers from whom the Member is entitled to receive Covered Services.

PacifiCare
Attention: Continuity of Care Department
Mail Stop: CY 124-0164
P.O. Box 6006
Cypress, CA 90630-9938
Fax: 1-888-361-0514

All Continuity of Care requests will be reviewed on a case-by-case basis. Reasonable consideration will be given to the severity of the newly enrolled Member's condition and the potential clinical effect of a change in Provider regarding the Member's treatment and outcome of the condition under treatment.

PacifiCare's Health Services department will complete a clinical review of your Continuity of Care request for the completion of Covered Services with a Non-Participating Provider and the decision will be made and communicated in a timely manner appropriate to the nature of your medical condition. In most instances, decisions for nonurgent requests will be made within five (5) business days of PacifiCare's receipt of the completed form. You will be notified of the decision by telephone and provided with a plan for your continued care. Written notification of the decision and plan of care will be sent to you, by United States mail, within two (2) business days of making the decision. If your request for continued care with a Non-Participating Provider is denied, you may appeal the decision. (To learn more about appealing a denial, please refer to **Section 9. Overseeing Your Health Care**.)

If you have any questions, would like a description of PacifiCare's continuity of care process, or want to appeal a denial, please contact our Customer Service department.

Please Note: It's not enough to simply prefer receiving treatment from a former Physician or other Non-Participating Provider. You should not continue care with a Non-Participating Provider without our formal approval. If you do not receive Preauthorization from PacifiCare or your Participating Medical Group, payment for routine services performed by a Non-Participating Provider will be your responsibility.

If You Are Pregnant

Every Member of PacifiCare needs a Primary Care Physician, including your newborn. If you are pregnant, we encourage you to plan ahead and pick a Primary Care Physician for your baby. Newborns remain enrolled with the mother's Participating Medical Group from birth until discharge from the hospital. You may enroll your newborn with a different Primary Care Physician or Participating Medical Group following the newborn's discharge by calling PacifiCare's Customer Service department. If a Primary Care Physician isn't chosen for your child, the newborn will remain with the mother's Primary Care Physician or Participating Medical Group. If you call the Customer Service department by the 15th of the current month, your newborn's transfer will be effective on the first day of the following month. If the request for transfer is received after the 15th of the current month, your newborn's transfer will be effective the first day of the second succeeding month. For example, if you call PacifiCare on June 12th to request a new doctor for your newborn, the transfer will be effective on July 1st. If you call PacifiCare on June 16th, the transfer will be effective August 1st.

If your newborn has not been discharged from the hospital, is being followed by the Case Management or is receiving acute institutional or noninstitutional care at the time of your request, a change in your newborn's Primary Care Physician or Participating Medical Group will not be effective until the first day of the second month following the newborn's discharge from the institution or termination of treatment. When PacifiCare's Case Management is involved, the Case Manager is also consulted about the effective date of your requested Physician change for your newborn.

You can learn more about changing Primary Care Physicians in **Section 4. Changing Your Doctor or Medical Group**. (For more about adding a newborn to your coverage, see **Section 8. Member Eligibility**.)

Does your group or Hospital restrict any reproductive services?

Some Hospitals and other Providers do not provide one or more of the following services that may be covered under your plan contract 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, 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 the family planning benefits you need, and these benefits have been purchased by the University of California, please call our Customer Service department.

Seeing the Doctor

Section 2. Seeing the Doctor

- **Scheduling Appointments**
- **Referrals to Specialists**
- **PacifiCare Express Referrals®**
- **Seeing the OB/GYN**
- **Second Medical Opinions**
- **Prearranging Hospital Stays**

Now that you've chosen a Primary Care Physician, you have a doctor for your routine health care. Your Primary Care Physician will determine when you need a specialist, arrange any necessary Hospital care and oversee your health care needs. This section will help you begin taking advantage of your health care coverage. It will also answer common questions about seeing a specialist and receiving medical services that are not Emergency Services or Urgently Needed Services. (For information on see **Section 3. Emergency Services or Urgently Needed Services**.)

Seeing the Doctor: Scheduling Appointments

To visit your Primary Care Physician, simply make an appointment by calling your doctor's office. Your Primary Care Physician is your first stop for accessing care except when you need Emergency Services, or when you require Urgently Needed Services and you are outside of the area served by your Participating Medical Group, or when your Participating Medical Group is unavailable. Without an authorized referral from your Primary Care Physician or PacifiCare, no Physician or other health care services will be covered except for Emergency Services and Urgently Needed Services. (There is an exception if you wish to visit an obstetrical and gynecological Physician. See below, "OB/GYN: Getting Care Without a Referral.")

When you see your Primary Care Physician or use one of your health care benefits, you may be required to pay a charge for the visit. This charge is called a Copayment. The amount of a Copayment depends upon the health care service. Your Copayments are outlined in your *Schedule of Benefits*. More detailed information can also be found in **Section 7. Payment Responsibility**.

Referrals to Specialists and Non-Physician Health Care Practitioners

The Primary Care Physician you have selected will coordinate your health care needs. If your Primary Care Physician determines you need to see a specialist or Non-Physician Health Care Practitioner, he or she will make an appropriate referral. (There is an exception for visits to obstetrical and gynecological (OB/GYN) Physicians. This is explained in "OB/GYN: Getting Care without a Referral.")

(Your plan may not cover services provided by all Non-Physician Health Care Practitioners. Please refer to the "Medical Benefits" and "Exclusions and Limitations" sections in this *Combined Evidence of Coverage and Disclosure Form* for further information regarding Non-Physician Health Care Practitioner services excluded from coverage or limited under this Health Plan.)

Your Primary Care Physician will determine the number of specialist or Non-Physician Health Care Practitioner visits that you require and will provide you with any other special instructions.

This referral may also be reviewed by the Primary Care Physician's Utilization Review Committee. For more information regarding the role of the Utilization Review Committee, please refer to the definition of "Utilization Review Committee." A Utilization Review Committee meets on a regular basis as determined by membership needs, special requests or issues and the number of authorization or referral requests to be addressed. Decisions may be made outside of a formal committee meeting to assure a timely response to emergency or urgent requests.

PacifiCare Express Referrals®

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

Standing Referrals to Specialists

A standing referral is a referral by your Primary Care Physician that authorizes more than one visit to a participating specialist. A standing referral may be provided if your Primary Care Physician, in consultation with you, the specialist and your Participating Medical Group's Medical Director (or a PacifiCare Medical Director), determines that as part of a treatment plan you need continuing care from a specialist. You may request a standing referral from your Primary Care Physician or PacifiCare.

PLEASE NOTE: A standing referral and treatment plan is only allowed if approved by your Participating Medical Group or PacifiCare.

Your Primary Care Physician will specify how many specialist visits are authorized. The treatment plan may limit your number of visits to the specialist and the period for which visits are authorized. It may also require the specialist to provide your Primary Care Physician with regular reports on your treatment and condition.

Extended Referral for Care by a Specialist

If you have a life-threatening, degenerative or disabling condition or disease that requires specialized medical care over a prolonged period, you may receive an "extended specialty referral." This is a referral to a participating specialist or specialty care center, so the specialist can oversee your health care. The Physician or center will have the necessary experience and skills for treating the condition or disease.

You may request an extended specialty referral by asking your Primary Care Physician or PacifiCare. Your Primary Care Physician must then determine if it is Medically Necessary. Your Primary Care Physician will do this in consultation with the specialist or specialty care center, as well as your Participating Medical Group's Medical Director or a PacifiCare Medical Director.

If you require an extended specialty referral, the referral will be made according to a treatment plan approved by your Participating Medical Group's Medical Director or a PacifiCare Medical Director. This is done in consultation with your Primary Care Physician, the specialist and you. Once the extended specialty referral begins, the specialist begins serving as the main coordinator of your care. The specialist does this in accordance with your treatment plan.

OB/GYN: Getting Care Without a Referral

Women may receive obstetrical and gynecological (OB/GYN) Physician services directly from a Participating OB/GYN, family practice Physician, or surgeon identified by your Participating Medical Group as providing OB/GYN Physician services. This means you may receive these services without Preauthorization or a referral from your Primary Care Physician. In all cases, however, the doctor must be affiliated with your Participating Medical Group.

PLEASE REMEMBER: If you visit an OB/GYN or family practice Physician not affiliated with your Participating Medical Group without Preauthorization or a referral, you will be financially responsible for these services. All OB/GYN inpatient or Hospital Services, except Emergency or Urgently Needed Services, need to be authorized in advance by your Participating Medical Group or PacifiCare.

If you would like to receive OB/GYN Physician services, simply do the following:

- Call the telephone number on the front of your ID card and request the names and telephone numbers of the OB/GYNs affiliated with your Participating Medical Group;
- Telephone and schedule an appointment with your selected Participating OB/GYN.

After your appointment, your OB/GYN will contact your Primary Care Physician about your condition, treatment and any needed follow-up care.

PacifiCare also covers important wellness services for our Members. For more information, see "Health Education Services" in **Section 5: Your Medical Benefits**.

Second Medical Opinions

A second medical opinion is a reevaluation of your condition or health care treatment by an appropriately qualified Provider. This Provider must be either a Primary Care Physician or a specialist acting within his or her scope of practice and must possess the clinical background necessary for examining the illness or condition associated with the request for a second medical opinion. Upon completing the examination, the Provider's opinion is included in a consultation report.

Seeing the Doctor

Either you or your treating Participating Provider may submit a request for a second medical opinion. Requests should be submitted to your Participating Medical Group; however, in some cases, the request is submitted to PacifiCare. To find out how you should submit your request, talk to your Primary Care Physician.

Second medical opinions will be provided or authorized in the following circumstances:

- When you question the reasonableness or necessity of recommended surgical procedures;
- When you question a diagnosis or treatment plan 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);
- When the clinical indications are not clear, or are complex and confusing;
- When a diagnosis is in doubt due to conflicting test results;
- When the treating Provider is unable to diagnose the condition;
- When the treatment plan in progress is not improving your medical condition within an appropriate period of time given the diagnosis, and you request a second opinion regarding the diagnosis or continuance of the treatment;
- When you have attempted to follow the treatment plan or consulted with the initial Provider and still have serious concerns about the diagnosis or treatment.

Either the Participating Medical Group or, if applicable, a PacifiCare Medical Director will approve or deny a request for a second medical opinion. The request will be approved or denied in a timely fashion appropriate to the nature of your condition. For circumstances other than an imminent or serious threat to your health, a second medical opinion request will be approved or denied within five (5) business days after the request is received by the Participating Medical Group or PacifiCare.

When there is an imminent and serious threat to your health, a decision about your second opinion will be made within 72 hours after receipt of the request by your Participating Medical Group or PacifiCare. An imminent and serious threat includes the potential loss of life, limb or other major bodily function, or where a lack of timeliness would be detrimental to your ability to regain maximum function.

If you are requesting a second medical opinion about care given by your Primary Care Physician, the second medical opinion will be provided by an appropriately qualified health care professional of your choice within the same Participating Medical Group. (If your Primary Care Physician is independently contracted with PacifiCare and not affiliated with any Participating Medical Group, you may request a second opinion from a Primary Care Physician or specialist listed in our *Provider Directory*.) If you request a second medical opinion about care received from a specialist, the second medical opinion will be provided by any health care professional of your choice from any medical group within the PacifiCare Participating Provider network of the same or equivalent specialty.

The second medical opinion will be documented in a consultation report which will be made available to you and your treating Participating Provider. It will include any recommended procedures or tests that the Provider giving the second opinion believes are appropriate. If this second medical opinion includes a recommendation for a particular treatment, diagnostic test or service covered by PacifiCare – and the recommendation is determined to be Medically Necessary by your Participating Medical Group or PacifiCare – the treatment, diagnostic test or service will be provided or arranged by your Participating Medical Group or PacifiCare.

PLEASE NOTE: The fact that an appropriately qualified Provider gives a second medical opinion and recommends a particular treatment, diagnostic test or service does not necessarily mean that the recommended action is Medically Necessary or a Covered Service. You will also remain responsible for paying any outpatient office Copayments to the Provider who gives your second medical opinion.

If your request for a second medical opinion is denied, PacifiCare will notify you in writing and provide the reasons for the denial. You may appeal the denial by following the procedures outlined in **Section 9. Overseeing Your Health Care Decisions**. If you obtain a second medical opinion without Preauthorization from your Participating Medical

Group or PacifiCare, you will be financially responsible for the cost of the opinion.

To receive a copy of the Second Medical Opinion timeline, you may call or write PacifiCare's Customer Service department at:

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

What is PacifiCare's Case Management program?

PacifiCare has licensed registered nurses who, in collaboration with the Member, Member's family and the Member's Participating Medical Group, help arrange care for PacifiCare Members experiencing a major illness or recurring hospitalizations. Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's health care needs based on the health care benefits and available resources.

Prearranging Hospital Stays

Your Primary Care Physician will prearrange any Medically Necessary Hospital or facility care, including inpatient Transitional Care or care provided in a Subacute/Skilled Nursing Facility. If you've been referred to a specialist and the specialist determines you need hospitalization, your Primary Care Physician and specialist will work together to prearrange your Hospital stay.

Your Hospital costs, including semi-private room, tests and office visits, will be covered, minus any required Copayments, as well as any deductibles. Under normal circumstances, your Primary Care Physician will coordinate your admission to a local PacifiCare Participating Hospital or facility; however, if your situation requires it, you could be transported to a regional medical center.

If Medically Necessary, your Primary Care Physician may discharge you from the Hospital to a Subacute/Skilled Nursing Facility. He or she can also arrange for skilled home health care.

PLEASE NOTE: If a Hospitalist program applies, a Hospitalist may direct your inpatient hospital or facility care In consultation with of your Primary Care Physician.

Hospitalist Program

If you are admitted to a Participating Hospital for a Medically Necessary procedure or treatment, a Hospitalist may coordinate your health care services in consultation with your Primary Care Physician. A Hospitalist is a dedicated hospital-based Physician who assumes the primary responsibility for managing the process of inpatient care for Members who are admitted to a hospital. The Hospitalist will manage your hospital stay, monitor your progress, coordinates and consult with specialists, and communicate with your, your family and your Primary Care Physician. Hospitalists will work together with your Primary Care Physician during the course of your hospital stay to ensure coordination and continuity of care and to transition your care upon discharge. Upon discharge from the hospital, your Primary Care Physician will again take over the primary coordination of your health care services.

Emergency and Urgently Needed Services

Section 3. Emergency and Urgently Needed Services

- **What is an Emergency Medical Condition?**
- **What To Do When You Require Emergency Services**
- **What To Do When You Require Urgently Needed Services**
- **Post-Stabilization and Follow-Up Care**
- **Out-of-Area Services**
- **What To Do If You're Abroad**

Worldwide, wherever you are, PacifiCare provides coverage for Emergency Services and Urgently Needed Services. This section will explain how to obtain Emergency Services and Urgently Needed Services. It will also explain what you should do following receipt of these services.

IMPORTANT!

If you believe you are experiencing an Emergency Medical Condition, call 911 or go directly to the nearest Hospital emergency room or other facility for treatment.

What are Emergency Medical Services?

Emergency Services are Medically Necessary ambulance or ambulance transport services provided through the 911 emergency response system. It is also the 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. If this condition exists, Emergency Services include the care, treatment and/or surgery by a Physician necessary to stabilize or eliminate the Emergency Medical Condition or psychiatric medical condition within the capabilities of the facility.

What is an Emergency Medical Condition?

The state of California defines an Emergency Medical Condition as: 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, as a Prudent Layperson, to result in any of the following:

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

If you believe you are experiencing an Emergency Medical Condition, **call 911 or go directly to the nearest Hospital emergency room or other facility** for treatment. You do not need to obtain Preauthorization to seek treatment for an Emergency Medical Condition that could cause you harm.

What To Do When You Require Emergency Services

Ambulance transport services provided through the 911 emergency response system are covered if you reasonably believe that your medical condition requires emergency ambulance transport services. PacifiCare covers all Medically Necessary Emergency Services provided to Members in order to stabilize an Emergency Medical Condition.

You, or someone else on your behalf, must notify PacifiCare or your Primary Care Physician within 24 hours, or as soon as reasonably possible, following your receipt of Emergency Services so that your Primary Care Physician can coordinate your care and schedule any necessary follow-up treatment. When you call, please be prepared to give the name and location of the facility and a description of the Emergency Services that you received.

Post-Stabilization and Follow-up Care

Following the stabilization of an Emergency Medical Condition, the treating health care Provider may believe that you require additional Medically Necessary Hospital (health care) Services prior to your being safely discharged. In such a situation, the medical facility (Hospital) will contact your Participating Medical Group, or PacifiCare, in order to obtain the timely authorization for these post-stabilization services. PacifiCare reserves the right, in certain

circumstances, to transfer you to a Participating Hospital in lieu of authorizing post-stabilization services at the treating facility.

Following your discharge from the Hospital, any Medically Necessary follow-up medical or Hospital Services must be provided or authorized by your Primary Care Physician in order to be covered by PacifiCare. Regardless of where you are in the world, if you require additional follow-up medical or Hospital Services, please call your Primary Care Physician or PacifiCare's out-of-area unit to request authorization. PacifiCare's out-of-area unit can be reached during regular business hours (8 a.m. – 5 p.m. PST) at 1-800-762-8456.

Out-of-Area Services

PacifiCare arranges for the provision of Covered Services through its Participating Medical Groups and other Participating Providers. With the exception of Emergency Services, Urgently Needed Services, authorized post-stabilization care or other specific services authorized by your Participating Medical Group or PacifiCare, when you are away from the geographic area served by your Participating Medical Group, you are not covered for any other medical or Hospital Services. If you do not know the area served by your Participating Medical Group, please call your Primary Care Physician or the Participating Medical Group's administrative office to inquire.

The out-of-area services that are not covered include, but are not limited to:

- Routine follow-up care to Emergency or Urgently Needed Services, such as treatments, procedures, X-rays, lab work and doctor visits, Rehabilitation Services, Skilled Nursing Care or home health care.
- Maintenance therapy and durable medical equipment, including, but not limited to, routine dialysis, routine oxygen, routine laboratory testing or a wheelchair to assist you while traveling outside the geographic area served by your Participating Medical Group.
- Medical care for a known or Chronic Condition without acute symptoms as defined under Emergency Services or Urgently Needed Services
- Ambulance services are limited to transportation to the nearest facility with the expertise for treating your condition.

Your Participating Medical Group provides 24-hour access to request authorization for out-of-area care. You can also request authorization by calling the PacifiCare out-of-area Unit during regular business hours (8 a.m. – 5 p.m. PST) at **1-800-762-8456**.

What To Do When You Require Urgently Needed Services

If you need Urgently Needed Services when you are in the geographic area served by your Participating Medical Group, you should contact your Primary Care Physician or Participating Medical Group. The telephone numbers for your Primary Care Physician and/or Participating Medical Group are on the front of your PacifiCare ID card. Assistance is available 24 hours a day, seven days a week. Identify yourself as a PacifiCare Member and ask to speak to a Physician. If you are calling during nonbusiness hours and a Physician is not immediately available, ask to have the Physician-on-call paged. A Physician should call you back shortly. Explain your situation and follow any provided instructions. If your Primary Care Physician or Participating Medical Group is temporarily unavailable or inaccessible, you should seek Urgently Needed Services from a licensed medical professional wherever you are located.

You, or someone else on your behalf, 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. When you call, please be prepared to give a description of the Urgently Needed Services that you received.

Out-of-Area Urgently Needed Services

Urgently Needed Services are Medically Necessary health care services required to prevent the serious deterioration of a Member's health, resulting from an unforeseen illness or injury for which treatment cannot be delayed until the Member returns to the geographic area served by the Member's Participating Medical Group.

Urgently Needed Services are required in situations where a Member is temporarily outside the geographic area served by the Member's Participating Medical Group and the Member experiences a medical

condition that, while less serious than an Emergency Medical Condition, could result in the serious deterioration of the Member's health if not treated before the Member returns to the geographic area served by his or her Participating Medical Group or contacts his or her Participating Medical Group.

When you are temporarily outside the geographic area served by your Participating Medical Group and you believe that you require Urgently Needed Services, you should, if possible, call (or have someone else call on your behalf) your Primary Care Physician or Participating Medical Group as described in "What To Do When You Require Urgently Needed Services." The telephone numbers for your Primary Care Physician and/or Participating Medical Group are on the front of your PacifiCare ID card. Assistance is available 24 hours a day, seven days a week. Identify yourself as a PacifiCare Member and ask to speak to a Physician. If you are calling during nonbusiness hours and a Physician is not immediately available, ask to have the Physician-on-call paged. A Physician should call you back shortly. Explain your situation and follow any provided instructions.

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

You, or someone else on your behalf, 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. When you call, please be prepared to give a description of the Urgently Needed Services that you received.

International Emergency and Urgently Needed Services

If you are out of the country and require Urgently Needed Services, you should still, if possible, call your Primary Care Physician or Participating Medical Group. Just follow the same instructions outlined above. If you are out of the country and experience an Emergency Medical Condition, either use the available emergency response system or go directly to the nearest Hospital emergency room. Following receipt of Emergency Services, please notify your Primary Care Physician or Participating Medical Group within 24 hours, or as soon as reasonably possible, after initially receiving these services.

Note: Under certain circumstances, you may need to initially pay for your Emergency or Urgently Needed Services. If this is necessary, please pay for such services and then contact PacifiCare at the earliest opportunity. Be sure to keep all receipts and copies of relevant medical documentation. You will need these to be properly reimbursed. For more information on submitting claims to PacifiCare, please refer to **Section 7. Payment Responsibility** in this *Combined Evidence of Coverage and Disclosure Form*.

Always Remember

Emergency Services: Following receipt of Emergency Services, you, or someone else on your behalf, must notify PacifiCare or your Primary Care Physician within 24 hours, or as soon as reasonably possible, after initially receiving these services.

Urgently Needed Services: When you require Urgently Needed Services, you should, if possible, call (or have someone else call on your behalf) your Primary Care Physician or Participating Medical Group. If you are unable to contact your Primary Care Physician or Participating Medical Group, and you receive medical or Hospital Services, you must notify PacifiCare or your Primary Care Physician within 24 hours, or as soon as reasonably possible, of initially receiving these services.

Section 4. Changing Your Doctor or Medical Group

- **How To Change Your Primary Care Physician**
- **How To Change Your Participating Medical Group**
- **When We Change Your Physician or Medical Group**
- **When Medical Groups or Doctors Are Terminated by PacifiCare**

There may come a time when you want or need to change your Primary Care Physician or Participating Medical Group. This section explains how to make this change, as well as how we continue your care.

Changing Your Primary Care Physician

Whether you want to change doctors within your Participating Medical Group or transfer out of your Participating Medical Group entirely, you should contact our Customer Service department. PacifiCare will approve your request, if the Primary Care Physician you've selected is accepting new patients and meets the other criteria in **Section 1. Getting Started: Your Primary Care Physician**. This includes being located within 30 miles of your Primary Residence or Primary Workplace.

In addition, you must meet the following criteria:

- You are not an inpatient in a hospital, a Skilled Nursing Facility or other medical institution;
- Your pregnancy is not high-risk or has not reached the third trimester; and
- The change isn't likely to adversely affect the quality of your health care.

PacifiCare reviews these requests on a case-by-case basis. If you meet these requirements and call us by the 15th of the current month, your transfer will be effective on the first day of the following month. If you meet the criteria but your request is received after the 15th of the current month, your transfer will be effective the first day of the second succeeding month. For example, if you meet the above requirements and you call PacifiCare on June 12th to request a new doctor, the transfer will be effective on July 1st. If you meet the above requirements and you call PacifiCare on June 16th, the transfer will be effective August 1st.

If you are hospitalized, confined in a Skilled Nursing Facility, being followed by a Case Management program or receiving acute institutional or noninstitutional care at the time of your request, a change in your Primary Care Physician or Participating Medical Group will not be effective until the first day of the second month following your discharge from the institution or termination of treatment. When PacifiCare's Case Management is involved, the Case Manager is also consulted about the effective date of your Physician change request.

If you are changing Participating Medical Groups, our Customer Service department may be able to help smooth the transition. At the time of your request, please let us know if you are currently under the care of a specialist, receiving home health services or using durable medical equipment such as a wheelchair, walker, Hospital bed or an oxygen-delivery system.

Please Note: PacifiCare does not advise that you change your Primary Care Physician if you are an inpatient in a hospital, a Skilled Nursing Facility or other medical institution or are undergoing radiation or chemotherapy, as a change may negatively impact your coordination of care.

If you wish to transfer out of your Participating Medical Group and you are an inpatient in a hospital, a Skilled Nursing Facility or other medical institution, the change will not be effective until the first day of the second month following your discharge from the institution.

If you are pregnant and wish to transfer out of your Participating Medical Group and your pregnancy is high-risk or has reached the third trimester, to protect your health and the health of your unborn child, PacifiCare does not permit such change until after the pregnancy.

If you change your Participating Medical Group, authorizations issued by your previous Participating Medical Group will not be accepted by your new group. Consequently, you should request a new referral from your new Primary Care Physician within your new Participating Medical Group, which may require further evaluation by your new Participating Medical Group or PacifiCare

Please note that your new Participating Medical Group or PacifiCare may refer you to a different Provider than

the Provider identified on your original authorization from your previous group.

If you are changing Participating Medical Groups, our Customer Service department may be able to help smooth the transition. When PacifiCare's Case Management is involved, the Case Manager is also consulted about the effective date of your Physician change request. At the time of your request, please let us know if you are currently under the care of a specialist, receiving home health services or using durable medical equipment such as a wheelchair, walker, hospital bed or an oxygen-delivery system.

When We Change Your Participating Medical Group

Under special circumstances, PacifiCare may require that a Member change his or her Participating Medical Group. Generally, this happens at the request of the Participating Medical Group after a material detrimental change in its relationship with a Member. If this occurs, we will notify the Member of the effective date of the change, and we will transfer the Member to another Participating Medical Group, provided he or she is medically able and there's an alternative Participating Medical Group within 30 miles of the Member's Primary Residence or Primary Workplace.

PacifiCare will also notify the Member in the event that the agreement terminates between PacifiCare and the Member's Participating Medical Group. If this occurs, PacifiCare will provide 30 days of notice of the termination. PacifiCare will also assign the Member a new Primary Care Physician. If the Member would like to select a different Primary Care Physician, he or she may do so by contacting Customer Service. Upon the effective date of transfer, the Member can begin receiving services from his or her new Primary Care Physician.

PLEASE NOTE: Except for Emergency and Urgently Needed Services, once an effective date with your new Participating Medical Group has been established, a Member must use his or her new Primary Care Physician or Participating Medical Group to authorize all services and treatments. **Receiving services elsewhere will result in PacifiCare's denial of benefit coverage.**

Continuing Care With a Terminated Physician

Under certain circumstances, you may be eligible to continue receiving care from a Terminated Provider to ensure a smooth transition to a new Participating Provider and to complete a course of treatment with the same Terminated Provider or to maintain the same Terminating Provider.

The care must be Medically Necessary, and the cause of Termination by PacifiCare or your Participating Medical Group also has to be for a reason other than a medical disciplinary cause, fraud or any criminal activity.

For a Member to continue receiving care from a Terminated Provider, the following conditions must be met:

1. Continuity of Care services from a Terminated Provider must be Preauthorized by PacifiCare;
2. The requested treatment must be a Covered Service under this Plan;
3. The Terminated Provider must agree in writing to be subject to the same contractual terms and conditions that were imposed upon the Provider prior to Termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements, notwithstanding the provisions outlined in the Provider contract related to Continuity of Care;
4. The Terminated Provider must agree in writing to be compensated at rates and methods of payment similar to those used by PacifiCare or Participating Medical Groups/Independent Practice Associations (PMG/IPA) for current Participating Providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the Terminated Provider.

Covered Services provided by a Terminated Provider to a Member who at the time of the Participating Provider's contract Termination was receiving services from that Participating Provider for one of the Continuity of Care Conditions will be considered complete when:

i. The Member's Continuity of Care Condition under treatment is medically stable, and

ii. There are no clinical contraindications that would prevent a medically safe transfer to a Participating Provider as determined by a PacifiCare Medical Director in consultation with the Member, the Terminated Participating Provider and, as applicable, the Member's receiving Participating Provider.

Continuity of Care also applies to Members who are receiving Mental Health care services from a Terminated Mental Health Provider on the effective Termination date. Members eligible for continuity of Mental Health care services may continue to receive Mental Health services from the Terminated Mental Health Provider for a reasonable period of time to safely transition care to a Participating Mental Health Provider. Please refer to "Medical Benefits" and "Exclusions and Limitations" in **Section 5. Your Medical Benefits** of the PacifiCare *Combined Evidence of Coverage and Disclosure Form*, and the *Schedule of Benefits* for supplemental Mental Health care coverage information, if any. For a description of coverage of Mental Health care services for the diagnosis and treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED), please refer to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form*.

All Continuity of Care requests will be reviewed on a case-by-case basis. Reasonable consideration will be given to the severity of the Member's condition and the potential clinical effect of a change in Provider regarding the Member's treatment and outcome of the condition under treatment.

If you are receiving treatment for any of the specified Continuity of Care Conditions as limited and described in **Section 11. Definitions** and believe you qualify for continued care with the Terminating Provider, please call the Customer Service department and request the form "Request for Continuity of Care Benefits."

Complete and return the form to PacifiCare as soon as possible, but no later than thirty (30) calendar days of the Provider's effective date of Termination. Exceptions to the thirty (30)-calendar-day time frame will be considered for good cause. The address is:

PacifiCare
Attention: Continuity of Care Department
Mail Stop: CY 44-164
P.O. Box 6006
Cypress, California 90630-9938
Fax: 1-888-361-0514

PacifiCare's Health Services department will complete a clinical review of your Continuity of Care request for Completion of Covered Services with the Terminated Provider and the decision will be made and communicated in a timely manner appropriate for the nature of your medical condition. In most instances, decisions for nonurgent requests will be made within five (5) business days of PacifiCare's receipt of the completed form. You will be notified of the decision by telephone and provided with a plan for your continued care. Written notification of the decision and plan of care will be sent to you, by United States' mail, within two (2) business days of making the decision. If your request for continued care with a Terminated Provider is denied, you may appeal the decision. (To learn more about appealing a denial, please refer to **Section 9. Overseeing Your Health Care Decisions**.)

If you have any questions, would like a description of PacifiCare's continuity of care process, or want to appeal a denial, please contact our Customer Service department.

Please Note: It's not enough to simply prefer receiving treatment from a Terminated physician or other terminated Provider. You should not continue care with a terminated Provider without our formal approval. *If you do not receive Preauthorization by PacifiCare or your Participating Medical Group, payment for routine services performed from a Terminated Provider will be your responsibility.*

In the above section "Continuity of Care with a Terminating Provider," **Termination, Terminated** or **Terminating** references any circumstance which Terminates, non-renews or otherwise ends the arrangement by which the Participating Provider routinely renders Covered Services to PacifiCare Members.

Your Medical Benefits

Section 5. Your Medical Benefits

- **Inpatient Benefits**
- **Outpatient Benefits**
- **Exclusions and Limitations**
- **Other Terms of Your Medical Coverage**
- **Terms and Definitions**

This section explains your medical benefits, including what is and isn't covered by PacifiCare. You can find some helpful definitions in the back of this publication. For any Copayments that may be associated with a benefit, you should refer to your *Schedule of Benefits*, a copy of which is included with this document.

I. Inpatient Benefits*

These benefits are provided when admitted or authorized by either the Member's Participating Medical Group or PacifiCare. All services must be Medically Necessary as defined in this *Combined Evidence of Coverage and Disclosure Form.*

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

1. **Alcohol, Drug or Other Substance Abuse Detoxification –** Detoxification is the medical treatment of withdrawal from alcohol, drug or other substance addiction. Treatment in an acute care setting is covered for the acute stage of alcohol, drug or other substance abuse withdrawal when medical complications occur or are highly probable. Detoxification is initially covered up to 48 hours and extended when Medically Necessary. Methadone treatment for detoxification is not covered. Rehabilitation for substance abuse or addiction is not covered. (Coverage for rehabilitation of alcohol, drug or other substance abuse or addiction is covered as a supplemental benefit. Please see the "How Your PacifiCare Behavioral Health Benefits Work" section of this *Combined Evidence of Coverage and Disclosure Form*.)
2. **Blood and Blood Products –** Blood and blood products are covered. Autologous (self-donated), donor-directed, and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.
3. **Bloodless Surgery –** Surgical procedures performed without blood transfusions or blood products, including Rho(D) Immune Globulin for Members who object to such transfusion on religious grounds, are covered only when available within the Member's Participating Medical Group.
4. **Bone Marrow and Stem-Cell Transplants –** Non-Experimental/Non-Investigational autologous and allogeneic bone marrow and stem-cell transplants are covered. The testing of immediate blood relatives to determine the compatibility of bone marrow and stem cells is limited to immediate blood relatives who are sisters, brothers, parents and natural children. The testing for compatible unrelated donors and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem-cell donors conducted through a registry are covered when the Member is the intended recipient. Costs for such searches are covered up to a maximum of $15,000. A PacifiCare National Preferred Transplant Network Facility Center approved by PacifiCare must conduct the computerized searches. There is no dollar limitation for Medically Necessary donor-related clinical transplant services once a donor is identified.
5. **Cancer Clinical Trials –** All Routine Patient Care Costs related to an approved therapeutic clinical trial for cancer (Phases I, II, III and IV) are covered for a Member who is diagnosed with cancer and whose Participating Treating Physician recommends that the clinical trial has a meaningful potential to benefit the Member.

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

*The benefits described in **Section Five** will not be Covered Services unless they are determined to be Medically Necessary by Member's Participating Medical Group or PacifiCare and are provided by Member's Primary Care Physician or authorized by Member's Participating Medical Group or PacifiCare.

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

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

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

- Drugs or devices that have not been approved by the federal Food and Drug Administration and that are associated with the clinical trial.
- Services other than health care services, such as travel, transportation, housing, companion expenses and other nonclinical expenses that the Member may require as a result of the treatment being provided for purposes of the clinical trial.
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the Member's care.
- Health care services that, except for the fact that they are being provided in a clinical trial, are otherwise specifically excluded from coverage under PacifiCare.
- Health care services customarily provided by the research sponsor free of charge.

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

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

A clinical trial with end-points defined exclusively to test toxicity is not an approved clinical trial.

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

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

Any additional expenses the Member may have to pay beyond PacifiCare's negotiated rate as a result of using a Non-Participating Provider do not apply to the Member's annual Copayment maximum.

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

   Hospice services include skilled nursing services, certified home health aide services and homemaker services under the supervision of a qualified registered nurse; bereavement services; social services/counseling services; medical direction; volunteer services; pharmaceuticals, medical equipment and supplies that are reasonable and necessary for the palliation and management of the terminal illness and related conditions; and physical and occupational therapy and speech language pathology services for purposes of symptom control, or to enable the Member to maintain activities of daily living and basic functional skills. Inpatient Hospice services are provided in an appropriately licensed Hospice facility when the Member's interdisciplinary team has determined that the Member's care cannot be managed at home because of acute complications or when it is necessary to relieve the Family Members or other persons caring for the Member ("respite care"). Respite care is limited to an occasional basis and to no more than five (5) consecutive days at a time.

7. **Inpatient Hospital Benefits/Acute Care** – Medically Necessary inpatient Hospital Services authorized by the Member's Participating Medical Group or PacifiCare are covered, including, but not limited to: semi-private room; nursing and other licensed health professionals; intensive care; operating room; recovery room; laboratory and professional charges by the Hospital pathologist or radiologist; and other miscellaneous Hospital charges for Medically Necessary care and treatment.

8. **Inpatient Physician and Specialist Care** – Services from Physicians, including specialists and other licensed health professionals within, or upon referral from, the Member's Participating Medical Group, are covered while the Member is hospitalized as an inpatient. A specialist is a licensed health care professional with advanced training in an area of medicine or surgery.

9. **Inpatient Rehabilitation Care** – Rehabilitation Services that must be provided in an inpatient rehabilitation facility are covered. Inpatient rehabilitation consists of the combined and coordinated use of medical, social, educational and vocational measures for training or retraining individuals disabled by disease or injury. The goal of these services is for the disabled Member to obtain his or her highest level of functional ability. Rehabilitation Services include, but are not limited to, physical, occupational and speech therapy. This benefit does not include drug, alcohol or other substance abuse rehabilitation.

10. **Inpatient Transgender Surgery** – Inpatient Transgender surgery requires prior authorization from PacifiCare. Transgender surgery and services related to the surgery that are authorized by PacifiCare are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member. PacifiCare covers certain transgender surgery and services related to the surgery to change a Member's physical characteristics to those of the opposite gender.

    Travel expense reimbursement is limited to reasonable expenses for transportation, meals, and lodging for the Member to obtain authorized surgical consultation, transgender reassignment surgical procedure(s), and follow-up care, when the authorized surgeon and facility are located

*The benefits described in **Section Five** will not be Covered Services unless they are determined to be Medically Necessary by Member's Participating Medical Group or PacifiCare and are provided by Member's Primary Care Physician or authorized by Member's Participating Medical Group or PacifiCare.

more than 200 miles from the Member's Primary Residence. The transportation and lodging arrangements must be arranged by or approved in advance by PacifiCare. Reimbursement excludes coverage for alcohol and tobacco. Food and lodging expenses are not covered for any day a Member is not receiving authorized transgender reassignment services. Travel expenses are included in the $75,000 lifetime benefit maximum.

11. **Mastectomy, Breast Reconstruction After Mastectomy and Complications From Mastectomy** – Medically Necessary mastectomy and lymph node dissection are covered, including prosthetic devices and/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. Coverage is provided for surgery and reconstruction of the other breast if, in the opinion of the attending surgeon, this surgery is necessary to achieve symmetrical appearance. Medical treatment for any complications from a mastectomy, including lymphedema, is covered.

12. **Maternity Care** – Prenatal and maternity care services are covered, including labor, delivery and recovery room charges, delivery by cesarean section, treatment of miscarriage and complications of pregnancy or childbirth.

    - Educational courses on lactation, childcare and/or prepared childbirth classes are not covered.
    - Alternative birthing center services are covered when provided or arranged by a Participating Hospital affiliated with the Member's Participating Medical Group.
    - Licensed/Certificated nurse midwife services are covered only when available within the Member's Participating Medical Group.
    - Elective home deliveries are not covered.

    A minimum 48-hour inpatient stay for normal vaginal delivery and a minimum 96-hour inpatient stay following delivery by cesarean section are covered. Coverage for inpatient Hospital care may be for a time period less than the minimum hours if the decision for an earlier discharge of the mother and newborn 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 minimum time periods, a post-discharge follow-up visit for the mother and newborn will be provided within 48 hours of discharge, when prescribed by the treating Physician.

13. **Morbid Obesity (Surgical Treatment)** – PacifiCare covers Roux-en-Y gastric bypass or vertical banded gastroplasty surgical procedures when Medically Necessary and Preauthorized; PacifiCare utilized the National Institutes of Health (NIH) Consensus Report criteria as a factor for determining the Medical Necessity of requests for surgical treatment for morbid obesity. Please refer to your *Schedule of Benefits* under the inpatient hospitalization benefit for your Copayment information, if any.

14. **Newborn Care** – Postnatal Hospital Services are covered, including circumcision (if desired and performed in the Hospital) and special care nursery. A newborn Copayment applies in addition to the Copayment for maternity care, unless the newborn is discharged with the mother within 48 hours of the baby's normal vaginal delivery or within 96 hours of the baby's cesarean delivery. Circumcision is covered for male newborns prior to hospital discharge. See "Circumcision" under "Outpatient Benefits" for an explanation of coverage after hospital discharge.

15. **Organ Transplant and Transplant Services** – Non-experimental and non-investigational organ transplants and transplant services are covered when the recipient is a Member and the transplant is performed at a National Preferred Transplant Network Facility. Listing of the Member at a second Preferred Transplant Network Center is excluded, unless the Regional Organ Procurement Agencies are different for the two facilities and the Member is accepted for listing by both facilities. In these cases, organ transplant listing is limited to two National Preferred Transplant Network facilities. If the Member is dual listed, his or her coverage is limited to the actual transplant at the second facility. The Member will be responsible for any duplicated diagnostic costs incurred at the

second facility. Covered Services for living donors are limited to Medically Necessary clinical services once a donor is identified. Transportation and other nonclinical expenses of the living donor are excluded and are the responsibility of the Member who is the recipient of the transplant. (See the definition for "National Preferred Transplant Network.")

16. **Reconstructive Surgery** – Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. The purpose of reconstructive surgery is to correct abnormal structures of the body to improve function or create a normal appearance to the extent possible. Reconstructive procedures require Preauthorization by the Member's Participating Medical Group or PacifiCare in accordance with standards of care as practiced by Physicians specializing in reconstructive surgery. PacifiCare covers certain transgender surgery and services related to the surgery to change a Member's physical characteristics to those of the opposite gender. Inpatient and Outpatient Services for transgender surgery and services related to the surgery require prior authorization by PacifiCare and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member
17. **Skilled Nursing/Subacute and Transitional Care** – Medically Necessary Skilled Nursing Care and Skilled Rehabilitation Care are covered. The Member's Participating Medical Group or PacifiCare will determine where the Skilled Nursing Care and Skilled Rehabilitation Care will be provided.

    Skilled Nursing Facility room and board charges are covered up to 100 consecutive days per admission. Days spent out of a Skilled Nursing Facility when transferred to an acute Hospital setting are not counted toward the 100-consecutive-day room and board limitation when the Member is transferred back to a Skilled Nursing Facility. Such days spent in an acute Hospital setting also do not count toward renewing the 100-consecutive-day benefit. In order to renew the room and board coverage in a Skilled Nursing Facility, the Member must either be out of all Skilled Nursing Facilities for 60 consecutive days, or if the Member remains in a Skilled Nursing Facility, then the Member must not have received Skilled Nursing Care or Skilled Rehabilitation Care for 60 consecutive days.
18. **Voluntary Termination of Pregnancy** – Refer to the *Schedule of Benefits* for the terms of any coverage, if any.

II. Outpatient Benefits*

The following benefits are available on an outpatient basis and must be provided by the Member's Primary Care Physician or authorized by the Member's Participating Medical Group or PacifiCare. All services must be Medically Necessary as defined in this *Combined Evidence of Coverage and Disclosure Form*.

1. **Alcohol, Drug or Other Substance Abuse Detoxification** – Detoxification is the medical treatment of withdrawal from alcohol, drug or other substance addiction. Medically Necessary detoxification is covered. Methadone treatment for detoxification is not covered. In most cases of alcohol, drug or other substance abuse or toxicity, outpatient treatment is appropriate unless another medical condition requires close inpatient monitoring. Rehabilitation for substance abuse or addiction is not covered.
2. **Allergy Testing** – Allergy serum, as well as needles, syringes, and other supplies for the administration of the serum, are covered for the treatment of allergies. Allergy serum, needles and syringes must be obtained through a PacifiCare Participating Physician.
3. **Allergy Treatment** – Services and supplies are covered, including provocative antigen testing, to determine appropriate allergy treatment. Services and supplies for the treatment of allergies, including allergen/antigen immunotherapy and serum, are covered according to an established treatment plan.
4. **Ambulance** – The use of an ambulance (land or air) is covered without Preauthorization, when the Member, as a Prudent Layperson, reasonably

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believes that the medical or psychiatric condition requires Emergency Services, and an ambulance transport is necessary to receive these services. Such coverage includes, but is not limited to, ambulance or ambulance transport services provided through the 911 emergency response system. Ambulance transportation is limited to the nearest available emergency facility having the expertise to stabilize the Member's Emergency Medical Condition. Use of an ambulance for a non-Emergency Service is covered only when specifically authorized by the Member's Participating Medical Group or PacifiCare.

5. **Attention Deficit/Hyperactivity Disorder –** The medical management of Attention Deficit/ Hyperactivity Disorder (ADHD) is covered, including the diagnostic evaluation and laboratory monitoring of prescribed drugs. Coverage for outpatient prescribed drugs is covered as a supplemental benefit (please see "Outpatient Prescription Drug Program" section of this *Combined Evidence of Coverage and Disclosure Form*. This benefit does not include non-crisis mental health counseling or behavior modification programs.

6. **Blood and Blood Products –** Blood and blood products are covered. Autologous (self-donated), donor-directed, and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.

7. **Bloodless Surgery –** Please refer to the benefit described under "Inpatient Benefits for Bloodless Surgery." Outpatient services Copayments and/or deductibles apply for any services received on an outpatient basis.

8. **Cancer Clinical Trials –** Please refer to the benefit described under "Inpatient Cancer Clinical Trials." Outpatient services Copayments and/or deductibles apply for any Cancer Clinical Trials services received on an outpatient basis according to the Copayments for that specific outpatient service. PacifiCare is required to pay for the services covered under this benefit at the rate agreed upon by PacifiCare and a Participating Provider, minus any applicable Copayment, coinsurance or deductibles. In the event the Member participates in a clinical trial provided by a Non-Participating Provider that does not agree to perform these services at the rate PacifiCare negotiates with Participating Providers, the Member will be responsible for payment of the difference between the Non-Participating Provider's billed charges and the rate negotiated by PacifiCare with Participating Providers, in addition to any applicable Copayment, coinsurance or deductibles. Any additional expenses the Member may have to pay beyond PacifiCare's negotiated rate as a result of using a Non-Participating Provider do not apply to the Member's annual Copayment maximum.

9. **Circumcision –** Circumcision is covered for male newborns prior to hospital discharge. Circumcision is covered after hospital discharge only when:

   - Circumcision was delayed by the Participating Provider during initial hospitalization. Unless the delay was for medical reasons, the circumcision is covered after discharge only through the 28-day neonatal period, or
   - Circumcision was determined to be medically inappropriate during initial hospitalization due to medical reasons (for example, prematurity, congenital deformity, etc.). The circumcision is covered when the Participating Provider determines it is medically safe and only up to a maximum age of six months.

   Circumcision other than noted under the outpatient "Circumcision" benefit will be reviewed for Medical Necessity by the Participating Medical Group or PacifiCare Medical Director.

10. **Cochlear Implant Device –** An implantable cochlear device for bilateral, profoundly hearing impaired individuals who are not benefited from conventional amplification (hearing aids) is covered. Coverage is for Members at least 18 months of age who have profound bilateral sensory hearing loss or for prelingual Members with minimal speech perception under the best hearing aided condition. Please also refer to "Cochlear Implant Medical and Surgical Services."

11. **Cochlear Implant Medical and Surgical Services –** The implantation of a cochlear device for bilateral, profoundly hearing impaired or prelingual individuals who are not benefited from conventional amplification (hearing aids) is

covered. This benefit includes services needed to support the mapping and functional assessment of the cochlear device at the authorized Participating Provider. (For an explanation of speech therapy benefits, please refer to "Outpatient Medical Rehabilitation Therapy.")

12. **Dental Treatment Anesthesia** – See "Oral Surgery and Dental Services: Dental Treatment Anesthesia."

13. **Diabetic Management and Treatment** – Coverage includes outpatient self-management training, education and medical nutrition therapy services. The diabetes outpatient self-management training, education and medical nutrition therapy services covered under this benefit will be provided by appropriately licensed or registered health care professionals. These services must be provided under the direction of and prescribed by a Participating Provider.

14. **Diabetic Self-Management Items** – Equipment and supplies for the management and treatment of Type 1, Type 2 and gestational diabetes are covered, based upon the medical needs of the Member, including, but not necessarily limited to: blood glucose monitors; blood 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, podiatry services and devices to prevent or treat diabetes-related complications. Members must have coverage under the Outpatient Prescription Drug Benefit for insulin, glucagon and other diabetic medications to be covered. Visual aids are covered for Members who have a visual impairment that would prohibit the proper dosing of insulin. Visual aids do not include eyeglasses (frames and lenses) or contact lenses. The Member's Participating Provider will prescribe insulin syringes, lancets, glucose test strips and ketone urine test strips to be filled at a pharmacy that contracts with PacifiCare.

15. **Dialysis** – Acute and chronic hemodialysis services and supplies are covered. For chronic hemodialysis, application for Medicare Part A and Part B coverage must be made. Chronic dialysis (peritoneal or hemodialysis) must be authorized by the Member's Participating Medical Group or PacifiCare and provided within the Member's Participating Medical Group. The fact that the Member is outside the geographic area served by the Participating Medical Group will not entitle the Member to coverage for maintenance of chronic dialysis to facilitate travel.

16. **Durable Medical Equipment (Rental, Purchase or Repair)** – Durable Medical Equipment is covered when it is designed to assist in the treatment of an injury or illness of the Member, and the equipment is primarily for use in the home. Durable Medical Equipment is medical equipment that can exist for a reasonable period of time without significant deterioration. Examples of covered Durable Medical Equipment include wheelchairs, hospital beds, standard oxygen-delivery systems and equipment for the treatment of asthma (nebulizers, masks, tubing and peak flow meters, the equipment and supplies must be prescribed by and are limited to the amount requested by the Participating Physician). Outpatient drugs, prescription medications and inhaler spacers for the treatment of asthma are available under the prescription drug benefit if purchased as a supplemental benefit. Please refer to the *Pharmacy Schedule of Benefits*, "Medication Covered By Your Benefit" under "Miscellaneous Prescription Drug Coverage" for coverage.

    - Replacements, repairs and adjustments to Durable Medical Equipment are limited to normal wear and tear or because of a significant change in the Member's physical condition. The Member's Participating Medical Group or PacifiCare has the option to repair or replace Durable Medical Equipment items. Replacement of lost or stolen Durable Medical Equipment is not covered. The following equipment and accessories are not covered: Non-Medically Necessary optional attachments and modifications to Durable Medical Equipment for the comfort

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or convenience of the Member, accessories for portability or travel, a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment, and home and/or car modifications to accommodate the Member's condition.

For a detailed listing of covered Durable Medical Equipment, please contact the PacifiCare Customer Service department at 1-800-624-8822.

17. **Family Planning –** Refer to the *Schedule of Benefits* for the specific terms of coverage under your Health Plan.

18. **Footwear –** Specialized footwear, including foot orthotics, custom-made or standard orthopedic shoes, are covered for a Member with diabetic foot disease or when an orthopedic shoe is permanently attached to a Medically Necessary orthopedic brace.

19. **Health Education Services –** Includes wellness programs such as a stop smoking program available to enrolled Members. PacifiCare also makes health and wellness information available to Members. For more information about the stop smoking program or any other wellness program, call the PacifiCare Customer Service department at 1-800-624-8822, or visit the PacifiCare Web site.

    The Member's Participating Medical Group may offer additional community health programs. These programs are independent of health improvement programs offered by PacifiCare and are not covered. Fees charged will not apply to the Member's Copayment maximum.

20. **Home Health Care –** A Member is eligible to receive Home Health Care Visits if the Member: (i) is confined to the home (home is wherever the Member makes his or her home but does not include acute care, rehabilitation or Skilled Nursing Facilities); (ii) needs Medically Necessary skilled nursing visits or needs physical, speech or occupational therapy; and (iii) the Home Health Care Visits are provided under a plan of care established and periodically reviewed and ordered by a PacifiCare Participating Provider. "Skilled Nursing Services" means the services provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a Home Health Aide. Skilled nursing visits may be provided by a registered nurse or licensed vocational nurse.

    If a Member is eligible for Home Health Care Visits in accordance with the authorized treatment plan, the following Medically Necessary Home Health Care Visits may be included but are not limited to:

    a. Skilled nursing visits;

    b. Home Health Aide Services visits that provide supportive care in the home which are reasonable and necessary to the Member's illness or injury;

    c. Physical, occupational, or speech therapy that is provided on a per visit basis;

    d. Medical supplies, durable medical equipment; and

    e. Infusion therapy medications and supplies and laboratory services as prescribed by a Participating Provider to the extent such services would be covered by PacifiCare had the Member remained in the hospital, rehabilitation or Skilled Nursing Facility.

    f. Drugs, medications and related pharmaceutical services are covered for those Members enrolled in PacifiCare's Outpatient Prescription Benefit. Outpatient prescription drugs may be available as a supplemental benefit. Please refer to your *Schedule of Benefits*.

    If the Member's Participating Medical Group determines that Skilled Nursing Service needs are more extensive than the services described in this benefit, the Member will be transferred to a Skilled Nursing Facility to obtain services. PacifiCare, in consultation with the Member's Participating Medical Group, will determine the appropriate setting for delivery of the Member's Skilled Nursing Services.

    Please refer to the *Schedule of Benefits* for any applicable Copayments and benefit limitations.

21. **Hospice Services –** Hospice services are covered for Members with a terminal illness, defined as a medical condition resulting in a prognosis of life expectancy of one year or less, if the disease follows its natural course. Hospice services are provided pursuant to the plan of care developed

by the Member's interdisciplinary team, which includes, but is not limited to, the Member, the Member's Primary Care Physician, a registered nurse, a social worker and a spiritual caregiver.

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

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

22. **Immunizations** – Immunizations for children (through age 18 years) are covered consistent with the most current version of the Recommended Childhood Immunization Schedule/United States[1]. An exception is made if, within 45 days of the published date of the schedule, the State Department of Health Services determines that the schedule is not consistent with state law.

    Immunizations for adults are covered consistent with the most current recommendations of the Center for Disease Control (CDC) for routine adult immunizations as advised by the Advisory Committee on Immunization Practices. For children under 2 years of age, refer to "Periodic Health Evaluations – Well Baby." Routine boosters and immunizations must be obtained through the Member's Participating Medical Group. Travel and/or required work immunizations are not covered.

23. **Infertility Services** – Please refer to the *Schedule of Benefits* for coverage, if any. Coverage for Infertility Services is only available if purchased by the Subscriber's Employer Group as a supplemental benefit. If the Member's Health Plan includes an Infertility Services supplemental benefit, a supplement to the Combined Evidence of Coverage and Disclosure Form will be provided to the member.

24. **Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications)** –

    - **Infusion Therapy** – Infusion therapy refers to the therapeutic administration of drugs or other prepared or compounded substances by the Intravenous route. Infusion therapy is covered when furnished as part of a treatment plan authorized by the Member's Primary Care Physician, Participating Medical Group or PacifiCare. The infusions must be administered in the Member's home, Participating Physician's office or in an institution, such as a board and care, Custodial Care, or assisted living facility, that is not a hospital or institution primarily engaged in providing Skilled Nursing Services or Rehabilitation Services.

    - **Outpatient Injectable Medications** – Outpatient injectable medications (except insulin) include those drugs or preparations which are not usually self-administered and which are given by the Intramuscular or Subcutaneous route. Outpatient injectable medications (except insulin) are covered when administered as a customary component of a Physician's office visit, and when not otherwise limited or excluded (e.g., insulin, certain

[1] This is jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Family Physicians.

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immunizations, infertility drugs, birth control, or off-label use of covered injectable medications). Outpatient injectable medications must be obtained through a Participating Provider, the Member's Participating Medical Group or PacifiCare Designated Pharmacy, and may require Preauthorization by PacifiCare.

- **Self-Injectable Medications** – Self-injectable medications (except insulin) are defined as those drugs which are either generally self-administered by Intramuscular injection at a frequency of one or more times per week, or which are generally self-administered by the Subcutaneous route. Self-injectable medications (except insulin) are covered when prescribed by a Participating Provider, as authorized by the Member's Participating Medical Group or by PacifiCare. Self-injectable medications must be obtained through a Participating Provider, through the Member's Participating Medical Group or PacifiCare-designated pharmacy/specialty injectable vendor, and may require Preauthorization by PacifiCare. A separate Copayment applies to all self-injectable medications for a 30-day supply (or for the prescribed course of treatment if shorter), whether self-administered or injected in the Physician's office, and is applied in addition to any office visit Copayment.

25. **Laboratory Services** – Medically Necessary diagnostic and therapeutic laboratory services are covered.

26. **Maternity Care, Tests and Procedures** – Physician visits, laboratory services (including the California Department of Health Services' expanded alpha fetoprotein (AFP) program) and radiology services are covered for prenatal and postpartum maternity care. Nurse midwife services are covered when available within and authorized by the Member's Participating Medical Group. Genetic testing and counseling are covered when authorized by the Member's Participating Medical Group as part of an amniocentesis or chorionic villus sampling procedure.

27. **Medical Supplies and Materials** – Medical supplies and materials necessary to treat an illness or injury are covered when used or furnished while the Member is treated in the Participating Provider's office, during the course of an illness or injury, or stabilization of an injury or illness, under the direct supervision of the Participating Provider. Examples of items commonly furnished in the Participating Provider's office to treat the Member's illness or injury are gauzes, ointments, bandages, slings and casts.

28. **Mental Health Services** – Only services to treat Severe Mental Illness for adults and children, and Serious Emotional Disturbances of a Child are covered. (See your Supplement to this *Combined Evidence of Coverage and Disclosure Form* for a description of this coverage.) Refer to the *Schedule of Benefits* for additional coverage of Mental Health Services, if any.

29. **OB/GYN Physician Care** – See "Physician OB/GYN Care."

30. **Oral Surgery and Dental Services** – Emergency Services for stabilizing an acute injury to sound natural teeth, the jawbone or the surrounding structures and tissues are covered. Coverage is limited to treatment provided within 48 hours of injury or as soon as the member is medically stable. Other covered oral surgery and dental services include:

    - Oral surgery or dental services, rendered by a Physician or dental professional, for treatment of primary medical conditions. Examples include, but are not limited to:
    - Biopsy and excision of cysts or tumors of the jaw, treatment of malignant neoplastic disease(s) and treatment of temporomandibular joint syndrome (TMJ);
    - Biopsy of gums or soft palate;
    - Oral or dental examinations performed on an inpatient or outpatient basis as part of a comprehensive workup prior to transplantation surgery;
    - Preventive fluoride treatment prior to an aggressive chemotherapeutic or radiation therapy protocol. Fluoride trays and/or bite guards used to protect the teeth from caries and possible infection during radiation therapy;
    - Reconstruction of a ridge that is performed as a result of and at the same time as the surgical removal of a tumor (for other than dental purposes);

- Reconstruction of the jaw when Medically Necessary (e.g., radical neck or removal of mandibular bone for cancer or tumor);
- Ridge augmentation or alveoplasty are covered when determined to be Medically Necessary based on state cosmetic reconstructive surgery law and jawbone surgery law;
- Setting of the jaw or facial bones;
- Tooth extraction prior to a major organ transplant or radiation therapy of neoplastic disease to the head or neck;
- Treatment of maxillofacial cysts, including extraction and biopsy.

Dental Services beyond emergency treatment to stabilize an acute injury, including, but not limited to, crowns, fillings, dental implants, caps, dentures, braces, dental appliances and orthodontic procedures, are not covered. Charges for the dental procedure(s) beyond emergency treatment to stabilize an acute injury, 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; dental services including those for crowns, root canals, replacement of teeth; complete dentures, gold inlays, fillings and other dental services specific to the replacement of teeth or structures directly supporting the teeth and other dental services specific to the treatment of the teeth, are not covered except for services covered by PacifiCare under this outpatient benefit, "Oral Surgery and Dental Services."

31. **Oral Surgery and Dental Services: Dental Treatment Anesthesia** – Anesthesia and associated facility charges for dental procedures provided in a Hospital or outpatient surgery center are covered when: (1) the Member's clinical status or underlying medical condition requires use of an outpatient surgery center or inpatient setting for the provision of the anesthesia for dental procedure(s) that ordinarily would not require anesthesia in a Hospital or outpatient surgery center setting; and (2) one of the following criteria is met:
    - The Member is under 7 years of age;
    - The Member is developmentally disabled, regardless of age; or
    - The Member's health is compromised and general anesthesia is Medically Necessary, regardless of age.

    The Member's dentist must obtain Preauthorization from the Member's Participating Medical Group or PacifiCare before the dental procedure is provided.

    Dental Anesthesia in a dental office or dental clinic 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, "Oral Surgery and Dental Services."
32. **Outpatient Medical Rehabilitation Therapy** – Services provided by a registered physical, speech or occupational therapist for the treatment of an illness, disease or injury are covered.
33. **Outpatient Surgery** – Short-stay, same-day or other similar outpatient surgery facilities are covered when provided as a substitute for inpatient care.
34. **Outpatient Transgender Services** – Outpatient Services including outpatient surgery services for transgender surgery, services related to the surgery, outpatient office visit, and related services require prior authorization by PacifiCare and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member. PacifiCare covers certain transgender surgery and services related to the surgery to change a Member's physical characteristics to those of the opposite gender.

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35. **Periodic Health Evaluation** – Periodic Health Evaluations are covered as recommended by PacifiCare's Preventive Health Guidelines and the Member's Primary Care Physician. This may include, but is not limited to, the following screenings:

    - Breast Cancer Screening and Diagnosis – Services are covered for the screening and diagnosis of breast cancer. Screening and diagnosis will be covered consistent with generally accepted medical practice and scientific evidence, upon referral by the Member's Primary Care Physician. Mammography for screening or diagnostic purposes is covered as authorized by the Member's participating nurse practitioner, participating certified nurse midwife or Participating Provider.
    - Hearing Screening – Routine hearing screening by a participating health professional is covered to determine the need for hearing correction. Hearing aids are not covered, nor is their testing or adjustment. (Hearing Screenings are limited to Dependents under age 19.)
    - Prostate Screening – Evaluations for the screening and diagnosis of prostate cancer is covered (including, but not limited to, prostate-specific antigen testing and digital rectal examination). These evaluations are provided when consistent with good professional practice.
    - Vision Screening – Annual routine eye health assessment and screening by a Participating Provider are covered to determine the health of the Member's eyes and the possible need for vision correction. An annual retinal examination is covered for Members with diabetes.
    - Well-Baby Care – Up to the age of 2, preventive health services are covered (including immunizations) when provided by the child's Participating Medical Group. An office Copayment applies when infants are ill at the time services are provided.
    - Well-Woman Care – Medically Necessary services, including a Pap smear (cytology), are covered. The Member may receive obstetrical and gynecological Physician services directly from an OB/GYN or Family Practice Physician or surgeon (designated by the Member's Participating Medical Group as providing OB/GYN services) affiliated with Member's Participating Medical Group.

    Please refer to your *Schedule of Benefits* for applicable Copayments.

36. **Phenylketonuria (PKU) Testing and Treatment** – Testing for Phenylketonuria (PKU) is covered to prevent the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU enzyme deficiency. PKU includes those formulas and special food products that are part of a diet prescribed by a Participating Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who participates in or is authorized by PacifiCare, provided that the diet is deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. Special food products do not include food that is naturally low in protein but may include a special low-protein formula specifically approved for PKU and special food products that are specially formulated to have less than 1 gram of protein per serving.

37. **Physician Care (Primary Care Physician and Specialist)** – Diagnostic, consultation and treatment services provided by the Member's Primary Care Physician are covered. Services of a specialist are covered upon referral by Member's Participating Medical Group or PacifiCare. A specialist is a licensed health care professional with advanced training in an area of medicine or surgery.

38. **Physician OB/GYN Care** – The Member may obtain obstetrical and gynecological Physician services directly from an OB/GYN, Family Practice Physician or surgeon (designated by the Member's Participating Medical Group as providing OB/GYN services) affiliated with the Member's Participating Medical Group.

39. **Prosthetics and Corrective Appliances –** Prosthetics and Corrective Appliances Prosthetics (except for bionic or myoelectric as explained below) are covered when Medically Necessary as determined by the Member's Participating Medical Group or PacifiCare. 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 contact lens in an eye following a surgical cataract extraction and removable, non-dental prosthetic devices such as a limb that does not require surgical connection to nerves, muscles or other tissue.

    Custom-made or custom-fitted corrective appliances are covered when Medically Necessary as determined by the Member's Participating Medical Group or PacifiCare. Corrective appliances are devices that are designed to support a weakened body part. These appliances are manufactured or custom-fitted to an individual Member.

    - Bionic and myoelectric prosthetics are not covered. Bionic prosthetics are prosthetics that require surgical connection to nerves, muscles or other tissues. Myoelectric prosthetics are prosthetics which have electric motors to enhance motion.
    - Deluxe upgrades that are not Medically Necessary are not covered.
    - Replacements, repairs and adjustments to corrective appliances and prosthetics coverage are limited to normal wear and tear or because of a significant change in the Member's physical condition. Repair or replacement must be authorized by the Member's Participating Medical Group or PacifiCare.
    - Refer to "Footwear" in Benefits Available on an Outpatient Basis.

    For a detailed listing of covered durable medical equipment, including prosthetic and corrective appliances, please contact the PacifiCare Customer Service department at 1-800-624-8822.

40. **Radiation Therapy (Standard and Complex) –**
    - Standard photon beam radiation therapy is covered.
    - Complex radiation therapy is covered. This therapy requires specialized equipment, as well as specially trained or certified personnel to perform the therapy. Examples include, but are not limited to: brachytherapy (radioactive implants) and conformal photon beam radiation. (Gamma knife procedures and stereotactic procedures are covered as outpatient surgeries for the purpose of determining Copayments. (Please refer to your *Schedule of Benefits* for applicable Copayment, if any.)
41. **Reconstructive Surgery –** Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. The purpose of reconstructive surgery is to improve function or create a normal appearance to the extent possible. Reconstructive procedures require Preauthorization by the Member's Participating Medical Group or PacifiCare in accordance with standards of care as practiced by Physicians specializing in reconstructive surgery.
42. **Refractions –** Routine testing every 12 months is covered to determine the need for corrective lenses (refractive error), including a written prescription for eyeglass lenses. (Coverage for frames and lenses may be available if the Member's Health Plan includes a supplemental vision benefit.) Coverage under this benefit also includes one initial pair of eyeglasses when prescribed following cataract surgery with an intra ocular lens implant. Eyeglasses must be obtained through Participating Medical Group.
43. **Standard X-Rays –** Standard X-rays are covered for the diagnosis of an illness or injury, or to screen for certain defined diseases. Standard X-rays are defined to included conventional plain film X-rays, oral and rectal contrast gastrointestinal studies (such as upper GIs, barium enemas, and oral cholecystograms), mammograms, obstetrical

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ultrasounds, and bone mineral density studies (including ultrasound and DEXA scans).

44. **Specialized Scanning and Imaging Procedures** – Specialized Scanning and Imaging Procedures are covered for the diagnosis and ongoing medical management of an illness or injury. Specialized procedures are defined to include those which, unless specifically classified as Standard X-rays, are digitally processed, or computer-generated, or which require contrast administered by injection or infusion. Examples of Specialized Scanning and Imaging Procedures include, but are not limited to, the following scanning and imaging procedure: CT,PET, SPECT, MRI, MRA, EKG, EEG, EMG, and nuclear scans, anigograms (includes heart catherterizations), arthrograms and myelograms.

III. Exclusions and Limitations of Benefits

Unless described as a Covered Service in an attached supplement, all services and benefits described below are excluded from coverage or limited under this Health Plan. Any supplement must be an attachment to this *Combined Evidence of Coverage and Disclosure Form*. (**NOTE:** Additional exclusions and limitations may be included with the explanation of your benefits in the additional materials.)

General Exclusions

Services that are not Medically Necessary, as defined in the "Definitions" section of this *Combined Evidence of Coverage and Disclosure Form*, are not covered. Services not specifically included in this *Combined Evidence of Coverage and Disclosure Form*, or any supplement purchased by the Subscriber's Employer Group, are not covered.

1. Services that are rendered without authorization from the Member's Participating Medical Group or PacifiCare (except for Emergency Services or Urgently Needed Services described in this *Combined Evidence of Coverage and Disclosure Form* and for obstetrical and gynecological Physician services obtained directly from an OB/GYN, Family Practice Physician or surgeon designated by the Member's Participating Medical Group as providing OB/GYN services) are not covered.
2. Services obtained from Non-Participating Providers or Participating Providers who are not affiliated with the Member's Participating Medical Group, when such services were offered or authorized by the Member's Participating Medical Group and the Member refused to obtain the services as offered by the Member's Participating Medical Group, are not covered.
3. Services rendered prior to the Member's effective date of enrollment or after the effective date of disenrollment are not covered.
4. PacifiCare does not cover the cost of services provided in preparation for a non-Covered Service where such services would not otherwise be Medically Necessary. Additionally, PacifiCare does not cover the cost of routine follow-up care for non-Covered Services (as recognized by the organized medical community in the state of California). PacifiCare will cover Medically Necessary services directly related to non-Covered Services when complications exceed routine follow-up care such as life-threatening complications of cosmetic surgery.
5. Services performed by immediate relatives or members of your household are not covered.
6. Services obtained outside the Service Area are not covered except for Emergency Services or Urgently Needed Services.

Other Exclusions and Limitations

1. **Acupuncture and Acupressure** – Acupuncture and acupressure are not covered.
2. **Air Conditioners, Air Purifiers and Other Environmental Equipment** – Air conditioners, air purifiers and other environmental equipment are not covered.
3. **Alcoholism, Drug Addiction and Other Substance Abuse Rehabilitation** – Inpatient, outpatient and day treatment rehabilitation for chronic alcoholism, drug addiction or other substance abuse are not covered. Methadone treatment for detoxification is not covered. Coverage for rehabilitation of alcohol, drug or other substance abuse or addiction may be covered as a supplemental benefit (please see **Section 6. How Your PacifiCare Behavioral Health Benefits Work** of this *Combined Evidence of Coverage and Disclosure Form*).

Not Covered:

- Rapid anesthesia opioid detoxification;
- Alcoholism, drug addiction and other substance abuse rehabilitation services beyond detoxification are not covered;
- Services that are required by a court order as a part of parole or probation, or instead of incarceration.

4. **Ambulance** – Ambulance service is covered only when Medically Necessary. Ambulance service is not covered when used only for the Member's convenience, or when another available form of transportation would be more appropriate except under circumstances when a Member believes that there is an emergency. Wheelchair transportation services (e.g., a private vehicle or taxi faire) are also not covered.

   Please refer to "Ambulance" in the "Outpatient Benefits" section and "Organ Transplants" in the "Other Exclusions and Limitations" section.

5. **Artificial Hearts and Ventricular Assist Devices (VADs)** – Artificial hearts and Ventricular Assist Devices as destination therapy devices are considered experimental and are therefore not covered. Destination therapy is defined as, "the VAD is placed with the expectation that the patient will likely require permanent mechanical cardiac support." Ventricular Assist Devices (VADs) are limited to use as a bridge or temporary device for Members authorized for heart transplantation or to support circulation of blood following open-heart surgery (postcardiotomy).

   A Member may be entitled to an expedited external, independent review of PacifiCare's coverage determination regarding Experimental or Investigational therapies as described in **Section 9. Overseeing Your Health Care Decisions**.

6. **Bariatric Surgery** – Bariatric surgery will only be covered when Medically Necessary for the treatment of Morbid Obesity. PacifiCare will use scientifically valid, evidence-based criteria to determine coverage of bariatric surgery, such as the most recent National Institutes of Health (NIH) guidelines, in determining the medical necessity of requests for surgical treatment for morbid obesity. PacifiCare requires the Member to participate in a PacifiCare sponsored/approved program for no less than 6 months, which includes but is not limited to a multidisciplinary nonsurgical approach to supervised diet, exercise and behavioral modification. Furthermore, documented success by the treating physician that the Member complied with the non-surgical program must occur in order for the Member to qualify for surgical consideration. If a Member is unable to finish the six month program or participate in the program due to extenuating medical circumstances, the Member may qualify for bariatric surgery if approved by the Member's Participating Medical Group's Medical Director (or a PacifiCare Medical Director) in consultation with the treating physician. After surgery the Member must actively participate in a PacifiCare multi-disciplinary program of diet, exercise, and behavior modification.

   Surgical treatments for morbid obesity and services related to this surgery are subject to prior approval by PacifiCare's Medical Director or designee, and are limited to one (1) procedure per Member's lifetime except as approved by PacifiCare's Medical Director or designee when due to medical or surgical complications, it is Medically Necessary and not as a result of non-compliance. Please also see Weight Alteration Program (Inpatient or Outpatient).

7. **Behavior Modification and Non-crisis Mental Health Counseling and Treatment** – Behavior modification and non-crisis mental health counseling and treatment are not covered. Examples include, but are not limited to, art therapy, music therapy and play therapy.

8. **Biofeedback** – Biofeedback services are not covered except for bladder rehabilitation as part of an authorized treatment plan.

9. **Blood and Blood Products** – The costs of transportation and processing for autologous, donor-directed or donor-designated blood are

*The benefits described in **Section Five** will not be Covered Services unless they are determined to be Medically Necessary by Member's Participating Medical Group or PacifiCare and are provided by Member's Primary Care Physician or authorized by Member's Participating Medical Group or PacifiCare.

not covered in excess of $120.00 per unit for a scheduled procedure.

10. **Bloodless Surgery Services** – Bloodless surgery services are only covered to the extent available within the Member's Participating Medical Group.

11. **Bone Marrow and Stem-Cell Transplants** – Autologous or allogeneic bone marrow or stem-cell transplants are not covered when they are Experimental or Investigational unless required by an external, independent review panel as described in **Section 9. Overseeing Your Health Care Decisions** of this *Combined Evidence of Coverage and Disclosure Form*, under the caption "Independent Medical Review Procedures." Unrelated Donor Computer Searches for Members who require a bone marrow or stem-cell transplant are limited to $15,000. Unrelated Donor Searches must be performed at a PacifiCare approved transplant center. (See "National Preferred Transplant Network" in **Section 11. Definitions**.)

12. **Chiropractic Care** – Care and treatment provided by a chiropractor are not covered.

13. **Communication Devices** – Computers, personal digital assistants and any speech-generating devices are not covered. Please also refer to "Durable Medical Equipment" and "Prosthetic and Corrective Appliances." For a detailed listing of covered durable medical equipment, including prosthetic and corrective appliances, please contact the PacifiCare Customer Service department at 1-800-624-8822.

14. **Complementary and Alternative Medicine** – Complementary and Alternative Medicine is not covered. (See the definition for "Complementary and Alternative Medicine.")

15. **Cosmetic Services and Surgery** – Cosmetic surgery and cosmetic services are not covered. Cosmetic surgery and cosmetic services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered. Cosmetic surgeries or cosmetic services do not become reconstructive surgery because of a Member's psychological or psychiatric condition. PacifiCare covers certain transgender surgery and services related to the surgery to change a Member's physical characteristics to those of the opposite gender. Inpatient and Outpatient Services for transgender surgery and services related to the surgery require prior authorization by PacifiCare and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member.

    No benefits are provided for:

    a. Liposuction to reshape waist, hips, thighs and buttocks;

    b. Cosmetic chest reconstruction or augmentation mammoplasty;

    c. Electrolysis and laser hair removal, except when required as part of covered transgender genital reconstruction surgery;

    d. Drugs for hair loss or growth;

    e. Voice therapy or voice modification surgery;

    f. Sperm or gamete procurement for future infertility or storage of sperm, gametes, or embryos;

    g. Penile implant devices, penile device implantation, and penile implant revision or reinsertion;

    h. Intersex surgery (transsexual operations) except as specifically provided under the "Limited Transgender Benefit" or treatment of any resulting complications, unless that treatment is determined to be Medically Necessary.

16. **Custodial Care** – Custodial Care is not covered except for those services provided by an appropriately licensed Hospice agency or appropriately licensed Hospice facility incident to a Member's terminal illness as described in the explanation of "Hospice Services" in **Section 5. Medical Benefits** of this *Combined Evidence of Coverage and Disclosure Form*.

17. **Dental Care, Dental Appliances and Orthodontics** – Except as otherwise provided under the outpatient benefit captioned, "Oral Surgery and Dental Services," dental care, dental appliances and orthodontics are not covered. Dental Care means 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, routine tooth extraction, dental embryonal tissue disorders, periodontal disease, crowns, fillings, dental implants, caps, dentures, braces and orthodontic procedures. (Coverage for Dental Care may be available if purchased by the University of California as a separate benefit. If your Health Plan includes a separate Dental Care benefit, a brochure describing it will be enclosed with these materials.)

18. **Dental Treatment Anesthesia –** Dental treatment 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, "Oral Surgery and Dental Services."

19. **Dialysis –** Chronic dialysis (peritoneal or hemodialysis) is not covered outside of the Member's Participating Medical Group. The fact that the Member is outside the geographic area served by the Participating Medical Group will not entitle the Member to coverage for maintenance of chronic dialysis to facilitate travel.

20. **Disabilities Connected to Military Services –** Treatment in a government facility for a disability connected to military service that the Member is legally entitled to receive through a federal governmental agency and to which Member has reasonable access is not covered.

21. **Drugs and Prescription Medication (Outpatient) –** Outpatient drugs and prescription medications are not covered; however, coverage for prescription medications may be available as a supplemental benefit. If your Health Plan includes a supplemental benefit, a brochure will be enclosed with these materials. Infusion drugs and infusion therapy are not considered outpatient drugs for the purposes of this exclusion. Refer to outpatient benefits, "Injectable Drugs" and "Infusion Therapy," for benefit coverage. Pen devices for the delivery of medication, other than insulin or as required by law, are not covered.

22. **Durable Medical Equipment –** Replacements, repairs and adjustments to durable medical equipment are limited to normal wear and tear or because of a significant change in the Member's physical condition. Replacement of lost or stolen durable medical equipment is not covered. The following equipment and accessories are not covered: Non-Medically Necessary optional attachments and modifications to durable medical equipment for the comfort or convenience of the Member, accessories for portability or travel, a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment and home and car remodeling. For a detailed listing of covered durable medical equipment, please contact the PacifiCare Customer Service department at 1-800-624-8822.

23. **Educational Services for Developmental Delays and Learning Disabilities –** Educational services to treat developmental delays or learning disabilities are not covered. A learning disability is a condition where there is a meaningful difference between a child's current academic level of function and the level that would be expected for a child of that age. Educational services include, but are not limited to, language and speech training, reading and psychological and visual integration training as defined by the *American Academy of Pediatrics Policy Statement – Learning Disabilities, Dyslexia and Vision: A Subject Review*.

24. **Elective Enhancements –** Procedures, services and supplies for elective, non-Medically Necessary enhancements to normal body parts (items, devices or services to improve appearance or performance) are not covered. This includes, but is not limited to, elective enhancements related to hair growth, athletic performance, cosmetic changes and anti-aging. Please refer to "Reconstructive Surgery" for a description of

*The benefits described in **Section Five** will not be Covered Services unless they are determined to be Medically Necessary by Member's Participating Medical Group or PacifiCare and are provided by Member's Primary Care Physician or authorized by Member's Participating Medical Group or PacifiCare.

Reconstructive Surgery services covered by your Health Plan.

25. **Exercise Equipment and Services** – Exercise equipment or any charges for activities, instructions or facilities normally intended or used for developing or maintaining physical fitness are not covered. This includes, but is not limited to, charges for physical fitness instructors, health clubs or gyms or home exercise equipment or swimming pools, even if ordered by a health care professional.

26. **Enteral Feeding** – Enteral Feedings (food and formula) and the accessories and supplies are not covered. Formulas and special food products for phenylketonuria (PKU) are covered as described under the outpatient benefit captioned "Phenylketonuria (PKU) Testing and Treatment." Pumps and tubing are covered under the "Durable Medical Equipment" outpatient benefit.

27. **Experimental and/or Investigational Procedures, Items and Treatments** – Experimental and/or investigational procedures, items and treatments are not covered unless required by an external, independent review panel as described in **Section 9. Overseeing Your Health Care Decisions** of this *Combined Evidence of Coverage and Disclosure Form* captioned, "Eligibility for Independent Medical Review; Experimental or Investigational Treatment Decisions," or as described under "Cancer Clinical Trials" in the "Inpatient Benefits" and "Outpatient Benefits" sections of this *Combined Evidence of Coverage and Disclosure Form*. Unless otherwise required 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 a PacifiCare Medical Director or his or her designee. For the purposes of this *Combined Evidence of Coverage and Disclosure Form*, procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/guidelines are met:

    - It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA), and such approval has not been granted at the time of its use or proposed use.
    - It is a subject of a current investigation of new drug or new device (IND) application on file with the FDA.
    - It is the subject of an ongoing clinical trial (Phase I, II or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and Department of Health and Human Services (DHHS).
    - It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum-tolerated dose or effectiveness in comparison to conventional treatments.
    - Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect.
    - The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
    - It is not Experimental or Investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab tests or imaging ordered to evaluate the effectiveness of an experimental therapy).
    - The 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 plan, include, but are not 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 informed 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 and scientific literature regarding the drug, device, treatment or procedure;
- Expert medical opinion;
- Opinions of other agencies or review organizations (e.g., ECRI Health Technology Assessment Information Services, HAYES New Technology Summaries or MCMC Medical Ombudsman);
- Regulations and other official actions and publications issued by agencies such as the FDA, DHHS and Agency for Health Care Policy and Research (AHCPR);

A Member with a life-threatening or seriously debilitating condition may be entitled to an expedited external, independent review of PacifiCare's coverage determination regarding Experimental or Investigational therapies as described in **Section 9. Overseeing Your Health Care Decisions**, "Experimental or Investigational Treatment Decisions."

28. **Eyewear and Corrective Refractive Procedures** – Corrective lenses and frames, contact lenses and contact lens fitting and measurements are not covered (except for initial post-cataract extraction or corneal bandages and for the treatment of keratoconus and aphakia). Surgical and laser procedures to correct or improve refractive error are not covered. Routine screenings for glaucoma are limited to Members who meet the medical criteria.
29. **Family Planning** – Family planning benefits, other than those specifically listed in the *Schedule of Benefits* that accompanies this document, are not covered.
30. **Follow-Up Care: Emergency Services or Urgently Needed Services** – Services following discharge after receipt of Emergency Services or Urgently Needed Services, including, but not limited to, treatments, procedures, X-rays, lab work, Physician visits, rehabilitation and Skilled Nursing Care are not covered without the Participating Medical Group's or PacifiCare's authorization. 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.
31. **Foot Care** – Except as Medically Necessary, routine foot care, including, but not limited to, removal or reduction of corns and calluses and clipping of toenails, is not covered.
32. **Foot Orthotics/Footwear** – Specialized footwear, including foot orthotics and custom-made or standard orthopedic shoes, is not covered, except for Members with diabetic foot disease or when an orthopedic shoe is permanently attached to a Medically Necessary orthopedic brace.
33. **Genetic Testing, Treatment or Counseling** – Genetic testing treatment or counseling are excluded for all of the following:
    - Non-PacifiCare Members
    - Solely to determine the gender of a fetus.
    - Nonmedical reasons (e.g. court-ordered tests, work-related tests, paternity tests).
    - Non-medically necessary screening of newborns, children or adolescents to determine carrier status for inheritable disorders when there would not be an immediate medical benefit or when results would not be used to initiate medical interventions/treatment while a newborn, a child or adolescence.
    - Members who have no clinical evidence or family history of a genetic abnormality.
    - Members who do not meet PacifiCare's Medical Necessity criteria for genetic testing and counseling.

    Refer to "Maternity Care, Tests, Procedures, and Genetic Testing" in the "Outpatient Benefits" section for coverage of amniocentesis and chorionic villus sampling.
34. **Government Services and Treatment** – Any services that the Member receives from a local,

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state or federal governmental agency are not covered, except when coverage under this Health Plan is expressly required by federal or state law.

35. **Hearing Aids and Hearing Devices** – Hearing aids and nonimplantable hearing devices are not covered. Audiology services (other than screening for hearing acuity) are not covered. Hearing aid supplies are not covered. Implantable hearing devices are not covered except for cochlear devices for bilaterally, profoundly hearing impaired individuals or for prelingual Members who have not benefited from conventional amplification (hearing aids).

36. **Hospice Services** – Hospice services are not covered for:

    a. Members who do not meet the definition of terminally ill. Terminal illness is defined as a medical condition resulting in a prognosis of life expectancy of one year if the disease follows its natural course.

    b. Hospice services that are not reasonable and necessary for the management of a terminal illness (e.g., care provided in a noncertified Hospice program).

    Note: Hospice services provided by a Non-Participating Hospice Agency are not covered except in certain circumstances in counties in California in which there are no Participating Hospice Agencies and only when prior authorized and arranged by PacifiCare or the Member's Participating Medical Group.

37. **Immunizations** – Immunization and vaccines for travel and/or required work-related, insurance, school, marriage, adoption, immigration, camp, volunteer work, licensure, certification or registration, sports or recreational activities are not covered. Immunizations that are not specifically listed on the most current version of the Recommended Childhood and Adolescent Immunization Schedule – United States and Recommended Adult Immunization Schedule are not covered.

38. **Infertility Reversal** – Reversals of sterilization procedures are not covered.

39. **Infertility Services** – Infertility Services are not covered unless purchased by the Subscriber's Employer Group. Please refer to your *Schedule of Benefits*. The following services are excluded under the PacifiCare Health Plan: Ovum transplants, ovum or ovum bank charges, sperm or sperm bank charges and the medical or Hospital Services incurred by surrogate mothers who are not PacifiCare Members are not covered. Medical and Hospital Infertility Services for a Member whose fertility is impaired due to an elective sterilization, including surgery, medications and supplies, are not covered.

40. **Institutional Services and Supplies** – Except for Skilled Nursing Services provided in a Skilled Nursing Facility, any services or supplies furnished by a facility that is primarily a place of rest, a place for the aged, a nursing home or any similar institution, regardless of affiliation or denomination, are not covered. (Skilled Nursing Services are covered as described in this *Combined Evidence of Coverage and Disclosure Form* in the sections titled, "Inpatient Benefits" and "Outpatient Benefits.") Members residing in these facilities are eligible for Covered Services that are determined to be Medically Necessary by Member's Participating Medical Group or PacifiCare, and are provided by Member's Primary Care Physician or authorized by Member's Participating Medical Group or PacifiCare.

41. **Maternity Care, Tests, and Procedures** – Elective home deliveries are not covered. Educational courses on lactation, child care and/or prepared childbirth classes are not covered.

42. **Medicare Benefits for Medicare Eligible Members** – The amount payable by Medicare for Medicare Covered Services is not covered by PacifiCare for Medicare Eligible Members, whether or not a Medicare Eligible Member has enrolled in Medicare Part A and Medicare Part B.

43. **Mental Health and Nervous Disorders** – Mental Health Services are not covered except for diagnosis and treatment of Severe Mental Illness for adults and children, and for diagnosis and treatment of Serious Emotional Disturbances of Children. Please refer to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form* for a description of this coverage. Academic or educational testing, as well as educational counseling or remediation

are not covered. Coverage for Crisis Intervention may also be available as an additional benefit. Please refer to the *Schedule of Benefits* for coverage, if any.

44. **Non-Physician Health Care Practitioners –** This Plan may not cover services of all Non-Physician Health Care Practitioners. Treatment by Non-Physician Health Care Practitioners such as acupuncturists, chiropractors, licensed clinical social workers, marriage and family therapists are not covered. Psychologists or licensed clinical social workers may be covered as a supplemental benefit (please see the "How Your PacifiCare Behavioral Health Benefits Work" section of this *Combined Evidence of Coverage and Disclosure Form*). For coverage of Severe Mental Illnesses (SMI) of adults and children, and for children, the treatment of Serious Emotional Disturbances (SED), refer to "Outpatient Benefits, Mental Health Services."

45. **Nurse Midwife Services –** Nurse midwife services are covered only when available within the Member's Participating Medical Group. Home deliveries at home are not covered.

46. **Nursing, Private Duty –** Private-duty nursing is not covered.

47. **Nutritional Supplements or Formulas –** Formulas, food, vitamins, herbs and dietary supplements are not covered, except as described under the outpatient description of "Phenylketonuria (PKU) Testing and Treatment."

48. **Off-Label Drug Use –** Off-Label Drug Use which means the use of a drug for a purpose that is different from the use for which the drug has been approved for by the FDA, including off-label, self-injectable drugs, is not covered except as follows. If the self-injectable drug is prescribed for Off-Label Use, the drug and its administration is covered only when the following criteria are met:

    - The drug is approved by the FDA;
    - The drug is prescribed by a Participating Provider for the treatment of a life-threatening condition or for a chronic and seriously debilitating condition;
    - The drug is Medically Necessary to treat the condition;
    - 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 Pharmacopeia Dispensing Information, Volume 1*, 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;
    - The drug is covered under the "Injectable Drug" benefit described in the "Outpatient Benefits" section of this *Combined Evidence of Coverage and Disclosure Form*.

    Nothing in this section shall prohibit PacifiCare from use of a Formulary, Copayment, technology assessment panel or similar mechanism as a means for appropriately managing 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.

49. **Oral Surgery and Dental Services –** Dental services, including, but not limited to, crowns, fillings, dental implants, caps, dentures, braces and orthodontic procedures, are not covered.

50. **Oral Surgery and Dental Services: Dental Treatment Anesthesia –** Dental anesthesia in a dental office or dental clinic is not covered. Professional fees of the dentist are not covered. (Please see "Dental Care, Dental Appliances and Orthodontics" and "Dental Treatment Anesthesia.")

51. **Organ Donor Services –** Medical and Hospital Services, as well as other costs of a donor or prospective donor, are only covered when the recipient is a Member. The testing of blood

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relatives to determine compatibility for donating organs is limited to sisters, brothers, parents and natural children. The testing for compatible unrelated donors and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors conducted through a registry are covered when the Member is the intended recipient. Costs for such searches are covered up to a maximum of $15,000 per procedure. Donor searches are only covered when performed by a Provider included in the "National Preferred Transplant Network Facility."

52. **Organ Transplants –** All organ transplants must be Preauthorized by PacifiCare and performed in a PacifiCare Preferred Transplant Network facility.

    - Transportation is limited to the transportation of the Member and one escort to a Preferred Transplant Network facility greater than 60 miles from the Member's Primary Residence as Preauthorized by PacifiCare. Transportation and other nonclinical expenses of the living donor are excluded and are the responsibility of the Member who is the recipient of the transplant. (See the definition for "Preferred Transplant Network.")
    - Food and housing is not covered unless the Preferred Transplant Network Center is located more than 60 miles from the Member's Primary Residence, in which case food and housing is limited to $125.00 a day to cover both the Member and escort, if any (excludes liquor and tobacco). Food and housing expenses are not covered for any day a Member is not receiving Medically Necessary transplant services.
    - Listing of the Member at a second Preferred Transplant Network Center is a covered benefit, unless the Regional Organ Procurement Agencies (the Agency that obtains the organ) is the same for both facilities. Organ transplant listing is limited to two (2) Preferred Transplant Network Facilities. If the Member is listed at two facilities PacifiCare will only cover the costs associated with the transplant surgical procedure (includes donor surgical procedure and services) and post transplant services at the facility where the transplant is performed. The Member is responsible for any duplicated diagnostic costs for a transplant evaluation incurred at the second facility. (See the definition for Regional Organ Procurement Agency under "National Preferred Transplant Network Facility" in Section Eleven Definitions.)

53. **Pain Management –** Pain management services are covered for the treatment of chronic and acute pain only when they are received from a Participating Provider and authorized by PacifiCare or its designee.

54. **Phenylketonuria (PKU) Testing and Treatment –** Food products naturally low in protein are not covered.

55. **Physical or Psychological Examinations –** Physical or psychological examinations for court hearings, travel, premarital, pre-adoption or other nonpreventive health reasons are not covered. Court-ordered or other statutorily allowed psychological evaluation, testing, and treatment are no t covered unless Medically Necessary and preauthorized by PacifiCare.

56. **Private Rooms and Comfort Items –** Personal or comfort items, and non-Medically Necessary private rooms during inpatient hospitalization are not covered.

57. **Prosthetics and Corrective Appliances –** Replacement of lost prosthetics or corrective appliances is 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. For a detailed listing of covered durable medical equipment, including prosthetics and corrective appliances, please contact the PacifiCare Customer Service department at 1-800-624-8822.

58. **Pulmonary Rehabilitation Programs –** Pulmonary rehabilitation programs are covered only when determined to be Medically Necessary by a PacifiCare Medical Director or designee.

59. **Reconstructive Surgery** – Reconstructive surgeries are not covered under the following circumstances:

    - When there is another more appropriate surgical procedure that has been offered to the Member; or
    - When only a minimal improvement in the Member's appearance is expected to be achieved.

    Preauthorizations for proposed reconstructive surgeries will be reviewed by Physicians specializing in such reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested.

60. **Recreational, Lifestyle, Educational or Hypnotic Therapy** – Recreational, lifestyle, educational or hypnotic therapy, and any related diagnostic testing is not covered.

61. **Rehabilitation Services and Therapy** – Rehabilitation services and therapy are either limited or not covered, as follows:

    - Speech, occupational or physical therapy is not covered when medical documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals or when a Member has already met the treatment goals.
    - Speech therapy is limited to Medically Necessary therapy to treat speech disorders caused by a defined illness, disease or surgery (for example, cleft palate repair).
    - Cognitive Rehabilitation Therapy is limited to an initial neuropsychological testing by an authorized Physician or licensed Provider and the Medically Necessary treatment of functional deficits as a result of traumatic brain injury or cerebral vascular insult. This benefit is limited to outpatient rehabilitation limitation, if any.
    - Exercise programs are only covered when they require the direct supervision of a licensed Physical Therapist and are part of an authorized treatment plan.
    - Activities that are motivational in nature or that are primarily recreational, social or for general fitness are not covered.
    - Aquatic/pool therapy is not covered unless conducted by a licensed Physical Therapist and part of an authorized treatment plan.
    - Massage therapy is not covered.

    The following Rehabilitation Services, special evaluations and therapies are not covered;

    - Biofeedback (except for urinary incontinence, fecal incontinence or constipation for Members with organic neuromuscular impairment when part of an authorized treatment plan.)
    - Cognitive Behavioral Therapy.
    - Developmental and Neuroeducational Testing beyond initial diagnosis
    - Hypnotherapy
    - Psychological Testing
    - Vocational Rehabilitation

    (Please refer to **Section 11** for definitions of capitalized terms.)

62. **Respite Care** – Respite care is not covered, unless part of an authorized Hospice plan and is necessary to relieve the primary caregiver in a Member's residence. Respite care is covered only on an occasional basis, not to exceed five (5) consecutive days at a time.

63. **Routine Laboratory Testing Out-of-Area** – Routine laboratory tests are not a covered benefit while the Member is outside of the geographic area served by the Member's Participating Medical Group. Although it may be Medically Necessary, out-of-area routine laboratory testing is not considered an Urgently Needed Service because it is not unforeseen and is not considered an Emergency Service.

64. **Services in the Home** – Services in the home provided by relatives or other household members are not covered.

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65. **Services Provided at No Charge to Member** – Services and supplies that are provided free of charge if the member did not have coverage under this Health Plan or for which the Member will not be held financially responsible, unless PacifiCare has agreed to payment arrangements prior to the provision of the services or supplies to the Member.

66. **Skilled Nursing Facility Care/Subacute and Transitional Care** – Skilled Nursing Facility room and board charges are excluded after 100 consecutive days per admission. Days spent out of the Skilled Nursing Facility when transferred to an acute Hospital setting are not counted toward the 100 consecutive days when the Member is transferred back to a Skilled Nursing Facility, but the count resumes upon the Member's return to a Skilled Nursing Facility. Such days in an acute Hospital setting also do not count toward renewing the 100-consecutive-day benefit. In order to renew the room and board coverage in a Skilled Nursing Facility, a Member must either be out of all Skilled Nursing Facilities for 60 consecutive days or if the Member remains in a facility, then the Member may not have received Skilled Nursing Care or Skilled Rehabilitation Care for 60 days.

67. **Surrogacy** – Infertility and maternity services for non-Members are not covered. PacifiCare may seek recovery of actual costs incurred by PacifiCare from a Member who is receiving reimbursement for medical expenses for maternity services while acting as a surrogate.

68. **Telehealth and Telemedicine** – Telehealth and Telemedicine services are not covered except as provided by California law unless determined to be Medically Necessary by a PacifiCare Medical Director.

69. **Third-Party Liability** – Expenses incurred due to liable third parties are not covered, as described in the section, "PacifiCare's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Member's Health Care Expenses."

70. **Transportation** – Transportation is not a covered benefit except for ambulance transportation as defined in this *Combined Evidence of Coverage and Disclosure Form*.

71. **Veterans Affairs Services** – Except for Emergency or Urgently Needed Services, services received by a Member in a Veterans' Administration facility are not covered.

72. **Vision Care** – See "Eyewear and Corrective Refractive Procedures" listed in "Exclusions and Limitations."

73. **Vision Training** – Vision therapy and ocular training programs (orthoptics) that are not part of an authorized treatment plan are not covered.

74. **Weight Alteration Programs (Inpatient or Outpatient)** – Weight loss or weight gain programs are not covered. These programs include, but are not limited to, dietary evaluations, counseling, exercise, behavioral modification, food and food supplements, vitamins and other nutritional supplements. Also excluded are non authorized weight loss program laboratory tests associated with monitoring weight loss or weight gaine, except as described under inpatient benefits "Morbid Obesity (Surgical Treatment)." For the treatment of anorexia nervosa and bulimia nervosa, please refer to the behavioral health supplement of your *Combined Evidence of Coverage and Disclosure Form.*

Outpatient Prescription Drug Program

Outpatient Prescription Drug Program

Retail:

HMO Pharmacy Schedule of Benefits

Summary of Benefits	Generic Formulary	Brand-name Formulary	Non-Formulary
Retail Pharmacy Copayment *(per Prescription Unit or up to 30 days)*	$10	$20	$35
Mail Service Pharmacy Copayment *(three Prescription Units or up to a 90-day supply)* UC Medical Center Pharmacy Copayment *(three Prescription Units or up to a 90-day supply)*	$20	$40	$70

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

What do I pay when I fill a prescription?

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

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

Preauthorization

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

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

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

Medication Covered by Your Benefit

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

- **Disposable all-in-one prefilled insulin pens**, insulin cartridges and needles for nondisposable pen devices are covered when Medically Necessary, in accordance with PacifiCare's Preauthorization process.
- **Federal Legend Drugs**: Any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription."
- **Generic Drugs:** Comparable generic drugs may be substituted for brand-name drugs unless they are on PacifiCare's Selected Brands List. A copy of the

Selected Brands List is available upon request from PacifiCare's Customer Service department or may be found on PacifiCare's Web site at **www.pacificare.com**.

- **Miscellaneous Prescription Drug Coverage**: For the purposes of determining coverage, the following items are considered prescription drug benefits and are covered when Medically Necessary: glucagons, insulin, insulin syringes, blood glucose test strips, lancets, inhaler extender devices, urine test strips and anaphylaxis prevention kits (including, but not limited to, EpiPen®, Ana-Kits® and Ana-Guard®). See the medical Combined Evidence of Coverage and Disclosure Form for coverage of other injectable medications in Section Five under "Your Medical Benefits."
- **Oral Contraceptives:** Federal Legend oral contraceptives, prescription diaphragms and oral medications for emergency contraception.
- **Sexual Dysfunction Medication**: Medically Necessary outpatient prescription medications prescribed by a Participating Physician to treat sexual dysfunction when Preauthorized by PacifiCare. Prescription medications for the treatment of sexual dysfunction are non-Formulary drugs and require Preauthorization by PacifiCare. Medically Necessary prescription medications prescribed for the treatment of sexual dysfunction are limited to eight (8) tablets per month.
- **State Restricted Drugs**: Any medicinal substance that may be dispensed by prescription only, according to state law.
- Hormone drugs subject to the Harry Benjamin International Gender Dysphoria Association's (HBIGDA) *Standards of Care for Gender Identity Disorder.*

Exclusions and Limitations

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

- **Administered Drugs**: Drugs or medicines delivered or administered to the Member by the prescriber or the prescriber's staff are not covered. Injectable drugs are covered under your medical benefit when administered during a Physician's office visit or self-administered pursuant to training by an appropriate health care professional. Refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form titled "Your Medical Benefits" for more information about medications covered under your medical benefit.
- **Compounded Medication**: Any medicinal substance that has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount. Compounded medications are not covered unless Preauthorized as Medically Necessary by PacifiCare.
- **Diagnostic Drugs**: Drugs used for diagnostic purposes are not covered. Refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form for information about medications covered for diagnostic tests, services and treatment.
- **Dietary or nutritional** products, medical foods and food supplements, whether prescription or nonprescription, including vitamins (except prenatal), minerals and fluoride supplements, health or beauty aids, herbal supplements and/or alternative medicine, are not covered. Phenylketonuria (PKU) testing and treatment is covered under your medical benefit including those formulas and special food products that are a part of a diet prescribed by a Participating Physician provided that the diet is Medically Necessary. For additional information, refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form.
- **Drugs prescribed by a dentist** or drugs when prescribed for dental treatment are not covered.
- **Drugs when prescribed to shorten the duration of a common cold** are not covered.
- **Enhancement medications** when prescribed for the following nonmedical conditions are not covered: weight loss, hair growth, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. Examples of drugs that are excluded when prescribed for such conditions include, but are not

limited to, Penlac®, Retin-A®, Renova®, Vaniqa®, Propecia®, Lustra®, Xenical® or Meridia®. This exclusion does not exclude coverage for drugs when Preauthorized as Medically Necessary to treat morbid obesity or diagnosed medical conditions affecting memory, including, but not limited to, Alzheimer's dementia.

- **Infertility:** All forms of prescription medication when prescribed for the treatment of infertility are not covered. If your Employer has purchased coverage for infertility treatment, prescription medications for the treatment of infertility may be covered under that benefit. Please refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form titled "Your Medical Benefits" for additional information.
- **Injectable Medications:** Except as described under the section "Medications Covered by Your Benefit," injectable medications, including, but not limited to, self-injectables, infusion therapy, allergy serum, immunization agents and blood products, are not covered as an outpatient prescription drug benefit. However, these medications are covered under your medical benefit as described in and according to the terms and conditions of your medical Combined Evidence of Coverage and Disclosure Form. Outpatient injectable medications administered in the Physician's office (except insulin) are covered as a medical benefit when part of a medical office visit. Injectable medications may be subject to PacifiCare's Preauthorization requirements. For additional information, refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form under "Your Medical Benefits."
- **Inpatient Medications:** Medications administered to a Member while an inpatient in a Hospital or while receiving Skilled Nursing Care as an inpatient in a Skilled Nursing Facility are not covered under this Pharmacy Schedule of Benefits. Please refer to Section Five of your medical Combined Evidence of Coverage and Disclosure Form titled "Your Medical Benefits" for information on coverage of prescription medications while hospitalized or in a Skilled Nursing Facility. Outpatient prescription drugs are covered for Members receiving Custodial Care in a rest home, nursing home, sanitarium, or similar facility if they are obtained from a Participating Pharmacy in accordance with all the terms and conditions of coverage set forth in this Schedule of Benefits and in the Pharmacy Supplement to the Combined Evidence of Coverage and Disclosure Form. When a Member is receiving Custodial Care in any facility, relatives, friends or caregivers may purchase the medication prescribed by a Participating Physician at a Participating Pharmacy and pay the applicable Copayment on behalf of the Member.
- **Investigational or Experimental Drugs:** Medication prescribed for experimental or investigational therapies are not covered, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. Further information about Investigational and Experimental procedures and external review by an independent panel can be found in the medical Combined Evidence of Coverage and Disclosure Form in Section Five, "Your Medical Benefits" and Section Eight, "Overseeing Your Health Care" for appeal rights.
- **Medications dispensed by a non-Participating Pharmacy** are not covered except for prescriptions required as a result of an Emergency or Urgently Needed Service.
- **Medications prescribed by non-Participating Physicians** are not covered except for prescriptions required as a result of an Emergency or Urgently Needed Service.
- **New medications that have not been reviewed for safety, efficacy and cost-effectiveness and approved** by PacifiCare are not covered unless Preauthorized by PacifiCare as Medically Necessary.
- **Non-Covered Medical Condition:** Prescription medications for the treatment of a non-covered medical condition are not covered. This exclusion does not exclude Medically Necessary medications directly related to non-Covered Services when complications exceed follow-up care, such as life-threatening complications of cosmetic surgery.
- **Off-Label Drug Use:** Off-Label Drug Use means that the Provider has prescribed a drug approved by the Food and Drug Administration (FDA) for a use that is different than that for which the FDA approved the drug. PacifiCare excludes coverage for Off-Label Drug Use, including off-label, self-injectable drugs, except as described in the medical Combined Evidence of Coverage and Disclosure Form and any applicable Attachments. If a drug is prescribed for Off-Label Drug Use, the drug and its administration will be covered only if it satisfies the

following criteria: (1) The drug is approved by the FDA. (2) The drug is prescribed by a participating licensed health care professional. (3) The drug is Medically Necessary to treat the medical condition. (4) The drug has been recognized for treatment of a medical condition by one of the following: The American Hospital Formulary Service Drug Information, The United States Pharmacopeia Dispensing Information or in two articles from major peer-reviewed medical journals that present data supporting the proposed Off-Label Drug Use or uses as generally safe and effective. Nothing in this section shall prohibit PacifiCare from use of a Formulary, Copayment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA. Denial of a drug as Investigational or Experimental will allow the Member to use the Independent Medical Review System as defined in the medical Combined Evidence of Coverage and Disclosure Form.

- **Over-the-Counter Drugs:** Medications (except insulin) available without a prescription (over-the-counter) or for which there is a nonprescription chemical and dosage equivalent available, even if ordered by a Physician, are not covered. All nonprescription (over-the-counter) contraceptive jellies, ointments, foams or devices are not covered.
- **Prior to Effective Date:** Drugs or medicines purchased and received prior to the Member's effective Date or subsequent to the Member's termination are not covered.
- **Replacement** of lost, stolen or destroyed medications are not covered.
- **Saline and irrigation solutions** are not covered. Saline and irrigation solutions are covered when Medically Necessary, depending on the purpose for which they are prescribed, as part of the home health or Durable Medical Equipment benefit. Refer to your medical Combined Evidence of Coverage and Disclosure Form Section Five for additional information.
- **Smoking cessation products**, including, but not limited to, nicotine gum, nicotine patches and nicotine nasal spray, are not covered. However, smoking cessation products are covered when the Member is enrolled in a smoking cessation program approved by PacifiCare. For information on PacifiCare's smoking cessation program, refer to the medical Combined Evidence of Coverage and Disclosure Form in Section Five, "Your Medical Benefits, in the section titled "Outpatient Benefits", under "Health Education Services" or contact Customer Service or visit our Web site at **www.pacificare.com**.
- **Therapeutic devices or appliances**, including, but not limited to, support garments and other nonmedical substances, insulin pumps and related supplies (these services are provided as Durable Medical Equipment) and hypodermic needles and syringes not related to diabetic needs or cartridges are not covered. Birth control devices and supplies or preparations that do not require a Participating Physician's prescription by law are also not covered, even if prescribed by a Participating Physician. For further information on certain therapeutic devices and appliances that are covered under your medical benefit, refer to your medical Combined Evidence of Coverage and Disclosure Form in Section Five, titled "Your Medical Benefits" under "Outpatient Benefits" located, for example, in subsections titled "Diabetic Self Management", "Durable Medical Equipment," or "Home Health Care and Prosthetics and Corrective Appliances."
- **Workers' Compensation:** Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the patient is not covered. Further information about workers' compensation can be found in the medical Combined Evidence of Coverage and Disclosure Form in Section Six under "Payment Responsibility."

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

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 percent to 70 percent less than its equivalent brand-name counterpart.

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

- Generic drugs have the same active ingredients as the brand-name drug. Only the inactive ingredients, such as the fillers, can differ from the brand-name

version. This explains why the generic may be a different color or shape than the brand name.

- Generic drugs must meet FDA standards for identity, strength, quality, purity and potency.
- 70 percent to 80 percent 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.

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

Hearing Aid Benefits

Hearing Aid Benefits

50 percent 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. Retirees must acquire hearing aids through Newport Audiology.

Limitations

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.

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HMO Schedule of Benefits

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

General Features

Calendar Year Deductible	None
Maximum Benefits	Unlimited
Annual Copayment Maximum[1] *(3 individual maximum per family)*	$1,000/individual
Office Visits	$15 Copayment
Hospital Benefits *(Only one hospital Copayment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment.) (Autologous (self-donated) blood limited up to $120.00 per unit)*	$250 Copayment per admit[5]
Emergency Services *(Copayment waived if admitted)*	$50 Copayment
Urgently Needed Services *(Medically Necessary services required outside geographic area served by your Participating Medical Group. Please consult your brochure for additional details. Copayment waived if admitted)*	$50 Copayment
Pre-Existing Conditions	All conditions covered, provided they are covered benefits

Benefits Available While Hospitalized as an Inpatient

Alcohol, Drug or Other Substance Abuse Detoxification	$250 Copayment per admit[5]
Bone Marrow Transplants *(Donor searches limited to $15,000 per procedure)*	$250 Copayment per admit[5]
Cancer Clinical Trials[3]	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Hospice Services *(Prognosis of life expectancy of one year or less)*	$250 Copayment per admit[5]
Hospital Benefits[4] *(Only one hospital Copayment per admit is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment) (Autologous (self-donated) blood limited up to $120.00 per unit)*	$250 Copayment per admit[5]
Mastectomy/Breast Reconstruction *(After mastectomy and complications from mastectomy)*	$250 Copayment per admit[5]
Maternity Care	$250 Copayment per admit[5]
Mental Health Services *(As required by state law, coverage includes treatment for Severe Mental Illnesses (SMI) of adults and children and the treatment of Serious Emotional Disturbance of Children (SED); please refer to your Supplement to the PacifiCare Combined Evidence of Coverage and Disclosure Form for a description of this coverage)*	$250 Copayment per admit[5]
Newborn Care[4]	$250 Copayment per admit[5]

Benefits Available While Hospitalized as an Inpatient (Continued)

Physician Care	Paid in full
Reconstructive Surgery	$250 Copayment per admit[5]
Rehabilitation Care *(Including physical, occupational and speech therapy)*	$250 Copayment per admit[5]
Skilled Nursing Care *(Up to one hundred (100) consecutive calendar days from the first treatment per disability)*	Paid in full
Voluntary Termination of Pregnancy *(Medical/medication and surgical)* *1st trimester* *2nd trimester (12-20 weeks)* *– After 20 weeks, not covered unless mother's life is in jeopardy or fetus is not viable.*	 $15 Copayment $15 Copayment

Benefits Available on an Outpatient Basis

Alcohol, Drug or Other Substance Abuse Detoxification	$15 Office Visit Copayment
Allergy Testing/Treatment *(Serum is covered)*	$15 Office Visit Copayment
Ambulance *(Only one ambulance Copayment per trip may be applicable. If a subsequent ambulance transfer to another facility is necessary, you are not responsible for the additional ambulance Copayment)*	Paid in full
Cancer Clinical Trials[3]	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Cochlear Implants Devices *(Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply)*	Paid in full
Crisis Intervention *(Up to twenty (20) visits for Crisis Intervention per Calendar Year)*	$15 Copayment
Dental Treatment Anesthesia *(Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)*	Paid in full
Dialysis *(Physician office visit Copayment may apply)*	$15 Copayment per treatment
Durable Medical Equipment	Paid in full
Durable Medical Equipment for the Treatment of Pediatric Asthma *(Includes nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma of Dependent children under the age of 19.)*	Paid in full
Family Planning/Voluntary Termination of Pregnancy *Vasectomy & Tubal Ligation* *Insertion/Removal of Intra-Uterine Device (IUD)* *Intra-Uterine Device (IUD)* *Removal of Norplant* *Depo-Provera Injection* *Depo-Provera medication* *(Limited to one Depo-Provera injection every 90 days)* *Voluntary Termination of Pregnancy* *(Medical/medication and surgical)* *1st trimester* *2nd trimester (12-20 weeks)* *– After 20 weeks, not covered unless mother's life is in jeopardy or fetus is not viable.*	 $15 Copayment $15 Office Visit Copayment 50% of cost Copayment[2] $15 Office Visit Copayment $15 Office Visit Copayment $35 Copayment $15 Copayment $15 Copayment

Benefits Available on an Outpatient Basis (Continued)

Health Education Services	Paid in full
Hearing Screening	$15 Office Visit Copayment
Home Health Care Visits	Paid in full
Hospice Services *(Prognosis of life expectancy of one year or less)*	Paid in full
Immunizations *(For children under two years of age, refer to Well-Baby Care)*	$15 Office Visit Copayment
Infertility Services	50% of Cost Copayment[7]
Infusion Therapy *(Infusion therapy is a separate Copayment in addition to a home health care or an office visit Copayment. Copayment applies per 30 days or treatment plan, whichever is shorter)*	Paid in full
Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications) *(Copayment not applicable to allergy serum, immunizations, birth control, Infertility and insulin. The Self-Injectable Medications Copayment applies per 30 days or treatment plan, whichever is shorter. Please see the PacifiCare Combined Evidence of Coverage and Disclosure Form for more information on these benefits, if any. Office visit Copayment may also apply)*	Paid in full
Laboratory Services *(When available through and authorized by your Participating Medical Group)*	Paid in full
Maternity Care, Tests and Procedures	Paid in full
Mental Health Services *(As required by state law, coverage includes treatment for Severe Mental Illnesses (SMI) of adults and children and the treatment of Serious Emotional Disturbance of Children (SED); please refer to your Supplement to the PacifiCare Combined Evidence of Coverage and Disclosure Form for a description of this coverage)*	$15 Office Visit Copayment
Oral Surgery Services	Paid in full
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility *(Including physical, occupational and speech therapy)*	$15 Office Visit Copayment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Center	Paid in full
Periodic Health Evaluations *(Physician, laboratory, radiology and related services as recommended by the American Academy of Pediatrics (AAP), Advisory Committee on Immunization Practices (ACIP) and U.S. Preventive Services Task Force and authorized through your Primary Care Physician in your Participating Medical Group to determine your health status. For children under two years of age, refer to Well-Baby Care)*	$15 Office Visit Copayment
Physician Care *(for children under two years of age, refer to Well-Baby Care)*	$15 Office Visit Copayment
Prosthetics and Corrective Appliances	Paid in full

Benefits Available On an Outpatient Basis (Continued)

Radiation Therapy	Paid in full
Standard:	Paid in full
(Photon beam radiation therapy)	
Complex:	
(Examples include but are not limited to, brachytherapy, radioactive implants and conformal photon beam; Copayment applies per 30 days or treatment plan, whichever is shorter; Gamma Knife and stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount, if any)	
Radiology Services	
Standard:	Paid in full
Specialized Scanning and Imaging Procedures:	Paid in full
(Examples include but are not limited to, CT, SPECT, PET, MRA and MRI - with or without contrast media)	
Vision Screening/Refractions	$15 Office Visit 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. The applicable office visit Copayment applies to infants that are ill at time of services)	
Well-Woman Care	$15 Office Visit 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 US Preventive Services Task Force)	

[1] Annual Copayment Maximum does not include Copayments for durable medical equipment (except for nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthmas and diabetic supplies), pharmacy and supplemental benefits.

[2] Percentage Copayment amounts are based upon the PacifiCare negotiated rate.

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

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

[5] Each admission requires a $250 Copayment.

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

[7] Please refer to the Infertility Basic Diagnosis Treatment Supplement located within this *Combined Evidence of Coverage and Disclosure Form*.

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

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

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

Infertility Basic Diagnosis and Treatment Supplement to the Combined Evidence of Coverage and Disclosure Form

This brochure contains important information for our Members about the PacifiCare Infertility Basic Diagnosis and Treatment supplemental benefit. As a Member you shall be entitled to receive basic diagnostic services and treatment for infertility as described in this brochure. You will find important definitions in the back of this document regarding your infertility supplemental benefit.

Benefits

PacifiCare's Basic Infertility Services must be Medically Necessary and consistent with accepted standards of care for the diagnosis and treatment of infertility. Services must be authorized and directed by the Participating Medical Group or the PacifiCare SignatureValue® Advantage Participating Medical Group (for Advantage participants) and benefits are subject to the Exclusions and Limitations stated below:

Diagnosis of Infertility

a. Complete medical history.

b. Female general medical examinations. Examples include but are not limited to:

- Pelvic exam;
- Routine laboratory investigation for hormonal disturbances (e.g. FSH, LH, prolactin);
- Cultures for infectious agents;
- Serum progesterone determination;
- Laparoscopy;
- Hysterosalpingogram.

c. Male general medical examination. Examples include but are not limited to:

- Semen analysis up to three times following five days of abstinence;
- Huhner's Test or Post Coital Examinations;
- Laboratory studies (e.g. FSH, LH, prolactin, serum testosterone);
- Testicular biopsy when Member has demonstrated azoospermia;
- Scrotal ultrasound, when appropriate for azoospermia;
- Electrical Assistance for Recovery of Sperm (EARS), when medically indicated, as when the Member is a paraplegic or quadriplegic, as approved by PacifiCare's Medical Director or designee;
- HIV, Hepatitis B surface antibody, Hepatitis C antibody, HTLV-1 and syphilis testing of male partner prior to artificial insemination.

Treatment of Infertility

a. Insemination Procedures are limited to six procedures, per lifetime unless the Member conceives, in which case the benefit renews.

b. Clomid used during the covered periods of infertility is covered as part of this Supplemental Benefit and is not a covered pharmaceutical through PacifiCare's supplemental pharmacy coverage.

c. Injectable medications and syringes for the treatment of infertility are covered as part of this Supplemental Infertility Benefit and are not a covered pharmaceutical through PacifiCare's supplemental pharmacy coverage. Examples include:

- Pergonal;
- Profasi;
- Metrodin;
- Urofollitropin;
- Coverage for other injectable drugs not listed above will be reviewed based on Medical Necessity for the specific Member, and FDA recommendations, including off-label use for the drug requested.

Coverage

All benefits, including physician services, procedures, diagnostic services or medications are covered at 50 percent of cost Copayment (based upon PacifiCare's contractual rate for the services provided with the

infertility provider(s). Cost Copayment does not apply to Member's Annual Maximum Copayment.

Exclusions

- Services not authorized and directed by the Participating Medical Group or the AdvantageParticipating Medical Group (for Advantageparticipants).
- Medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, anorgasmy or hyporgasmy.
- Infertility service after a previous elective vasectomy or tubal ligation, whether or not a reversal has been attempted or completed.
- Reversal of a previous elective vasectomy or tubal ligation.
- All Medical and Hospital infertility services and supplies for a Member whose fertility is impaired due to an elective sterilization. This includes any supplies, medications, services and/or procedures used for an excluded benefit, e.g. GIFT, ZIFT or IVF.
- Further infertility treatment when either or both partners are unable due to an identified exclusion in this Supplemental Benefit or unwilling to participate in the treatment plan prescribed by the infertility physician.
- Treatment of female sterility in which a donor ovum would be necessary (e.g. post-menopausal syndrome).
- Insemination with semen from a partner with an infectious disease which, pursuant to guidelines of the Society of Artificial Reproductive Technology, has a high risk of being transmitted to the female partner and/or infecting any resulting fetus. This exclusion would not prohibit the Member's purchase of donor sperm or from obtaining a donor with appropriate testing, at the Member's expense, to receive the eligible infertility benefits.
- Microdissection of the zona or sperm microinjection.
- Experimental and/or Investigational diagnostic studies or procedures, as determined by PacifiCare's Medical Director or Designee.
- Advanced infertility procedures, as well as In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT) and procedures performed in conjunction with advanced infertility procedures, IVF, GIFT and ZIFT.
- Infertility services for non-members (e.g. surrogate mothers who are not PacifiCare Members).
- Maternity care and services for non-members.
- Intravenous Gamma Globulin (IVIG).
- Any costs associated with the collection, preparation, storage of or donor fees for the use of donor sperm that may be used during a course of artificial insemination. This includes HIV testing of donor sperm when male factor infertility exists; e.g. use of another male relative's sperm.
- Artificial insemination procedures in excess of six, when a viable infant has not been born as a result of infertility treatment(s) or unless the Member conceives. The benefit will renew if the Member conceives.
- Ovum transplants, ovum or ovum bank charges.

Definitions

1. Infertility is defined as either:
    a. The presence of a demonstrated medical condition recognized by a licensed physician or surgeon as a cause of infertility; or
    b. The inability of a woman to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception;
2. Basic Infertility Services are the reasonable and necessary services associated with the diagnosis and treatment as disclosed in this document, unless the PacifiCare Medical Director or designee determines that:
    a. Continued treatment has no reasonable chance of producing a viable pregnancy; or
    b. Advanced Reproductive Therapy services are necessary, which are excluded under this supplemental benefit.
    c. The Member has received the lifetime benefit maximum of six artificial insemination procedures; cumulatively under one or more PacifiCare Health Plans has occurred.
3. Advanced Reproductive Therapy, as excluded under this Basic Infertility Services benefit are:
    a. In Vitro Fertilization (IVF). A highly sophisticated infertility treatment that involves obtaining mature eggs (oocytes) by surgical or nonsurgical procedures and combining the eggs and sperm in a laboratory setting. If fertilization and cell division occur, the resulting embryo(s) are transferred to the uterine cavity where implantation and pregnancy may occur.

b. Gamete Intrafallopian Transfer (GIFT). An infertility treatment that involves obtaining eggs (through medical and surgical procedures) and sperm, loading the eggs and sperm into a catheter, then emptying the contents of the catheter into the fallopian tube. The intent of this procedure is to have fertilization occur in the fallopian tubes as it would in a fertile woman.

c. Zygote Intrafallopian Transfer (ZIFT). An infertility treatment that involves obtaining mature eggs (oocytes) by surgical or nonsurgical procedures and combining the eggs and sperm in a laboratory setting. The fertilized oocytes, or zygotes, are transferred to the fallopian tube before cell division occurs. The intent of this procedure is to have the zygote travel to the uterus via the fallopian tube as it would in a fertile woman.

4. Lifetime benefit maximum is individually cumulative for the Member over one or more PacifiCare plans. Any Member that terminates from a PacifiCare Health Plan with a lifetime benefit maximum, and subsequently re-enrolls in another PacifiCare Plan with a lifetime benefit maximum, will carry over any previous benefit utilization calculated by his or her previous PacifiCare benefit coverage into the new PacifiCare Benefit plan. In the event the Member has exhausted the lifetime benefit maximum on the previous PacifiCare Health Plan, the Member is no longer eligible for any further benefits.

Behavioral Health

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 *Unlimited days (based upon Medical Necessity)*	$250 per admission
Outpatient Treatment Unlimited visits (based upon Medical Necessity)	$15 Copayment per visit
Emergency and Urgently Needed Services[1] *(Copayment waived if admitted as inpatient)*	Same as medical plan Copayment for Emergency and Urgently Needed Services[1]

Chemical Dependency Health Services

Inpatient Deductible	None
Inpatient Treatment	$250 per admission
Outpatient Treatment	$15 Copayment per visit
Emergency and Urgently Needed Services[1] *(Copayment waived if admitted as inpatient)*	Same as medical plan Copayment for Emergency and Urgently Needed Services[1]

Serious Mental Illness Benefit[2]

Inpatient Deductible	None
Inpatient per Admittance	$250 per admission
Inpatient, Residential and Day Treatment *Unlimited days (based upon Medical Necessity)*	$250 per admission
Outpatient Treatment Unlimited visits *(based upon Medical Necessity)*	$15 Copayment per visit
Emergency and Urgently Needed Services[1] *(Copayment waived if admitted as inpatient)*	Same as medical plan Copayment for Emergency and Urgently Needed Services[1]

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

[2] Severe Mental Illness Diagnoses include: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, pervasive developmental disorders (autism), anorexia and bulimia nervosa. In addition, the Severe Mental Illness Benefit includes coverage of Serious Emotional Disturbance of Children (SED).

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

Section 6. How Your Behavioral Health Care Benefits Work

- **What are Behavioral Health Services?**
- **What is a Severe Mental Illness?**
- **What is the Serious Emotional Disturbance of a Child?**
- **What does PBHC do?**

This section helps you understand what behavioral health services are and provides a general understanding of some of the services PacifiCare Behavioral Health of California provides.

What are Behavioral Health Services?

Behavioral Health Services are those services provided or arranged by PBHC for the Medically Necessary treatment of:

- Mental Disorders, including treatment for the Severe Mental Illness of an adult or child and/or the Serious Emotional Disturbance of a Child, and/or
- Alcohol and drug problems, also known as Chemical Dependency, Substance Use or Substance Abuse.

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, including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified, including Atypical Autism;
- Schizoaffective Disorder;
- Schizophrenia.

What is the Serious Emotional Disturbance of a Child?

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

1. Has one or more Mental Disorders as defined by the *Diagnostic and Statistical Manual (DSM-IV-TR)*, 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
2. Is under the age of eighteen (18) years old.
3. Furthermore, the child must meet one or more of the following criteria:
    a. 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, or
        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,
    b. The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a Mental Disorder; or
    c. 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.

What does PacifiCare Behavioral Health of California do?

PBHC arranges for the provision of Behavioral Health Services to our Members.

- You have direct 24-hour phone access to our services.
- Your Medically Necessary Behavioral Health Services are coordinated and paid for as provided

under your Behavioral Health Plan, so long as you use PBHC Participating Providers.

- You may be responsible for payment of some Copayments or Coinsurance amounts, as set forth in the attached *Schedule of Benefits*.

All services covered under this Behavioral Health Plan will be provided by a PBHC Participating Provider and must be Preauthorized by PBHC, except in the case of an Emergency. If you have questions about your benefits, simply call the PBHC Customer Service Department at 1-800-999-9585 at any time. Our staff is always there to assist you 24 hours a day, with understanding your benefits, authorizing services, helping you select a provider, or anything else related to your PBHC Behavioral Health Plan.

Your PBHC Behavioral Health Plan provides coverage for the Medically Necessary treatment of Mental Disorders and Chemical Dependency on both an inpatient and outpatient basis. Details concerning your behavioral health benefits can be found in your *Schedule of Benefits* of this *Combined Evidence of Coverage and Disclosure Form.*

Getting Started: Your Participating Provider

- **Do I need a Referral?**
- **How do I access Behavioral Health Services?**
- **Choice of Physicians and Providers**
- **Continuity of Care**

This Section explains how to obtain PBHC Behavioral Health Services and the role of PBHC's Participating Providers.

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 conditions. 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 access Behavioral Health Services?

Step 1

To access 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 member of the PBHC Behavioral Health 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 provider?
- What kind of provider do you prefer?

You will then be given the name and telephone number of one or more PBHC Participating Providers 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 from PBHC for any additional services you need that are covered under the PBHC Behavioral Health Plan. You do not need to call PBHC again.

Choice of Physicians and Providers

PBHC's Participating Providers include hospitals, group practices, and licensed behavioral health professionals, which include psychiatrists, psychologists, social workers, and marriage and family therapists. All Participating Providers are carefully screened and must meet strict PBHC licensing and program standards.

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 our *Provider Directory*.

Facilities

Along with listing our Participating Providers, your PBHC Participating *Provider Directory* has detailed information about our Participating Providers. This includes a QUALITY INDEX® for helping you become familiar with our Participating Providers. If you need a copy or would like assistance picking you Participating Provider, please call our Customer Service Department. Your can also find an online version of the PBHC Participating *Provider Directory* at **www.pbhi.com.**

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 PBHC Behavioral Health 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 (except in an Emergency) with no reimbursement from PBHC.

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 at 1-800-999-9585. For the hearing and speech impaired, use 1-888-877-5378 (TDHI). A staff member is always there to help.

Continuity of Care With a Terminated Provider

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 as long as the terminated provider agrees to continue providing 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 authorized 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.

Continuity of Care With a Terminated Provider

In the event your Participating Provider is no longer a part of the PBHC provider network for reasons other than breach of contract, a medical disciplinary cause, fraud or other criminal activity, you may be eligible to continue receiving care from that provider to ensure a smooth transition to a new Participating Provider and to complete a course of treatment with the same terminated Provider.

For a Member to continue receiving care from a terminated Provider, the following conditions must be met:

1. Continuity of Care services from a terminated Provider must be Preauthorized by PBHC;
2. The requested treatment must be a Covered Service under this Plan;
3. The terminated Provider must agree in writing to be subject to the same contractual terms and conditions that were imposed upon the Provider prior to termination, including but not limited to, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements, notwithstanding the provisions outlined in the provider contract related to Continuity of Care;
4. The terminated Provider must agree in writing to be compensated at rates and methods of payment similar to those used by PBHC for current Participating Providers providing similar services who are practicing in the same or a similar geographic area as the terminated Provider.

Covered Services for the Continuity of Care Condition under treatment by the Terminated or Non-Participating Mental Health Provider will be considered complete, when:

i. the member's Continuity of Care Condition under treatment is medically stable, and

ii. there are no clinical contraindications that would prevent a medically safe transfer to a Participating Mental Health Provider as determined by a PBHC Medical Director (or designee) in consultation with the member, the Terminated Mental Health Provider and, as applicable, the member's receiving Participating Provider.

All Continuity of Care requests will be reviewed on a case-by-case basis. Reasonable consideration will be given to the severity of the Member's condition and the potential clinical effect of a change in provider regarding the Member's treatment and outcome of the condition under treatment.

If you are receiving treatment for any of the specified Continuity of Care Conditions as limited and described in "Definitions," and believe you qualify for continued care with the terminating Provider, please call the Customer Service Department and request the form "Request for Continuity of Care." Complete and return the form to PBHC as soon as possible, but within thirty (30) calendar days of the provider effective date of termination.

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.

Continuity of Care for New Members

Under certain circumstances, new Members of PBHC may be able to temporarily continue receiving services from a Non-Participating Provider. This short-term transition assistance may be available for a new Member who:

1. Did not have the option to continue with his or her previous behavioral health plan at time of enrollment;
2. Had no other behavioral health plan choice other than through PBHC;
3. Is under treatment by a Non-Participating Provider at the time of enrollment for an acute or serious chronic mental health condition;
4. Is receiving treatment that is a benefit under this PBHC Benefit Plan; and
5. Was not offered a plan with an out-of-network option.
6. The Member must be new to PBHC as a result of the Members' Employer Group changing health plans.

Behavioral Health Services provided by a Non-Participating Provider may be covered by PBHC for the purpose of safely transitioning you or your Dependent to a PBHC Participating Provider. If the Behavioral Health Services are Preauthorized by PBHC, PBHC may cover such services to the extent they would be covered if provided by a PBHC Participating Provider under the PBHC Behavioral Health Plan. This means that you will only be responsible for your Copayment or coinsurance listed on the *Schedule of Benefits* and any services received will count toward your PBHC benefit plan limits. The Non-Participating Provider must agree in writing to the same contractual terms and conditions that are imposed upon PBHC Participating Providers, including reimbursement methodologies and rates of payment.

All services, except for Emergency Services, must be approved by PBHC. If you would like to request continuing treatment from a Non-Participating Provider, call the PBHC Customer Service Department within 30 days of your effective with PBHC, or as soon as reasonably possible, prior to your effective date of coverage under the PBHC Behavioral Health Plan. If you have any questions or would like a copy of PBHC's continuity-of-care policy, call or write the PBHC Customer Service Department.

Outpatient Treatment

For outpatient treatment, PBHC will authorize an appropriate number of Visits for you to continue treatment with the existing Non-Participating Provider in order to transition you safely to a PBHC Participating Provider.

Continuity of Care for New Members

Under certain circumstances, new Members of PBHC may be able to temporarily continue receiving services from a Non-Participating Provider. This short-term transition assistance may be available for a new Member who:

1. Did not have the option to continue with his or her previous behavioral health plan at time of enrollment;
2. Had no other behavioral health plan choice other than through PBHC;
3. Is under treatment by a Non-Participating Provider at the time of enrollment for an acute, serious, or chronic mental health condition;
4. Is receiving treatment that is a benefit under this PBHC Benefit Plan; and
5. Was not offered a plan with an out-of-network option.

Behavioral Health Services provided by a Non-Participating Provider may be covered by PBHC for the purpose of safely transitioning you or your Dependent to a PBHC Participating Provider. If the Behavioral Health Services are Preauthorized by PBHC, PBHC may cover such services to the extent they would be covered if provided by a PBHC Participating Provider under the PBHC Behavioral Health Plan. This means that you will only be responsible for your Copayment or coinsurance listed on the *Schedule of Benefits* and any services received will count toward your PBHC benefit plan limits. The Non-Participating Provider must agree in writing to the same contractual terms and conditions that are imposed upon PBHC Participating Providers, including reimbursement methodologies and rates of payment.

All services, except for Emergency Services, must be approved by PBHC. If you would like to request continuing treatment from a Non-Participating

Provider, call the PBHC Customer Service Department within the first 30 days, or as soon as reasonably possible, prior to your effective date of coverage under the PBHC Behavioral Health Plan. If you have any questions or would like a copy of PBHC's continuity-of-care policy, call or write the PBHC Customer Service Department.

Outpatient Treatment

For outpatient treatment, PBHC will authorize an appropriate number of Visits for you to continue treatment with the existing Non-Participating Provider in order to transition you safely to a PBHC Participating Provider.

Emergency Services and Urgently Needed Services

- **What is an Emergency?**
- **What are Psychiatric Emergency Services?**
- **What To Do When You require Psychiatric Emergency Services?**
- **What To Do When You Require Urgently Needed Services**
- **Continuing or Follow Up of Emergency Treatment**
- **If I am out of state or traveling, am I still covered?**

Worldwide, wherever you are, PBHC provides coverage for Emergency Services and Urgently Needed Services. This section will explain how to obtain Emergency Services and Urgently Needed Services. It will also explain what you should do following receipt of these services.

IMPORTANT!

If you believe you are experiencing an Emergency condition, call 911 or go directly to the nearest hospital emergency room or other facility for treatment.

What is an Emergency?

An Emergency is defined as a condition manifesting itself by acute symptoms of sufficient severity such that the absence of immediate Behavioral Health Services could reasonably be expected by the Member to 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 and experience a situation which requires the immediate provision of Behavioral Health Services such that a delay caused by seeking treatment from a PBHC Participating Provider in California would result in a serious deterioration to your mental health.

What are Psychiatric Emergency Services?

Psychiatric Emergency Services are Medically Necessary ambulance or ambulance transport services provided through the 911 Emergency response system. It includes the medical screening, examination and evaluation by a physician, or other licensed personnel – to the extent provided by law – to determine if a Psychiatric Emergency exists. If a Psychiatric Emergency condition exists, Psychiatric Emergency Services include the care and treatment by a physician necessary to stabilize or eliminate the Emergency condition within the capabilities of the facility.

What To Do When You Require Emergency Services

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.

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, must call PBHC at 1-800-999-9585.

This is important.

Psychiatric 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.

What To Do When You Require Urgently Needed Services

In-Area Urgently Needed Services

If you need Urgently Needed Services when you are in the geographic area served by your Participating Provider, you should contact your Participating Provider. If you are calling during nonbusiness hours, and your Participating Provider is not immediately available, call PBHC Customer Service Department for assistance in finding a provider near your area. If your Participating Provider or PBHC is temporarily unavailable or inaccessible, you should seek Urgently Needed Services from a licensed behavioral health professional wherever you are located.

Out-of-Area Urgently Needed Services

Urgently Needed Services are required in situations where a Member is temporarily outside the geographic area served by the Member's Participating Provider and the Member experiences a mental condition that, while less serious than an Emergency, could result in the serious deterioration of the Member's mental health if not treated before the Member returns to the geographic area serviced by his or her Participating Provider.

When you are temporarily outside the geographic area served by your Participating Provider, and you believe that you require Urgently Needed Services, you should, if possible, call (or have someone else call on your behalf) your Participating Provider. If you are calling during nonbusiness hours and your Provider is not immediately available, call PBHC Customer Service Department for assistance in finding a provider near your area. If your Participating Provider or PBHC is temporarily unavailable or inaccessible, you should seek Urgently Needed Services from a licensed behavioral health professional wherever you are located.

You, or someone else on your behalf, must notify PBHC or your Participating Provider within 24 hours, or as soon as reasonably possible, after the initial receipt of Urgently Needed Services.

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

Continuing or Follow Up of Emergency Treatment or Urgently Needed Services

If you require Behavioral Health Services following an Emergency or Urgently Needed Services and you desire that these services be covered, the Behavioral Health Services must be coordinated and authorized by PBHC. In addition, if a transfer does not create an unreasonable risk to your health, PBHC may require that you transfer to a PBHC Participating Provider designated by PBHC for any treatment following the Emergency or Urgently Needed Services.

Failure to transfer or to obtain approval from PBHC for continued treatment may result in all further treatment being denied if the services were not Medically Necessary or did not meet the Emergency or Urgently Needed Services criteria outlined in this document.

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 PBHC Customer Service Department to ensure your Emergency Treatment or Urgently Needed Services are 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.

Note: Under certain circumstances, you may need to pay for your Emergency or Urgently Needed Services at the time of treatment. If this is necessary, please pay for such services and then contact PBHC at the earliest opportunity. Be sure to keep all receipts and copies of relevant medical documentation. You will need these to be properly reimbursed. For more information on submitting claims to PBHC, please refer to **Section 7. Payment Responsibility** in this *Combined Evidence of Coverage and Disclosure Form*.

Covered Behavioral Health Services

- **What Behavioral Health Services are covered?**
- **Exclusions and Limitations of Benefits**

This section explains your Behavioral Health Benefits, including what is and is not covered by PBHC. You can find some helpful definitions in the back of this publication. For any Copayments that may be associated with a benefit, you need to refer to your Schedule of Benefits, a copy of which is included with this document.

What Behavioral Health Services are covered?

Behavioral Health Services are covered only when they are:

- Incurred while the Member is eligible for coverage under this Behavioral Health Plan;
- Preauthorized by PBHC 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 of Mental Disorders and/or Chemical Dependency as outlined in the *Schedule of Benefits*, provided the above criteria have been satisfied. You should refer to your *Schedule of Benefits* for further information about your particular Behavioral Health Plan.

I. Mental Health Services (including services for the diagnosis and treatment of SMI and SED conditions):

A. **Inpatient**

1. **Inpatient Mental Health Services** provided at an Inpatient Treatment Center or Day Treatment Center are covered when Medically Necessary, Preauthorized by PBHC, and provided at a Participating Facility.
2. **Inpatient Physician Care –** Medically Necessary Mental Health Services provided by a Participating Practitioner while the Member is hospitalized as an inpatient at an Inpatient Treatment Center or is receiving services at a Participating Day Treatment Center and which have been Preauthorized by PBHC.

B. **Outpatient**

1. **Outpatient Provider Care –** Medically Necessary Mental Health Services provided by a Participating Practitioner and Preauthorized by PBHC. Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient Treatment Center.

II. Chemical Dependency Services

A. **Inpatient**

1. **Inpatient Chemical Dependency Services, including Medical Detoxification provided at an Inpatient Treatment Center –** Medically Necessary Chemical Dependency Services, including Medical Detoxification, which have been Preauthorized by PBHC and are provided by a Participating Practitioner while the Member is confined in a Participating Inpatient Treatment Center.
2. **Inpatient Physician Care –** Medically Necessary Chemical Dependency Services, including Medical Detoxification, provided by a Participating Practitioner while the Member is confined at an Inpatient Treatment Center or at a Residential Treatment Center, or is receiving services at a Participating Day Treatment Center and which have been Preauthorized by PBHC.
3. **Chemical Dependency Services Rendered at a Residential Treatment Center –** Medically Necessary Chemical Dependency Services provided by a Participating Practitioner, provided to a Member during a confinement at a Residential Treatment Center are covered, if provided or prescribed by a Participating Practitioner and Preauthorized by PBHC.
4. **Medical Detoxification –** Medical Detoxification services are covered when provided by a Participating Practitioner at a Participating Inpatient Treatment Center or at a Residential Treatment Center when Preauthorized by PBHC.

B. **Outpatient**

1. **Outpatient Provider –** Medically Necessary Chemical Dependency Services provided by a Participating Practitioner and Preauthorized by PBHC. Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient Treatment Center.

III. Other Behavioral Health Services

1. **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 only when specifically authorized by PBHC.
2. **Laboratory Services –** Diagnostic and therapeutic laboratory services are covered when ordered by a Participating Practitioner in connection with the Medically Necessary diagnosis and treatment of Mental Disorder and/or Chemical Dependency when Preauthorized by PBHC.
3. **Inpatient Prescription Drugs –** Inpatient prescription drugs are covered only when prescribed by a PBHC Participating Practitioner for treatment of a Mental Disorder or Chemical Dependency while the Member is confined to an Inpatient Treatment Center or, in the case of treatment of Chemical Dependency, a Residential Treatment Center.
4. **Injectable Psychotropic Medications –** Injectable psychotropic medications are covered if prescribed by a PBHC Participating Practitioner for treatment of a Mental Disorder when Preauthorized by PBHC.
5. **Psychological Testing –** Medically Necessary psychological testing is covered when Preauthorized by PBHC and provided by a Participating Practitioner who has the appropriate training and experience to administer such tests.

Exclusions and Limitations of Benefits

Unless described as a Covered Service in an attached supplement, all services and benefits described below are excluded from coverage under this Behavioral Health Plan. Any supplement must be an attachment to this *Combined Evidence of Coverage and Disclosure Form*.

1. Any confinement, treatment, service or supply not authorized by PBHC, except in the event of an Emergency.
2. All services not specifically included in the *PBHC Schedule of Benefits* included with this *Combined Evidence of Coverage and Disclosure Form*.
3. Services received prior to the Member's effective date of coverage, after the time coverage ends, or at any time the Member is ineligible for coverage.
4. Services or treatments which are not Medically Necessary, as determined by PBHC.
5. Services or treatment provided to you which duplicate the benefits to which you are entitled under any applicable Workers' Compensation law are not covered, as described in the section of this *Combined Evidence of Coverage and Disclosure Form* titled, "Non-duplication of benefits with Workers' Compensation."
6. Any services that are provided by a local, state or federal governmental agency are not covered except when coverage under this Behavioral Health Plan is expressly required by federal or state law.
7. Speech therapy, physical therapy and occupational therapy services provided in connection with the treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development.
8. Treatments which do not meet national standards for mental health professional practice.
9. Routine, custodial, and convalescent care, long-term therapy and/or rehabilitation. Individuals should be referred to appropriate community resources such as school district or regional center for such services.)
10. Any services provided by non-licensed providers.
11. Pastoral or spiritual counseling.

12. Dance, poetry, music or art therapy services except as part of a Behavioral Health Treatment Program.
13. 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.
14. Genetic counseling services.
15. Community Care Facilities that provide 24-hour nonmedical residential care.
16. Weight control programs and treatment for addictions to tobacco, nicotine or food.
17. Counseling for adoption, custody, family planning or pregnancy in the absence of a *DSM-IV-TR* diagnosis.
18. Sexual therapy programs, including therapy for sexual addiction, the use of sexual surrogates, and sexual treatment for sexual offenders/ perpetrators of sexual violence.
19. Personal or comfort items, and non-Medically Necessary private room and/or private-duty nursing during inpatient hospitalization are not covered.
20. With the exception of injectable psychotropic medication as set forth in Covered Behavioral Health Services, all nonprescription and prescription drugs which are prescribed during the course of outpatient treatment are not covered. Outpatient prescription drugs may be covered under your medical plan. Please refer to the Member disclosure materials describing the medical benefit. (Nonprescription and prescription drugs prescribed by a PBHC Participating Practitioner while the Member is confined at an Inpatient Treatment Center and nonprescription and prescription drugs prescribed during the course of inpatient Emergency treatment whether provided by a Participating or Non-Participating Practitioner are covered under the inpatient benefit.)
21. Surgery or acupuncture.
22. Services that are required by a court order as a part of parole or probation, or instead of incarceration, which are not Medically Necessary.
23. Neurological services and tests, including, but not limited to, EEGs, PET scans, beam scans, MRIs, skull X-rays and lumbar punctures.
24. Treatment sessions by telephone or computer Internet services.
25. Evaluation or treatment for education, professional training, employment investigations, fitness for duty evaluations, or career counseling.
26. Educational services to treat developmental disorders, developmental delays or learning disabilities are not covered. A learning disability is a condition where there is a meaningful difference between a child's current academic level of function and the level that would be expected for a child of that age. Educational services include, but are not limited to, language and speech training, reading and psychological and visual integration training as defined by the *American Academy of Pediatrics Policy Statement – Learning Disabilities, Dyslexia and Vision: A Subject Review*.
27. Treatment of problems that are not Mental Disorders are not covered, except for diagnostic evaluation.
28. Experimental and/or Investigational Therapies, Items and Treatments are not covered, unless required by an external, independent review panel as described in the section of this *Combined Evidence of Coverage and Disclosure Form* captioned "Experimental and Investigational Therapies." Unless otherwise required 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 the PBHC Medical Director or a designee. For the purpose of this *Combined Evidence of Coverage and Disclosure Form*, procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/guidelines are met:
    - It cannot lawfully be marketed without the approval of the Food and Drug Administration

(FDA), and such approval has not been granted at the time of its use or proposed use.

- It is a subject of a current investigation of new drug or new device (IND) applications on file with the FDA.
- It is the subject of an ongoing clinical trial (Phase I, II, or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and the Department of Health and Human Services.
- It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum-tolerated dose or effectiveness in comparison to conventional treatments.
- It is being delivered or should be delivered subject to approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).
- Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect.
- The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
- It is not Experimental or Investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab test or imaging ordered to evaluate the effectiveness of the Experimental therapy).
- The source of information to be relied upon by PBHC in determining whether a particular treatment is Experimental or Investigational, and therefore not a covered benefit under this Behavioral Health Plan, include but are not 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 informed 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 and scientific literature regarding the drug, device, treatment or procedure;
  - Expert medical opinion;
  - Opinions of other agencies or review organizations (e.g., ECRI Health Technology Assessment Information Services or HAYES New Technology Summaries);
  - Regulations and other official actions and publications issued by agencies such as the FDA, DHHS and Agency for Healthcare Research and Quality (AHRQ);
  - PBHC Technology Assessment Committee Guidelines.

A Member with a life-threatening or seriously debilitating condition may be entitled to an expedited external, independent review of PBHC's coverage determination regarding Experimental or Investigational therapies as described in the section of this *Combined Evidence of Coverage and Disclosure Form* captioned, "Experimental and Investigational Therapies."

29. Expenses incurred due to liable third parties are not covered, as described in the section of this *Evidence of Coverage* titled, "Reimbursement of Third Party Expenses."
30. Mental Health Services rendered at a Residential Treatment Center or other facilities or institutions that are not Inpatient Treatment Centers.
31. Methadone maintenance treatment is not covered.
32. Services provided to the Member on an Out-of-Network basis. (SMI and SED coverage is only covered on an In-Network basis under this plan.)

Overseeing Your Behavioral Health Services

- **How PBHC Makes Important Benefit Decisions**
- **Second Opinions**
- **New Treatment and Technologies**
- **Experimental and Investigational Therapies**
- **Appealing a Behavioral Health Benefit Decision**
- **Independent Medical Review**

This section explains how PBHC authorizes or makes changes to your Behavioral Health Services, how we evaluate new behavioral health technologies and how we reach decisions about your coverage.

You will also find out what to do if you are having a problem with your Behavioral Health Plan, including how to appeal a behavioral health benefit decision by PBHC or one of our Participating Providers. You will learn the process that is available for filing a formal grievance, as well as how to request an expedited decision when your condition requires a quicker review.

How PBHC Makes Important Benefit Decisions

Authorization, Modification and Denial of Behavioral Health Services

When a Member requests Mental Health Services or Chemical Dependency Services, PBHC uses established utilization management (UM) criteria to approve, deny, delay or modify authorization of benefits based on Medical Necessity. The criteria used for evaluating Mental Health Services are based on empirical research and industry standards. These are the *MCAP Behavioral Health Criteria*. For Chemical Dependency Services PBHC uses the *American Society of Addiction Medicine Placement Guidelines for Substance Related Disorder - Version II-Revised*. The UM criteria used to deny, delay, or modify requested services in the Member's specific case will be provided free of charge to the Participating Provider and to the Member. The public is also able to receive specific criteria or guideline, based on a particular diagnosis, upon request.

If you or your Dependent(s) are receiving Behavioral Health Services from a school district or a regional center, PBHC will coordinate with the school district or regional center to provide Case Management of your Behavioral Health Treatment Program. Upon PBHC's request, you or your Dependent(s) may be required to provide a copy of the most recent Individual Education Plan (IEP) that you or your Dependent(s) received from the school district and or the most recent Individual Program Plan (IPP) or Individual Family Service Plan (IFSP) from the regional center to coordinate these services.

The PBHC-qualified physician or other appropriate qualified licensed health care professional, and its Participating Providers make decisions to deny, delay, or modify requests for authorization of Behavioral Health Services, based on Medical Necessity, within the following time frames as required by California state law:

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

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

approve or deny the request for authorization within the time frame specified above as applicable.

PBHC notifies requesting Participating Providers of decisions to deny or modify request for authorization of Behavioral Health Services of Members within twenty-four (24) hours of the decision. Members are notified of decisions, in writing, within two (2) business days of the decision. The written decision will include the specific reason(s) for the decision, the clinical reason(s) for modifications or denials based on a lack of Medical Necessity, and information about how to file an appeal of the decision with PBHC. In addition, the internal criteria or benefit interpretation policy, if any, relied upon in making this decision will be made available upon request by the Member.

If the Member requests an extension of a previously authorized and currently ongoing course of treatment, and the request is an "Urgent Request," as defined above, PBHC will modify or deny the request as soon as possible, taking into account the Member's behavioral health condition, and will notify the Member of the decision within 24 hours of the request, provided the Member made the request to PBHC at least 24 hours prior to the expiration of the previously authorized course of treatment. If the concurrent care request is not an Urgent Request, as defined above, PBHC will treat the request as a new request for a Covered Service under the Behavioral Health Plan and will follow the time frame for non-Urgent requests, as discussed above.

If you would like a copy of PBHC's description of processes utilized for the authorization or denial of Behavioral Health Services, or the criteria or guidelines related to a particular condition, you may contact the PBHC Customer Service Department or visit the PBHC Web site at www.pbhi.com.

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:

- the Member questions the reasonableness or necessity of recommended procedures;
- 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;
- 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;
- 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
- 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 your or your Dependent's condition. For circumstances other than an imminent or serious threat to your health, a second opinion request will be approved or denied within five (5) business days after the Participating Provider or PBHC receives the request. When there is an imminent and serious threat to your behavioral health, a decision about your second opinion will be made within 72 hours after receipt of the request by your Participating Provider or PBHC.

If you are requesting a second opinion about care given by your Participating Provider, the second opinion will be provided by an appropriately qualified behavioral health professional of your choice within the same Participating Provider Network. If you request a second opinion about care received from a specialist, the second opinion will be provided by any behavioral health care professional of your choice from within the same Participating Provider Network. The Participating Provider providing the second opinion will possess the clinical background, including training and expertise, related to the illness or condition associated with the request for a second opinion.

If there is no qualified Participating Provider within the network, then PBHC will authorize a second

opinion by an appropriately qualified behavioral health professional outside the Participating Provider network. In approving a second opinion either inside or outside of the Participating Provider network, PBHC will take into account the ability of the Member to travel to the provider.

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 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 Behavioral Health Plan. You will be responsible for paying any Copayment, as set forth in your *Schedule of Benefits*, to the PBHC Provider who renders the second opinion. If you obtain a second opinion without Preauthorization from your Participating Provider or PBHC, you will be financially responsible for the cost of the opinion.

If you or your Dependent's request for a second opinion is denied, PBHC will notify you in writing and provide the reason for the denial. You or your Dependent may appeal the denial by following the procedures outlined in the "Appeals" section described below.

To receive a copy of the Second Opinion policy, you may call or write the PBHC Customer Service Department at:

PacifiCare Behavioral Health of California, Inc.
Post Office Box 55307
Sherman Oaks, California 91413-0307
1-800-999-9585

How are new treatment and technologies evaluated?

PBHC is committed to evaluating new treatments and technologies in behavioral health care. A committee composed of PBHC's Medical Director and people with subject matter expertise meet at least once a year to assess new advances and programs.

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:

1. You have a life-threatening or seriously debilitating condition, as defined below, and it meets the criteria listed in items #2, #3, #4 and #5 below:
   - "Life-threatening" means either or both of the following: (i) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; (ii) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.
   - "Seriously Debilitating" means diseases or conditions that cause major irreversible morbidity.
2. 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
3. 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 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

4. 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
5. 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. Independent Medical Review for coverage decisions regarding Experimental or Investigational therapies will be processed in accordance with the protocols outlined under "Independent Medical Review Involving a Disputed Health Care Service" section of this *Evidence of Coverage*.

Please refer to the "Independent Medical Review of Grievances Involving a Disputed Health Care Service" section found later in this *Combined Evidence of Coverage and Disclosure Form* for more information.

What to Do if You Have a Problem

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 within 180 days of your receipt of an initial determination over the telephone by calling the PBHC toll-free number at 1-800-999-9585. 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

Or at the PBHC Web site: **www.pbhi.com**

Appealing a Behavioral Health Benefit Decision

The individual initiating the appeal may submit written comments, documents, records, and any other information relating to the appeal regardless of whether this information was submitted or considered in the initial determination. The Member may obtain, upon request and free of charge, copies of all documents, records, and other information relevant to the Member's appeal. An individual who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person will review the appeal.

The PBHC Medical Director (or designee) will review your appeal and make a determination within a reasonable period of time appropriate to the circumstances by not later than thirty (30) days after PBHC's receipt of the appeal, except in the case of "expedited reviews" discussed below. For appeals involving the delay, denial, or modifications of Behavioral Health Services, PBHC'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 Behavioral Health Services based on a finding that the services are not Covered Services, the response will specify the provisions in the plan contract that exclude that coverage. If the complaint is related to quality of care, the complaint will be reviewed through the procedure described in the section of this *Combined Evidence of Coverage and Disclosure Form* captioned PBHC Quality Review Process.

Binding Arbitration and Voluntary Mediation

If the Member is dissatisfied with the appeal, the Member may submit or request that PBHC submit the appeal to voluntary mediation and/or binding arbitration before Judicial Arbitration and Mediation Service (JAMS). Such voluntary mediation or binding arbitration will be limited to claims that are not subject to the Employee Retirement Income Security Act of 1974 (ERISA).

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 JAMS Mediation 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.

Binding Arbitration – Any and all disputes of any kind whatsoever, including, claims for medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), except for claims subject to ERISA, between Member (including any heirs, successor or assigns of Member) and PBHC, or any of its parents, subsidiaries or affiliates shall be submitted to binding arbitration. Any such dispute will not be resolved by a lawsuit or resort to court process, except as the Federal Arbitration Act provides for judicial review of arbitration proceedings. Member and PBHC are giving up their constitutional rights to have any such dispute decided in a court of law before a jury and are instead accepting the use of binding arbitration by a single arbitrator in accordance with the Comprehensive Arbitration Rules and Procedures of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. The parties will endeavor mutually to 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 Comprehensive Arbitration Rules and Procedures will be utilized.

Arbitration hearings shall be held in the county in which the Member lives or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration. The arbitrator 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 shall have the power to grant all remedies provided by Federal and California law. The parties shall divide equally the expenses of JAMS and the arbitrator. In cases of extreme hardship, PBHC may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS. Please contact PBHC for more information on how to obtain a hardship application. The approval or denial of the hardship application will be determined solely by JAMS.

The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision. The requirement of binding arbitration shall not preclude a party from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court with jurisdiction; however, any and all other claims or causes of action including, but not limited to, those seeking damages, shall be subject to binding arbitration as provided herein. The Federal Arbitration Act, 9 U.S.C. SS 1-16, shall also apply to the arbitration.

BY ENROLLING IN PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA (PBHC) BOTH MEMBER (INCLUDING ANY HEIRS, SUCCESSOR OR ASSIGNS OF MEMBER) AND PBHC AGREE TO WAIVE THEIR CONSTITUTIONAL RIGHT TO A JURY TRIAL AND INSTEAD VOLUNTARILY AGREE TO THE USE OF BINDING ARBITRATION AS DESCRIBED IN THIS *COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM.*

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 functions 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 Department of Managed Health Care with a written statement of the disposition or pending status of the expedited review no later than three (3) days from receipt of complaint. The Department of Managed Health Care may waive the requirement that you complete the appeals process or participate in the appeals process for at least 30 days if the Department of Managed Health Care determines that an earlier review is necessary.

Independent Medical Review of Grievances Involving a Disputed Behavioral Health Service

A Member may request an Independent Medical Review (IMR) of disputed Behavioral Health Services from the Department of Managed Health Care (DMHC) if the Member believes that Behavioral Health Services have been improperly denied, modified,

or delayed by PBHC. A "disputed Behavioral Health Service" is any Behavioral Health Service eligible for coverage under the *Evidence of Coverage* that has been denied, modified, or delayed by PBHC, in whole or in part because the service requested by you or your Provider based on a finding that the requested service is experimental or investigational or is not Medically Necessary. The Member must meet the criteria described in the "Eligibility" section to see if his or her grievance qualifies for an IMR. The IMR process is in addition to the procedures and remedies that are available to the Member under the PBHC Appeal Process described above. If your complaint or appeal pertains to a disputed Behavioral Health Service subject to IMR (as discussed below), you should file your complaint or appeal within 180 days of receiving a denial notice.

Completed applications for IMR should be submitted to the DMHC. The Member pays no fee to apply for IMR. The Member has the right to include any additional information or evidence not previously provided to PBHC in support of the request for IMR. PBHC will provide the Member with an IMR application form with any grievance disposition letter that denies, modifies, or delays Behavioral Health Services. The Member may also reach the DMHC by calling 1-888-HMO-2219. The DMHC fax number is 1-916-229-0465.

A decision not to participate in the IMR process may cause the Member to forfeit any statutory right to pursue legal action against PBHC regarding the disputed behavioral health service.

IMR Eligibility for Independent Medical Review

Experimental or Investigational Treatment Decisions

If you suffer from a life-threatening or seriously debilitating condition, you may have the opportunity to seek IMR of PBHC's coverage decision regarding Experimental or Investigational therapies under California's Independent Medical Review System pursuant to Health and Safety Code Section 1370.4. Life-Threatening means either or both of the following: (a) conditions where the likelihood of death is high unless the course of the condition is interrupted; (b) conditions with potentially fatal outcomes, where the end point of clinical intervention is survival. Seriously Debilitating means conditions that cause major irreversible morbidity.

To be eligible for IMR of Experimental or Investigational treatment, your case must meet all of the following criteria:

1. Your Provider certifies that you have a life-threatening or seriously debilitating condition for which:
    a. Standard therapies have not been effective in improving your condition, or
    b. Standard therapies would not be medically appropriate for you, or
    c. There is no more beneficial standard therapy covered by PBHC than the proposed Experimental or Investigational therapy proposed by your Provider under the following paragraph.
2. Either (a) your PBHC 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 has included a statement of the evidence relied upon by the Provider in certifying his or her recommendation; or (b) you or your Non-Contracting Provider – who is licensed, board certified or board-eligible Provider qualified to practice in the specialty appropriate to treating your condition – has requested a therapy that, based on two documents of medical and scientific evidence identified in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial than any available standard therapy. To satisfy this requirement, the Provider certification must include a statement detailing the evidence relied upon by the Provider in certifying his or her recommendation. (Please note that PBHC is not responsible for the payment of services rendered by Non-Contracting Providers who are not otherwise covered under your PBHC benefits.)
3. A PBHC Medical Director has denied your request for a treatment or therapy recommended or requested pursuant to the above paragraph.
4. The treatment or therapy recommended pursuant to Paragraph 2 above would be a Covered Service, except for PBHC's determination that

the treatment, drug, device, procedure or other therapy is Experimental or Investigational.

If you have a life-threatening or seriously debilitating condition and PBHC denies your request for Experimental or Investigational therapy, PBHC will send a written notice of the denial within five (5) business days of the decision. The notice will advise you of your right to request IMR, and include a Provider certification form and an application form with a preaddressed envelope to be used to request IMR from the DMHC. (Please note that you may request an IMR, if PBHC denied your request for Experimental or Investigational therapy without going through the PBHC grievance process.)

Disputed Behavioral Health Services Regarding Medically Necessity

You may also request IMR when any Behavioral Health Service has been denied, modified or delayed by PBHC or one of its Providers, in whole or in part, due to a finding that the service is not Medically Necessary. (**Note:** Disputed Behavioral Health Services do not encompass coverage decisions. Coverage decisions are decisions that approve or deny services substantially based on whether or not a particular service is included or excluded as a covered benefit under the terms and conditions of your coverage.)

You are eligible to submit an application to the DMHC for IMR of a Disputed Behavioral Health Service if you meet all of the following criteria:

- The Member's provider has recommended a Behavioral Health Service as Medically Necessary; or
- The Member has received Urgently Needed Services or Emergency Services that a provider determined was Medically Necessary; or
- The Member has been seen by a PBHC Participating Provider for diagnosis and/or treatment of the medical condition for which the Member sought independent review;
- The disputed Behavioral Health Service has been denied, modified, or delayed by PBHC, based in whole or in part on a decision that the Behavioral Health Service is not Medically Necessary; and
- The Member has filed a grievance with PBHC and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days. If the grievance requires expedited review, the Member may bring it immediately to the DMHC's attention. The DMHC may waive the preceding requirement that the Member follow PBHC's grievance process in extraordinary and compelling cases.

Accepted Applications for the Independent Medical Review

Upon receiving a Member's application for IMR, the DMHC will review the request and notify the Member whether the Member's case has been accepted. If the Member's case is eligible for IMR, the dispute will be submitted to an Independent Medical Review Organization (IRO) contracted with the DMHC for review by one or more expert reviewers, independent of PBHC, who will make an independent determination of whether or not the care should be provided. The IRO selects an independent panel of behavioral health professionals knowledgeable in the treatment of the Member's conditions, the proposed treatment and the guidelines and protocols in the area of treatment under review. Neither the Member nor PBHC will control the choice of expert reviews.

PBHC must provide the following documents to the IRO within three (3) business days of receiving notice from the DMHC that the Member has successfully applied for an IMR:

- The relevant medical records in the possession of PBHC or its Participating Providers;
- All information provided to the Member by PBHC and any of its Participating Providers concerning PBHC and Participating Provider decision regarding the Member's condition and care (including a copy of PBHC's denial notice sent to the Member).
- Any materials that the Member or Provider submitted to PBHC and its Participating Providers in support of the request for the Behavioral Health Services.
- Any other relevant documents or information used by PBHC or its Participating Providers in determining whether the Behavioral Health Services should have been provided and any statement by PBHC or its Participating Providers explaining the reason for the decision. PBHC will provide copies of these documents to the Member

and the Member's Provider unless any information in them is found by the DMHC to be privileged.

If there is an imminent and serious threat to the Member's health, PBHC will deliver the necessary information and documents listed above to the IRO within 24 hours of approval of the request for IMR.

After submitting all of the required materials to the IRO, PBHC will promptly issue the Member a notification that includes an annotated list of the documents submitted and offer the Member the opportunity to request copies of those documents from PBHC.

If there is any information or evidence the Member or the Member's Provider wish to submit to the DMHC in support of IMR that was not previously provided to PBHC, the Member may include this information with the IMR application to the DMHC. Also as required, the Member or the Member's Provider must provide to the DMHC or the IRO copies of any relevant behavioral health records, and any newly developed or discovered relevant records after the initial documents are provided, and respond to any requests for additional records or other relevant information from the expert reviewers.

The Independent Medical Review Decision

The independent review panel will render its analysis and recommendations on the Member's IMR case in writing, and in layperson terms to the maximum extent practical, within 30 days of receiving the Member's request for IMR and supporting information. The time may be adjusted under any of the following circumstances:

- In the case of a review of Experimental or Investigational determination, if the Member's Provider determines that the proposed treatment or therapy would be significantly less effective if not promptly initiated. In this instance, the analysis and recommendations will be rendered within seven (7) days of the request for expedited review. The review period can be extended up to three (3) days for a delay in providing required documents at the request of the expert.
- If the Behavioral Health Services has not been provided and the Member's Provider or the DMHC certifies in writing that an imminent and serious threat to the Member's life exists, 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 Member's health. In this instance, any analyses and recommendation 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 expert reviewers' analyses and recommendations involving both regular and expedited reviews may be extended for up to three days in extraordinary circumstances or for good cause.

The IRO will provide the DMHC, PBHC, the Member and the Member's Provider 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. In the case of an Experimental or Investigational determination, the expert's analyses will state the reasons the requested Experimental or Investigational therapy is or is not likely to be more beneficial to the Member than any available standard therapy and the reasons for recommending why the therapy should or should not be provided by PBHC, citing the Member's specific medical condition, the relevant documents provided and the relevant medical and scientific evidence supporting the experts' recommendation. In the case of a review of the disputed health care service is Medically Necessary and cite the Member's medical condition, the relevant documents in the record and the reviewers' relevant findings.

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 Behavioral Health Services should be provided, the panel's decision will be deemed to be in favor of coverage. If the majority of the experts on the panel does not recommend providing the Behavioral Health Services, PBHC will not be required to provide the service.

When a Decision is Made

The DMHC will immediately adopt the decision of the IRO upon receipt and will promptly issue a written decision to the parties that will be binding on PBHC. PBHC will promptly implement the decision when received from the DMHC. In the case of an

IRO determination requiring reimbursement for services already rendered, PBHC will reimburse either the Member or the Member's Provider, whichever applies, within five (5) working days. In the case of services not yet rendered to the Member, PBHC will authorize the services within five (5) working days of receiving 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 the Member's Provider of the authorization.

PBHC will promptly reimburse the Member for reasonable costs associated with Urgently Needed Services or Emergency Services outside of PBHC Participating Provider network, if:

- The services are found by the IRO to have been Medically Necessary;
- The DMHC finds the Member's decision to secure services outside of PBHC's Participating Provider network prior to completing the PBHC grievance process or seeking IMR was reasonable under the circumstances; and
- The DMHC finds that the disputed health care services were a covered benefit under the PBHC Group Subscriber Agreement.

Behavioral Health Services required by IMR will be provided subject to the terms and conditions generally applicable to all other benefits under PBHC Plan.

For more information regarding the IMR process, or to request an application, the Member should contact the PBHC Customer Service Department at 1-800-999-9585.

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

The Quality Improvement Manager (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, a meeting may be arranged 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 Manager (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 Manager (or designee). After reviewing the medical records, the case may be 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 will 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 are confidential and cannot be shared with the Member. The outcome of the Quality Review Process cannot be submitted to voluntary mediation or binding arbitration, as described above under the PBHC Appeals Process. The Quality Improvement Manager 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 services plans. If you have a grievance against your health plan, you should first telephone your health plan at 1-800-999-9585 or 1-888-877-5378 (TDHI) and use your health plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal right or remedies that may be available to you. If you need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for

more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for Emergency or Urgent medical services. The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department's Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

How Your Behavioral Health Care Benefits Work

General Information

- **What if I get a bill?**
- **Your Financial Responsibilities**
- **Termination of Benefits**
- **Confidentiality of Information**
- **Translation Assistance**
- **Coverage in Extraordinary Situations**
- **Compensation for Providers**
- **Suspected Health Care Fraud**
- **Public Policy Participation**

What follows are answers to some questions about your coverage. If you have any questions of your own that have not been answered, please call our Customer Service Department.

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 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 *Evidence of Coverage and Disclosure Form*:

Forward the bill to:

PacifiCare Behavioral Health of California
Claim Department
P.O. Box 31053
Laguna Hills, CA 92654-1053

Your Financial Responsibilities

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

Termination of Benefits

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

Confidentiality of Information

PBHC takes the subject of Member confidentiality very seriously and takes great measures to protect the confidentiality of all Member information in its possession, including the protection of treatment records and personal information. PBHC provides information only to the professionals delivering your treatment or as otherwise required by law.

Confidentiality is built into the operations of PBHC through a system of control and security that protects both written and computer-based information.

A statement describing PBHC's policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request. If you would like a copy of PBHC's confidentiality policies and procedures, you may call our Customer Service Department at 1-800-999-9585.

Does PBHC offer a translation service?

PBHC uses a telephone translation service for almost 140 languages and dialects. That is in addition to the selection of Customer Service representatives who are fluent in a language other than English.

Does PBHC offer hearing and speech-impaired telephone lines?

PBHC has a dedicated telephone number for the hearing and speech impaired. This phone number is 1-888-877-5378 (TDHI).

How is my coverage provided under extraordinary circumstances?

In the unfortunate event of a major disaster, epidemic, war, riot, civil insurrection, or complete or partial destruction of facilities, our Participating Providers will do their best to provide the services you need. Under these extreme conditions, go to the nearest doctor or hospital for Emergency Services. PBHC will later provide appropriate reimbursement.

How does PBHC compensate its participating providers?

PBHC itself is not a provider of Behavioral Health Services. PBHC typically contracts with independent providers to provide Behavioral Health Services to its Members and with hospitals to provide hospital services. Once they are contracted, they become PBHC Participating Providers. PBHC's network

of Participating Providers includes individuals practitioners, group practices, and facilities.

PBHC Participating Providers, who are groups, or facilities, may in turn employ or contract with individual Psychiatrists, Psychologists or other licensed behavioral health professionals. None of the Participating Providers or their employees are employees or agents of PBHC. Likewise, neither PBHC nor any employee of PBHC is an employee or agent of any Participating Provider.

Our PBHC Participating Providers are paid on a discounted fee-for-service basis for the services they provide. They have agreed to provide services to you at the normal fee they charge, minus a discount. PBHC does not compensate nor does it provide any financial bonuses or any other incentives to 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.

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.

What do you do if you suspect health care fraud?

PBHC takes health care fraud by its Participating Providers or by its employees very seriously and has taken great measures to prevent, detect and investigate health care fraud. PBHC has put in place policies and procedures to address fraud and report fraud to the appropriate law enforcement and regulatory entities in the investigation and prosecution of health care fraud. If you suspect fraud by any PBHC Participating Provider or any PBHC employee, please call the PBHC anti-fraud hotline at 1-800-716-1166.

How can I participate in PBHC'S Public Policy Participation?

PBHC affords its Members the opportunity to participate in establishing its public policy. For the purpose of this paragraph, "public policy" means acts performed by PBHC and its employees to assure the comfort, dignity and convenience of Members who rely on Participating Providers to provide Covered Services. 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.

Definitions

PacifiCare Behavioral Health of California is dedicated to making its services easily accessible and understandable. To help you understand the precise meaning of many terms used to explain your benefits, we have provided the following definitions. These definitions apply to the capitalized terms used in your *Combined Evidence of Coverage and Disclosure Form*, as well as the *Schedule of Benefits*. Please refer to the *Schedules of Benefits* to determine which of the definitions below apply to your benefit plan.

Behavioral Health Services. Services for the Medically Necessary diagnosis and treatment of Mental Disorders and Chemical Dependency which are provided to Members pursuant to the terms and conditions of the PBHC Behavioral Health Plan.

Behavioral Health Plan. The PBHC Behavioral Health Plan that includes coverage for the Medically Necessary diagnosis and treatment of Mental Disorders and Chemical Dependency, as described in the Behavioral Health Group Subscriber Agreement, this *Combined Evidence of Coverage and Disclosure Form,* and the *Schedule of Benefits.*

Behavioral Health Treatment Plan. A written clinical presentation of the PBHC Participating Provider's diagnostic impressions and therapeutic intervention plans. The Behavioral Health Treatment Plan is submitted routinely to a PBHC 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 Chemical Dependency and/or Mental Disorders.

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

Calendar Year. The period of time commencing 12:00 a.m. on January 1 through 11:59 p.m. on December 31.

Case Management. A collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's behavioral health needs based on Medical Necessity, behavioral health benefits and available resources in order to promote a quality outcome for the individual Member.

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-TR.* 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. Medically Necessary services provided for the diagnosis and treatment of Chemical Dependency, which have been Preauthorized by PBHC.

Continuity of Care Condition(s). The completion of Covered Services will be provided by a terminated Participating Provider to a Member, who at all time of the Participating Provider's contract termination, was receiving any of the following Covered Services from that Participating Provider:

1. An Acute Condition: An acute condition is a behavioral health condition that involves a sudden onset of symptoms due to an illness, or other behavioral health problems that requires prompt medical attention and that has a limited duration. Completion of Covered Services will be provided for the duration of the acute condition.
2. A Serious Chronic Condition: A serious chronic condition is a behavioral health condition due to illness or other behavioral health conditions that is serious in nature, and that persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services will be provided for the period of time reasonably necessary to complete the active course of treatment and to arrange for a clinically safe transfer to a provider, as determined by the PBHC Medical Director (or designee) in consultation with the member, the terminated Participating Provider and as applicable, the receiving Participating Provider, consistent with good professional practice. Completion of Covered Services for this condition

will not exceed twelve (12) months from the agreement's termination.

3. Other Procedure: Other Procedure that has been authorized by PBHC or the member's assigned Participating Provider as part of a documented course of treatment and had been recommended and documented by the terminated Participating Provider to occur within 180 calendar days of the Agreement's termination date.

Copayments. Costs payable by the Member at the time Covered Services are received. Copayments may be a specific dollar amount or a percentage of covered charges as specified in this *Combined Evidence of Coverage and Disclosure Form* and are shown on the PBHC *Schedule of Benefits*.

Covered Services. Medically Necessary Behavioral Health Services provided pursuant to the Group Subscriber Agreement, this *Combined Evidence of Coverage and Disclosure Form* and *Schedule of Benefits* for Emergencies or those Behavioral Health Services which have been Preauthorized by PBHC.

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. 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.
Post Office Box 55307
Sherman Oaks, California 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 Behavioral Health Treatment Plan approved and monitored by a PBHC Participating Practitioner and which is also licensed, certified, or approved to provide such services by the appropriate state agency.

Dependent. Any Member of a Subscriber's family who meets all the eligibility requirements set forth by the Employer Group under this PBHC Behavioral Health Plan and for whom applicable Plan Premiums are received by PBHC.

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

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

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

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

Emergency Treatment. Medically Necessary ambulance and ambulance transport services provided through the 911 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 *Combined Evidence of Coverage and Disclosure Form*.

Employer Group. An employer, labor union, trust, organization, association, or other entity to which the PBHC Group Subscriber Agreement has been issued.

Family Member. The Subscriber's Spouse and any person related to the Subscriber or Spouse by blood, marriage, adoption or guardianship. An enrolled Family Member is a Family Member who is enrolled with PBHC, meets all the eligibility requirements of the Subscriber's Employer Group and PBHC, and for whom Premiums have been received by PBHC. An eligible Family Member is a Family Member who meets all the eligibility requirements of the Subscriber's Employer Group and PBHC.

Group Subscriber 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 (usually about six to 12 participants) by a PBHC Participating Practitioner. Group Therapy can be made available to the Member in lieu of individual outpatient therapy when Preauthorized by PBHC.

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

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

Limiting Age. The age established by the Employer Group when a Dependent is no longer eligible to be an enrolled Family Member under the Subscriber's coverage.

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.

Medical Detoxification. The medical treatment of withdrawal from alcohol, drug or other substance addiction, when Preauthorized by PBHC, is covered. In most cases of alcohol, drug or other substance abuse or toxicity, outpatient treatment is appropriate unless another medical condition requires treatment at an Inpatient Treatment Center.

Medically Necessary (or Medical Necessity) refers to an intervention, if, as recommended by the treating Practitioner and determined by the Medical Director of PBHC to be all of the following:

a. A health intervention for the purpose of treating a Mental or Chemical Dependency;

b. The most appropriate level of service or item, considering potential benefits and harms to the Member;

c. Known to be effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and

d. If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner that may be provided safely and effectively to the Member. "Cost-effective" does not necessarily mean lowest price.

A service or item will be covered under the PBHC Health Plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded and Medically Necessary. An intervention may be medically indicated yet not be a covered benefit or meet the definition of Medical Necessity.

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

i. *Treating Practitioner* means a Practitioner who has personally evaluated the patient.

ii. A *health intervention* is an item or service delivered or undertaken primarily to *treat* (that is, prevent, diagnosis, detect, treat or palliate) a Mental Disorder or Chemical Dependency or to maintain or restore functional ability. A *health intervention* is defined not only by the intervention itself, but also by the Mental Disorder or Chemical Dependency condition and the patient indications for which it is being applied.

iii. *Effective* means that the intervention can reasonably be expected to produce the intended result and to have expected benefits that outweigh potential harmful effects.

iv. *Health outcomes* are outcomes that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

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

vi. A *new intervention* is one that is not yet in widespread use for the Mental Disorder or Chemical Dependency and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.

vii. An intervention is considered *cost-effective* if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. The application of this criterion is to be on an individual case and the characteristics of the individual patient shall be determinative.

Medically Necessary (or Medical Necessity). Refers to Behavioral Health Services or supplies for treatment of a Mental Disorder or Chemical Dependency that are determined by PBHC's Medical Director (or designee) to be:

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

"Scientific evidence," as referenced above, shall include peer-reviewed medical literature, publications, reports and other authoritative medical sources.

Member. The Subscriber or any Dependent who is enrolled, covered and eligible for PBHC Behavioral Health Care coverage.

Mental Disorder. A mental or nervous condition diagnosed by a licensed practitioner according to the criteria in the *DSM-IV-TR* resulting in the impairment of a Member's mental, emotional, or behavioral functioning. Mental Disorders include the Severe Mental Illness of a person of any age and the Serious Emotional Disturbance of a Child.

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

Non-Participating Providers. Licensed psychiatrists, psychologists, marriage and family therapists, licensed clinical social workers, and other behavioral health professionals, hospitals, and other licensed behavioral health facilities which provide Behavioral Health Services to eligible Members, but have not entered into a written agreement with PBHC to provide such services to Members.

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

Participating Facility. An Inpatient Treatment Center, Day Treatment Center, Outpatient Treatment Center or Residential Treatment Center which is duly licensed in the State of California to provide either acute inpatient treatment, day treatment, or outpatient care for the diagnosis and/or treatment of Mental Disorders and/or Chemical Dependency, 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 Behavioral Health Services to Members.

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 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.

PBHC Clinician. A person licensed as a psychiatrist, psychologist, clinical social worker, marriage, family and child therapist, 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.

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.

Premiums. The periodic, fixed-dollar amount payable to PBHC by the Employer Group for or on behalf of the Subscriber and the Subscriber's eligible Dependents in consideration of Behavioral Health Services provided under this Plan.

Residential Treatment Center. A residential facility that provides services in connection with the diagnosis and treatment of behavioral health conditions and which is licensed, certified, or approved as such by the appropriate state agency.

Schedule of Benefits. The schedule of Behavioral Health Services which is provided to a Members under this Behavioral Health Plan. The *Schedule of Benefits* is attached and incorporated in full and made a part of this document.

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

1. Has one or more Mental Disorders as defined by the *Diagnostic and Statistical Manual* (*DSM-IV-TR*), 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
2. Is under the age of eighteen (18) years old.
3. Furthermore, the child must meet one or more of the following criteria:
    a. 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

b. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a Mental Disorder; or

c. 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.

Service Area. The geographic area in which PBHC is licensed to arrange for Behavioral Health Services in the State of California by the California Department of Managed Health Care.

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

- Anorexia Nervosa;
- Bipolar Disorder;
- Bulimia Nervosa;
- Major Depressive Disorder;
- Obsessive-Compulsive Disorder;
- Panic Disorder;
- Pervasive Developmental Disorder, including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified, including Atypical Autism;
- Schizoaffective Disorder;
- Schizophrenia.

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

Subscriber. The person whose employment or other status except for being a Family Member is the basis for eligibility to enroll in the PBHC Behavioral Health Plan and who meets all the applicable eligibility requirements of the Group and PBHC, and for whom Plan Premiums have been received by PBHC.

Totally Disabled or Total Disability. The persistent inability to engage reliably in any substantially gainful activity by reason of any determinable physical or mental impairment resulting from an injury or illness. 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 a medically determinable physical or mental impairment resulting from an injury or illness. The disability must be related to a Behavioral Health condition, as defined in the *DSM-IV-TR*, in order to qualify for coverage under this PBHC Plan. Determination of Total Disability shall be made by a PBHC Participating Provider based upon a comprehensive psychiatric examination of the Member or upon the concurrence by a PBHC Medical Director, if on the basis of a comprehensive psychiatric examination by a non-PBHC Participating Provider.

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

Urgent or Urgently Needed Services. Medically Necessary Behavioral Health Services received in an urgent care facility or in a provider's office for an unforeseen condition to prevent serious deterioration of a Member's health resulting from an unforeseen illness or complication of an existing condition manifesting itself by acute symptoms of sufficient severity such that treatment cannot be delayed.

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

NOTE: THIS *COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM* CONSTITUTES ONLY A SUMMARY OF THE PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA (PBHC) PLAN. THE GROUP SUBSCRIBER AGREEMENT BETWEEN PBHC AND THE EMPLOYER GROUP MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITONS OF COVERAGE. A COPY OF THE GROUP SUBSCRIBER AGREEMENT WILL BE FURNISHED UPON REQUEST AND IS AVAILABLE AT PBHC AND YOUR EMPLOYER GROUP'S PERSONNEL OFFICE.

PacifiCare Behavioral Health of California, Inc.
Post Office Box 55307
Sherman Oaks, California 91413-0307

Customer Service:
1-800-999-9585
1-888-877-5378 (TDHI)
www.pbhi.com

Section 7. Payment Responsibility

- **Premiums and Copayments**
- **What To Do If You Receive a Bill**
- **Coordinating Benefits With Another Plan**
- **Medicare Eligibility**
- **Workers' Compensation Eligibility**
- **Other Benefit Coordination Issues**

One of the advantages of your health care coverage is that most out-of-pocket expenses are limited to Copayments. This section explains these and other health care expenses. It also explains your responsibilities when you're eligible for Medicare or workers' compensation coverage and when PacifiCare needs to coordinate your benefits with another plan.

What are Premiums? (Prepayment Fees)

Premiums are fees the University of California pays to cover the basic costs of your health care package. The University usually pays these Premiums on a monthly basis. Often the Subscriber shares the cost of these Premiums with deductions from his or her salary. If you are the Subscriber, you should already know if you're contributing to your Premium payment; if you aren't sure, contact your University of California Benefits Representative at your campus or lab. You may also contact the University of California Customer Service number at 1-800-888-8267. He or she will know if you're contributing to your Premium, as well as the amount, method and frequency of this contribution.

What are Copayments? (Other Charges)

Aside from the Premium, you may be responsible for paying a charge when you receive a Covered Service. This charge is called a Copayment and is outlined in your *Schedule of Benefits*. If you review your *Schedule of Benefits*, you'll see that the amount of the Copayment depends on the service, as well as the Provider from whom you choose to receive your care.

Annual Copayment Maximum

For certain Covered Services, a limit is placed on the total amount you pay for Copayments during a calendar year. This limit is called your Annual Copayment Maximum, and when you reach it, for the remainder of the calendar year, you will not pay any additional Copayments for these Covered Services. You can find your Annual Copayment Maximum in your *Schedule of Benefits*. If you've surpassed your Annual Copayment Maximum, submit all your health care Copayment receipts and a letter of explanation to:

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

Remember, it's important to send us all Copayment receipts along with your letter. They confirm that you've reached your Annual Copayment Maximum. You will be reimbursed by PacifiCare for Copayments you make beyond your individual or family Annual Copayment Maximum. The Annual Copayment Maximum includes coverage for Severe Mental Illnesses (SMI) of adults and children and Serious Emotional Disturbances of a Child.

NOTE: The calculation of your Annual Copayment Maximum will not include supplemental benefits that may be offered by the University of California (e.g., coverage for outpatient prescription drugs, mental health benefits or hearing aid benefits). The Annual Copayment Maximum includes coverage for Severe Mental Illnesses (SMI) of adults and children and Serious Emotional Disturbances of a Child (SED).

If You Get a Bill (Reimbursement Provisions)

If you are billed for a Covered Service provided or authorized by your Primary Care Physician or Participating Medical Group or if you receive a bill for Emergency or Urgently Needed Services, you should do the following:

1. Call the Provider, then let them know you have received a bill in error and you will be forwarding the bill to PacifiCare.
2. Give the Provider your PacifiCare Health Plan information, including your name and PacifiCare Member number. Forward the bill to:

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

Include your name, your PacifiCare ID number and a brief note that indicates you believe the bill is for a Covered Service. The note should also include the date of service, the nature of the service and the name of

the Provider who authorized your care. No claim form is required. If you need additional assistance, call our Customer Service department.

PLEASE NOTE: Your Provider will bill you for services that are not covered by PacifiCare or haven't been properly authorized. You may also receive a bill if you've exceeded PacifiCare's coverage limit for a benefit.

What is a *Schedule of Benefits*?

Your *Schedule of Benefits* is printed separately from this document and lists the Covered Services unique to your plan. It also includes your Copayments, as well as the Annual Copayment Maximum and other important information. If you need assistance understanding your *Schedule of Benefits*, or need a new copy, please call our Customer Service department.

Bills From Non-Participating Providers

If you receive a bill for a Covered Service from a Physician who is not one of our Participating Providers and the service was Preauthorized and you haven't exceeded any applicable benefit limits, PacifiCare will pay for the service less the applicable Copayment. (Preauthorization isn't required for Emergency Services and Urgently Needed Services. See **Section 3. Emergency and Urgently Needed Services**.) You may also submit a bill to us if a Non-Participating Provider has refused payment directly from PacifiCare. You should file a claim within 90 days, or as soon as reasonably possible, of receiving any services and related supplies. Forward the bill to:

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

Include your name, PacifiCare ID number and a brief note that indicates your belief that you've been billed for a Covered Service. The note should also include the date of service, the nature of the service and the name of the Provider who authorized your care. No claim form is required.

PacifiCare will make a determination within 30 days from the date you submit a claim containing all information reasonably necessary to decide the claim. PacifiCare will not pay any claim that is filed more than one year from the date the services or supplies were provided. PacifiCare also will not pay for excluded services or supplies unless authorized by your Primary Care Physician, your Participating Medical Group or directly by PacifiCare. Any payment assumes you have not exceeded your benefit limits. If you've reached or exceeded any applicable benefit limit, these bills will be your responsibility.

How to Avoid Unnecessary Bills

Always obtain your care under the direction of PacifiCare, your Participating Medical Group, or your Primary Care Physician. By doing this, you only will be responsible for paying any related Copayments and for charges in excess of your benefit limitations. Except for Emergency or Urgently Needed Services, if you receive services not authorized by PacifiCare or your Participating Medical Group, you may be responsible for payment. This is also true if you receive any services not covered by your plan. (Services not covered by your plan are included in **Section 5. Your Medical Benefits.**)

Your Billing Protection

All PacifiCare Members have rights that protect them from being charged for Covered Services in the event a Participating Medical Group does not pay a Provider, a Provider becomes insolvent or a Provider breaches its contract with PacifiCare. In none of these instances may the Participating Provider send you a bill, charge you, or have any other recourse against you for a Covered Service. However, this provision does not prohibit the collection of Copayment amounts as outlined in the *Schedule of Benefits*.)

In the event of a Provider's insolvency, PacifiCare will continue to arrange for your benefits. If for any reason PacifiCare is unable to pay for a Covered Service on your behalf (for instance, in the unlikely event of PacifiCare's insolvency or a natural disaster), you are not responsible for paying any bills as long as you received proper authorization from your PacifiCare Participating Provider. You may, however, be responsible for any properly authorized Covered Services from a Non-Participating Provider or Emergency or Urgently Needed Services from a Non-Participating Provider.

NOTE: If you receive a bill because a Non-Participating Provider refused to accept payment from PacifiCare, you may submit a claim for reimbursement. See "Bills from Non-Participating Providers."

Coordination of Benefits

Coordination of Benefits (COB) is a process, regulated by law, which determines the financial responsibility for payment when a person has group health care coverage under more than one plan. "Plan" is defined below. COB is designed to provide maximum coverage for medical and Hospital Services at the lowest cost by avoiding excessive or duplicate payments.

The objective of COB is to ensure that all group Health Plans that provide coverage to an individual will pay no more than 100 percent of the allowable expense for services that are received. This payment will not exceed total expenses incurred or the reasonable cash value of those services and supplies when the group Health Plan provides benefits in the form of services rather than cash payments.

PacifiCare's COB activities will not interfere with your medical care.

The order of benefit determination rules below determine which Health Plan will pay as the Primary Plan. The Primary Plan that pays first pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payment from all group plans do not exceed 100 percent of the total allowable expense. "Allowable Expense" is defined below.

Definitions

The following definitions only apply to coverage provided under this explanation of Coordination of Benefits.

A. **Plan** is any of the following that provides benefits or services for medical or dental care or treatment.

   1. **Plan** includes: group insurance, closed panel (HMO, POS, PPO or EPO) coverage or other forms of group or group-type coverage (whether insured or uninsured); Hospital indemnity benefits in excess of $200.00 per day; medical care components of group long-term care contracts, such as Skilled Nursing Care; or other governmental benefits, as permitted by law (Medicare is not included as a "Plan" as defined here – however, PacifiCare does coordinate benefits with Medicare.) Please refer to **Section 7.** "Important Rules for Medicare and Medicare-Eligible Members."

   2. **Plan** does not include: non-group coverage of any type, including, but not limited to, individual or family insurance; amounts of Hospital indemnity insurance of $200.00 or less per day; school accident-type coverage; benefits for nonmedical components of group long-term care policies; Medicare supplement policies, a state-plan under Medicaid; and coverage under other governmental plans, unless permitted by law.

      Each contract for coverage under (1) or above is a separate Plan. However, if the same carrier provides coverage to members of a group under more than one group contract, each of which provide for different types of coverage (for example, one covering dental services and one covering medical services), the separate contracts are considered parts of the same plan, and there is no COB among those separate contracts. However, if a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **Primary Plan or Secondary Plan** – The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan," when compared to another Plan covering the person. When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

C. **Allowable Expense** means a health care service or expense, including deductibles and Copayments, that is covered at least in part by any of the Plans covering the person. When a plan provides benefits in the form of services, (for example, an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the plans is not an Allowable Expense. The following are examples of expenses or services that are not Allowable Expenses:

1. If a Covered Person is confined in a private Hospital room, the difference between the cost of a semi-private room in the Hospital and the private room (unless the patient's stay in a private Hospital room is Medically Necessary) is not an Allowable Expense.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the allowable expense for all plans.
5. The amount a benefit is reduced by the Primary Plan because a Covered Person does not comply with the Plan provisions. Examples of these provisions are precertification of admissions and preferred Provider arrangements.

D. **Claim Determination Period** means a calendar year or that part of the calendar year during which a person is covered by this Plan.

E. **Closed Panel Plan** is a plan that provides health benefits to Covered Persons primarily in the form of services through a panel of Providers that have contracted with or are employed by the Plan and that limits or excludes benefits for services provided by other Providers, except in cases of emergency or referral by a panel member.

F. **Custodial Parent** means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

Order of Benefit Determination Rules

If the Member is covered by another group Health Plan, responsibility for payment of benefits is determined by the following rules. These rules indicate the order of payment responsibility among PacifiCare and other applicable group Health Plans by establishing which plan is primary, secondary and so on:

A. The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

B. A Plan that does not contain a coordination of benefits provision is always primary. There is one exception: Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. The first of the following rules that describes which Plan pays its benefits before another Plan is the rule that will apply.

1. **Subscriber (Non-Dependent) or Dependent**. The Plan that covers the person other than as a Dependent; for example, as an employee, Member, Subscriber or retiree is primary and the Plan that covers the person as a Dependent is secondary.
2. **Child Covered Under More Than One Plan**. The order of benefits when a child is covered by more than one plan is:

a. **Birthday Rule**. The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:

– The parents are married;

- The parents are not separated (whether or not they ever have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.

b. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage, that Plan is primary if the parent has enrolled the child in the Plan and provided the Plan with a copy of the court order as required in the "Eligibility" section of this *Combined Evidence of Coverage and Disclosure Form*. This rule applies to Claim Determination Periods or Plan years, commencing after the Plan is given notice of the court decree.

c. If the parents are not married, and/or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- The Plan of the Custodial Parent;
- The Plan of the Spouse or Domestic Partner of the Custodial Parent;
- The Plan of the non Custodial parent; and then
- The Plan of the spouse of the non-Custodial parent.

3. **Active or Inactive Employee**. The Plan that covers a person as an employee who is neither laid off nor retired (or his or her Dependent) is primary in relation to a Plan that covers the person as a laid-off or retired employee (or his or her Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual by one Plan as a retired worker and by another Plan as a Dependent of an actively working Spouse will be determined under the rule labeled D(1).

4. **COBRA Continuation Coverage**. If a person whose coverage is provided under a right of continuation provided by federal (COBRA) or state law (similar to COBRA) also is covered under another Plan, the Plan covering the person as an employee, Member, Subscriber or retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

5. **Longer or Shorter Length of Coverage**. If the preceding rules do not determine the order or payment, the Plan that covered the person as an employee, Member, Subscriber or retiree for the longer period is primary.

Effect on the Benefits of This Plan

A. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Claim Determination Period are not more than 100 percent of total Allowable Expenses.

B. If a Covered Person is enrolled in two or more Closed Panel Plans and if, for any reason, including the person's having received services from a nonpanel provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. PacifiCare may obtain the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. Each person claiming benefits under this Plan must give PacifiCare any facts it needs to apply those rules and determine benefits payable. PacifiCare may use and disclose a Member's protected health information for the purposes of carrying out treatment, payment or health care operations, including, but not limited to, diagnoses payment of health care services rendered, billing, claims management or other administrative

functions of PacifiCare, without obtaining the Member's consent, in accordance with state and federal law.

PacifiCare's Right to Pay Others

A "payment made" under another Plan may include an amount that should have been paid under this Plan. If this happens, PacifiCare may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. PacifiCare will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the "amount of the payments made" by PacifiCare is more than it should have paid under this COB provision, PacifiCare may recover the excess from one or more of the persons it has paid or for whom it has paid or for any other person or organization that may be responsible for the benefits or services provided for the Covered Person. The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

Important Rules for Medicare and Medicare-Eligible Members

You must let PacifiCare know if you are enrolled, or eligible to enroll, in Medicare (Part A and/or Part B coverage). PacifiCare is typically primary (that is, PacifiCare's benefits are determined before those of Medicare) to Medicare for some initial period of time, as determined by the Medicare regulations. After the initial period of time, PacifiCare will be secondary to Medicare (that is, the benefits under this Health Plan will be reduced to the extent they duplicate any benefits provided or available under Medicare, if the Member is enrolled or eligible to enroll in Medicare.)

If you are eligible for Medicare, but fail to enroll in Medicare, your PacifiCare coverage will be reduced by the amount you would have received from Medicare. If you have questions about the coordination of Medicare benefits, contact your Benefits Representative at your campus or lab, the University of California Customer Service department, or the PacifiCare Customer Service department. For questions regarding Medicare eligibility, contact your local Social Security office.

Workers' Compensation

PacifiCare will not provide or arrange for benefits, services or supplies required as a result of a work-related injury or illness. This applies to injury or illness resulting from occupational accidents or sickness covered under any of the following: the California workers' compensation act, occupational disease laws, employer's liability or federal, state or municipal law. To recover benefits for a work-related illness or injury, the Member must pursue his or her rights under the workers' compensation act or any other law that may apply to the illness or injury. This includes filing an appeal with the workers' compensation Appeals Board, if necessary.

If for any reason PacifiCare provides or arranges for benefits, services or supplies that are otherwise covered under the workers' compensation act, the Member is required to reimburse PacifiCare for the benefits, services or supplies provided or arranged for, at prevailing rates, immediately after receiving a monetary award, whether by settlement or judgment. The Member must also hold any settlement or judgment collected as a result of a workers' compensation action in trust for PacifiCare. This award will be the lesser of the amount the Member recovers or the reasonable value of all services and benefits furnished to him or her or on his or her behalf by PacifiCare for each incident. If the Member receives a settlement from workers' compensation coverage that includes payment of future medical costs, the Member must reimburse PacifiCare for any future medical expenses associated with this judgment if PacifiCare covers those services.

When a legitimate dispute exists as to whether an injury or illness is work-related, PacifiCare will provide or arrange for benefits until such dispute is resolved if the Member signs an agreement to reimburse PacifiCare for 100 percent of the benefits provided.

PacifiCare will not provide or arrange for benefits or services for a work-related illness or injury when the Member fails to file a claim within the filing period allowed by law or fails to comply with other applicable provision of law under the workers' compensation act. Benefits will not be denied to a Member whose employer has not complied with the laws and regulations governing workers' compensation insurance, provided that such Member has sought and received Medically Necessary Covered Services under this Health Plan.

Payment Responsibility When an Injury or Sickness is Caused by a Third Party's Act or Omission

Applicability

This provision applies when a Member suffers an injury or sickness though an act or omission of another person(s) (the "third party").

Third-Party Liability – Expenses Incurred Due to Liable Third Parties Are Not Covered

Health care expenses incurred by a Member for which a third party or parties or a third party's (parties') insurance company (collectively, "liable third party") is liable or legally responsible by reason of negligence, a wrongful intentional act or the breach of any legal obligation on the part of such third party, are expressly excluded from coverage under this Health Plan. However, in all cases, PacifiCare will pay for the arrangement or provision of health care services for a Member that would have been Covered Services, except that they were required due to a liable third party, in exchange for the agreement as expressly set forth in the section of the *Combined Evidence of Coverage and Disclosure Form* captioned, "PacifiCare's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Member's Health Care Expenses."

PacifiCare's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Member's Health Care Expenses

Expenses incurred by a Member for which a third party or parties or a third party's (parties') insurance company (collectively, "liable third party") is liable or legally responsible by reason of negligence, a wrongful intentional act or the breach of any legal obligation on the part of such third party, are expressly excluded from coverage under this Health Plan. However, in all cases, PacifiCare will pay for the arrangement or provision of health care services for a Member that would have been Covered Services except that they were required due to a liable third party, in exchange for the following agreement:

If a Member is injured by a liable third party, the Member agrees to give PacifiCare, or its representative, agent or delegate, a security interest in any money the Member actually recovers from the liable third party by way of any final judgment, compromise, settlement or agreement, even if such money becomes available at some future time.

If the Member does not pursue, or fails to recover (either because no judgment is entered or because no judgment can be collected from the liable third party), a formal, informal, direct or indirect claim against the liable third party, then the Member will have no obligation to repay the Member's debt to PacifiCare, which debt shall include the cost of arranging or providing otherwise covered health care services to the Member for the care and treatment that was necessary because of a liable third party.

The security interest the Member grants to PacifiCare, its representative, agent or delegate applies only to the actual proceeds, in any form, that stem from any final judgment, compromise, settlement or agreement relating to the arrangement or provision of the Member's health care services for injuries caused by a liable third party.

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

If you are receiving benefits as a result of 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. PacifiCare will provide Covered Services over and above your automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage.

Member Eligibility

Section 8. Member Eligibility

- **Membership Requirements**
- **Adding Family Members**
- **Late Enrollment**
- **Updating Your Enrollment Information**
- **Termination of Enrollment**
- **Coverage Options Following Termination**

This section describes how you become a PacifiCare Member, as well as how you can add Family Members to your coverage. It will also answer other questions about eligibility, such as when late enrollment is permitted. In addition, you will learn ways you may be able to extend your PacifiCare coverage when it would otherwise terminate.

Who is a PacifiCare Member?

There are two kinds of PacifiCare Members: Subscribers and enrolled Family Members (also called Dependents). The Subscriber is the person who enrolls through his or employment with the University of California. The University of California, in turn, has signed a Group Agreement with PacifiCare. All Members must meet all eligibility requirements established by the University of California. You are eligible to enroll in PacifiCare if you have a Primary Residence within California; PacifiCare's Service Area in California, select a Participating Medical Group located within 30 miles of your Primary Residence or Primary Workplace, and meet the eligibility requirements defined by the University of California.

The following information applies to the University of California plan and supersedes any corresponding information that may be contained elsewhere in the document to which this insert is attached. The University establishes its own medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations ("Regulations") and any corresponding Administrative Supplements. Portions of the regulations are summarized below.

Eligibility

The following individuals are eligible to enroll in this Plan. If the Plan is a Health Maintenance Organization (HMO), Point of Service (POS) or Exclusive Provider Organization (EPO) Plan, they are only eligible to enroll in the plan if they meet the Plan's geographic service area criteria. Anyone enrolled in a non-University Medicare Advantage Managed Care contract is not eligible for this plan.

Subscriber

Employee: You are eligible if you are appointed to work at least 50 percent time for twelve (12) months or more or are appointed at 100 percent time for three (3) months or more or have accumulated 1,000* hours while on pay status in a twelve (12)-month period. To remain eligible, you must maintain an average regular paid time** of at least 17.5 hours per week and continue in an eligible appointment. If your appointment is at least 50 percent time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

* Lecturers – see your Benefits Office for eligibility.

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

Average regular paid time does not include full or partial month of zero paid hours when an employee works less than 43.75% of the regular paid hours available in the month due to furlough, leave without pay or initial employment.

Retiree

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

Survivor

A deceased Employee's or Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan.

As a Survivor, you may be eligible to continue coverage as set forth in the University's Group Insurance Regulations. For more information see the UC Group Insurance Eligibility Fact Sheet for Retirees and Eligible Family Members available through the University.

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

Eligible Dependents (Family Members)

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), adoption records or Federal Income Tax Return or other official documentation.

Spouse: Your Legal Spouse or Domestic Partner, as determined by the University of California.

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

a. Your natural or legally adopted children;

b. Your stepchildren (natural or legally adopted children of your Spouse or Domestic Partner), if living with you, dependent on you or your Spouse for at least 50 percent of their support and are your or your Spouse's Dependents for income tax purposes.

c. Grandchildren of you, your Spouse or your Domestic Partner, if living with you, dependent upon you or your Spouse for at least 50 percent of their support and are your or your Spouse's Dependents for income tax purposes.

d. Children for whom you are the legal guardian, if living with you, who are dependent on you for at least 50 percent of their support and who are your Dependents for income tax purposes.

Continuing Coverage for Certain Disabled Dependents

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

a. Incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous; and

b. Child is claimed as your Dependent for income tax purposes or is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Income; and

c. The child lives with you if he or she is not your or your Spouse's natural or adopted child.

Application must be made to the Plan 31 days prior to the child's 23rd birthday and is subject to approval by the Plan. The Plan may periodically request proof of continued disability.

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 incapacitated child, you may also apply for coverage for that child. The child must have had continuous group medical coverage since age 23, and you must apply for coverage during your Period of Initial Eligibility.

Other Eligible Dependents (Family Members): You may enroll a Domestic Partner and the Domestic Partner's children/stepchildren/grandchildren as set forth in the University of California Group Insurance Regulations. Effective January 1, 2005, the University will recognize an opposite-sex domestic partner as a Family Member that is eligible for coverage in UC-sponsored benefits if the Employee/Retiree or domestic partner is age 62 or older and eligible to receive Social Security benefits and both the Employee/Retiree and domestic partner are at least 18 years of age. An adult dependent relative is no longer eligible for coverage effective January 1, 2004. Only an adult dependent relative who was enrolled as an eligible Dependent as of December 31, 2003, may continue coverage in UC-sponsored plans.

For information on who qualifies and how to enroll, please contact your local Benefits Office or the University of California's Customer Service Center.

No Dual Coverage: Eligible individuals may be covered under only one of the following categories: as an employee, as a Retiree, as a Survivor, or as a Family Member, but not under any combination of these. If

an Employee and the Employee's Spouse or same-sex domestic partner are both eligible Subscribers, each may enroll separately or one may cover the other as a Family Member. If they enroll separately, neither may enroll the other as a Family Member. Eligible children may be enrolled under either parent's or same-sex domestic partner's coverage, but not under both. Additionally, a child who is also eligible as an Employee may not have Dual coverage through two University-sponsored medical plans.

Enrollment

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

During a Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

If you are an Employee, you may enroll yourself and any eligible Family Members during your PIE. Your PIE starts the day you become an eligible Employee.

You may enroll any newly eligible Family Member during his or her PIE. The Family Member's PIE starts the day your Family Member becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other eligible Family Member if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any eligible Family Member. Family Members are only eligible for the same plan you are enrolled in.

a. For a Spouse or Domestic Partner, on the date of marriage or start of the domestic partnership.

b. For a natural child, on the child's date of birth.

c. For an adopted child, the earlier of:

   i. the date you or your Spouse has the legal right to control the child's health care, or

   ii. the date the child is placed in your physical custody.

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

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

If you decline enrollment for yourself or your eligible Family Members because of other group medical plan coverage and you lose that coverage involuntarily, you may be able to enroll yourself and those eligible Family Members during a PIE that starts on the day the other coverage is no longer in effect.

If you are in an HMO, POS or EPO Plan and you move or are transferred out of that Plan's service area, or will be away from the Plan's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan. Your PIE starts with the effective date of the move or the date you leave the Plan's service area.

Adding Family Members to Your Coverage

The Subscriber's Spouse or Domestic Partner and eligible children may apply for coverage with PacifiCare during the University's Open Enrollment Period. If you are declining enrollment for yourself or your Dependents (including your Spouse or Domestic Partner) because of other health plan insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in PacifiCare if you and your Dependents lose eligibility for that other coverage (or if the Employer Group stops contributing toward your or your Dependent' other coverage.) However, you must request enrollment within 30 days after your or your Dependents other coverage ends (or after the Employer Group stops contributing toward your or your Dependent' other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. (Guardianship is not a qualifying event for other Family Members to enroll.) Under the following circumstances, new Family Members may be added

outside the Open Enrollment Period. To obtain more information contact our Customer Service department.

1. **Getting Married.** When a new Spouse or child becomes an eligible Family Member as a result of marriage, coverage begins on the first day of the month following the date of marriage. An application to enroll a Spouse or child eligible as a result of marriage must be made within 30 days of the marriage.
2. **Domestic Partnership.** When a new Domestic partner or Domestic Partner's child becomes an eligible Family Member as a result of a domestic partnership, coverage begins on the first of the month following the date of the domestic partnership. An application to enroll a Domestic Partner or child eligible as a result of a domestic partnership must be made within 30 days of the domestic partnership.
3. **Having a Baby**. Newborns are covered for the first 30 days of life. In order for coverage to continue beyond the first 30 days of life, the Subscriber must submit a Change Request Form to PacifiCare prior to the expiration of the 30-day period.
4. **Adoption or Placement for Adoption.** Subscriber may enroll an adopted child if Subscriber obtains an adoptive placement from a recognized county or private agency, or if the child was adopted as documented by a health Facility minor release form, a medical authorization form or a relinquishment form, granting Subscriber, Subscriber's Spouse or Domestic Partner the right to control the health care for the adoptive child or absent such a document, on the date there exists evidence of the Subscriber's Spouse's or Domestic Partner's right to control the health care of the child placed for adoption. For adopted children, coverage is effective on the date of adoption or placement for adoption. An application must be received within 30 days of the adoption placement.
5. **Guardianship.** To enroll a Dependent child for whom the Subscriber, Subscriber's Spouse or Domestic Partner has assumed legal guardianship, the Subscriber must submit a Change Request Form to PacifiCare along with a certified copy of a court order granting guardianship within 30 days of when the Subscriber, Subscriber's Spouse or Domestic Partner assumed legal guardianship. Coverage will be retroactively effective to the date the Subscriber assumed legal guardianship.

Late Enrollment

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

If you are an Employee and opt out of medical coverage or fail to enroll yourself during a PIE or open enrollment period, you may enroll yourself at any other time upon completion of a 90-consecutive-calendar-day waiting period.

The eligible employee (on his or her own behalf, or on behalf of any eligible Family Members) declined in writing to enroll in PacifiCare when they were first eligible because they had other health care coverage.

The other health care coverage is no longer available due to:

i. The employee or eligible Family Member has exhausted COBRA continuation coverage under another group Health Plan; or

ii. The termination of employment or reduction in work hours of a person through whom the employee or eligible Family Member was covered; or

iii. The termination of the other Health Plan coverage; or

iv. The cessation of an employer's contribution toward the employee or eligible Family Member coverage; or

v. The death, divorce or legal separation of a person through whom the employee or eligible Family Member was covered.

vi. The loss of coverage under the Healthy Families Program as a result of exceeding the program's income or age limits, or loss of no share-of-cost Medi-Cal coverage.

The Court has ordered health care coverage be provided for your Spouse or minor child.

If you are an Employee or Retiree and fail to enroll your eligible Family Members during a PIE or open enrollment period, you may enroll your eligible Family

Member Eligibility

Members at any other time upon completion of a 90-consecutive-calendar-day waiting period.

The 90-day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits office and ends 90 consecutive calendar days later.

If you have one or more children enrolled in the Plan, you may add a newly eligible Child at any time. See "Effective Date."

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

If you are a Survivor, you may not enroll your legal Spouse or domestic partner.

Qualified Medical Child Support Order

A Member (or a person otherwise eligible to enroll in PacifiCare) may enroll a child who is eligible to enroll in PacifiCare upon presentation of a request by a District Attorney, State Department of Health Services or a court order to provide medical support for such a Dependent child without regard to any enrollment period restrictions.

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. A copy of the court or administrative order must be included with the enrollment application. Information including, but not limited to, the ID 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.

Except for Emergency and Urgently Needed Services, to receive coverage, all care must be provided or arranged in the PacifiCare Service Area by the designated Participating Medical Group, as selected by the custodial parent or person having legal custody.

Effective Date

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

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

If you are a Retiree continuing enrollment in conjunction with retirement, coverage for you and your Family Members is effective on the first of the month following the first full calendar month of retirement income.

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

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

An Employee or Retiree already enrolled in adult plus child(ren) or family coverage may add additional children, if eligible, at any time after their PIE. Retroactive coverage is limited to the later of:

a. the date the Child becomes eligible, or

b. a maximum of 60 days prior to the date your Child's enrollment transaction is completed.

Change in Coverage

In order to change from single to adult plus child(ren) coverage, or two adult coverage, or family coverage, or to add another Child to existing family coverage, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Effect of Medicare on Retiree Enrollment

If you are a Retiree and you and/or an enrolled Family Member is or becomes eligible for premium-free Medicare Part A (Hospital Insurance) as primary coverage, then that individual must also enroll in and remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in both Part A and Part B must be continuous. This includes anyone who is entitled to Medicare benefits through their own or their Spouse's non-University employment.

Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan. Beginning January 1, 2004, Retirees or their Family Member(s) who become eligible for premium free Medicare Part A and do not enroll in Part B will permanently lose their UC-sponsored medical coverage.

Retirees and their Family Members who were eligible for premium-free Medicare Part A, but declined to enroll in Part B of Medicare before January 1, 2004, were assessed a monthly offset fee by the University to cover increased costs. The offset fee may increase annually, but will stop when the Retiree or Family Member becomes covered under Part B. Retirees or Family Members who are not eligible for premium-free Part A will not be assessed an offset fee nor lose their UC-sponsored medical coverage. Documentation attesting to their ineligibility for Medicare Part A will be required. (Retirees/Family Members who are not entitled to Social Security and premium-free Medicare Part A will not be required to enroll in Part B.)

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

Upon Medicare eligibility, you or your Family Member must complete a University of California Medicare Declaration. This notifies the University that you are covered by Part A and Part B of Medicare. The University's Medicare Declaration forms are available through the University's Customer Service Center. Completed forms should be returned to University of California, Human Resources and Benefits, Health & Welfare Administration – Retiree Insurance Program, P.O. Box 24570, Oakland, CA 94623-9911.

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care Contract must assign his or her Medicare benefit to that plan or lose UC-sponsored medical coverage.

Medicare Secondary Payer Law (MSP)

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. UC Retirees hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For Employees or their spouses who are age 65 or older and eligible for a group health plan due to employment, Medicare becomes the secondary payer and the employer plan becomes the primary payer.

Medicare Private Contracting Provision

Federal Legislation allows Physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services **(that would otherwise be covered by Medicare)** from these Physicians or practitioners will need to enter into written "private contracts" with these Physicians or practitioners requiring the beneficiary to be responsible for all payments to such Providers. Services provided under "private contracts" are not covered by Medicare, and the Medicare limiting charge will not apply.

If you are classified as a Retiree by the University (or otherwise have Medicare as a primary coverage) and enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement with one or more Physicians or practitioners, under the law you have in effect "opted out" of Medicare for the services provided by these Physicians or other practitioners. No benefits will be paid by this Plan for services rendered by these Physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered.

However, if you do sign a private contract with a Physician or practitioner, you may see other Physicians or practitioners without those private contract restrictions as long as they have not opted out of Medicare.

Termination of Coverage

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

Deenrollment Due to Loss of Eligible Status

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

Member Eligibility

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

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. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on deenrollment procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Deenrollment Due to Fraud

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

Leave of Absence, Layoff or Retirement

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

Optional Continuation of Coverage

If your coverage or that of a Family Member ends, you and/or your Family Member may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended and if that continued coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice *Continuation of Group Insurance Coverage*, available from the University's "At Your Service" Web site (**www.atyourservice.ucop.edu**). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center. You may also direct questions about these provisions to your local Benefits Office or the University's Customer Service Center if you are a Retiree.

Plan Administration

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

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

Sponsorship and Administration of the Plan

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

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

Retirees 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
1-800-624-8822

Group Contract Number

The Group Contract Number for this Plan is: 24537

Type of Plan

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

Plan Year

The plan year is January 1 through December 31.

Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all Employees, Retirees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, Premiums and what portion of the Premiums the University will pay. The portion of the Premiums that University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.

Financial Arrangements

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

Agent for Serving of Legal Process

Legal process may be served on PacifiCare at:

Associate General Counsel
PacifiCare Health Plans
5995 Plaza Drive
Cypress, CA 90630

Your Rights Under the Plan

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

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

Claims Under the Plan

To file a claim or to appeal a denied claim, refer to **Section 9. Overseeing Your Health Care Decisions** of this document.

Nondiscrimination Statement

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

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

Director of Diversity and Employee Programs, University of California Office of the President 300 Lakeside Drive, Oakland, CA 94612 and for faculty to: Director of Academic Affirmative Action, University of California Office of the President 1111 Franklin Street, Oakland, CA 94607.

What is a Service Area?

PacifiCare is licensed by the California Department of Managed Health Care to arrange for medical and Hospital Services in certain geographic areas of California. These service areas are defined by ZIP codes. Please call our Customer Service department for information about PacifiCare's Service Area.

Notifying You of Changes in Your Plan

Amendments, modifications or termination of the Group Agreement by either the University of California or PacifiCare do not require the consent of a Member. PacifiCare may amend or modify the Health Plan, including the applicable Premiums, at any time after sending written notice to the University of California 30 days prior to the effective date of any amendment or modification. The University of California may also change your Health Plan benefits during the contract year. In accordance with PacifiCare's Group Agreement, the University of California is obliged to notify employees who are PacifiCare Members of any such amendment or modification.

Member Eligibility

Updating Your Enrollment Information

Please notify the Benefits Representative at your campus or lab of any changes to the information you provided on the enrollment application within 31 days of the change. This includes changes to your name, address, telephone number, marital status or the status of any enrolled Family Members. For reporting changes in marital and/or Dependent status, please see "Adding Family Members to Your Coverage." If you wish to change your Primary Care Physician or Participating Medical Group, you may contact PacifiCare's Customer Service department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

About Your PacifiCare Identification Card (ID)

Your PacifiCare ID card is important for identifying you as a Member of PacifiCare. Possession of this card does not entitle a Member to services or benefits under this Health Plan. A Member should show this card each time he or she visits a Primary Care Physician or, upon referral, any other Participating Provider.

IMPORTANT NOTE: Any person using this card to receive benefits or services for which he or she is not entitled will be charged for such benefits or services. If any Member permits the use of his or her identification card by any other person, PacifiCare may immediately terminate that Member's membership.

Renewal and Reinstatement (Renewal Provisions)

The University of California Group's Group Agreement with PacifiCare renews automatically, on a yearly basis, subject to all terms of the Group Agreement. PacifiCare or the University of California may change your Health Plan benefits and Premium at renewal. If the Group Agreement is terminated by PacifiCare, reinstatement is subject to all terms and conditions of the Group Agreement. In accordance with PacifiCare's Group Subscriber Agreement, the University of California is required to notify employees who are PacifiCare Members of any such amendment or modification.

Ending Coverage (Termination of Benefits)

Usually your enrollment in PacifiCare terminates when the Subscriber or enrolled Family Member is no longer eligible for coverage under the University of California health benefit plan. In most instances, the University of California determines the date in which coverage will terminate. Coverage can be terminated, however, because of other circumstances as well, which are described below. Continuing coverage under this Health Plan is subject to the terms and conditions of the University of California's Group Agreement with PacifiCare.

When the Group Agreement between the University of California and PacifiCare is terminated, all Members covered under the Group Agreement become ineligible for coverage on the date of termination. If the Group Agreement is terminated by PacifiCare for nonpayment of Premiums, coverage for all Members covered under the Group Agreement will be terminated effective the last day for which Premiums were received. According to the terms of the Group Agreement, the University of California is responsible for notifying you if and when the Group Agreement is terminated for any reason, except in the event the Group Agreement is terminated for the nonpayment of Health Plan Premiums. In that circumstance, PacifiCare will notify you directly of such termination. PacifiCare is not obligated to notify you that you are no longer eligible or that your coverage has been terminated.

In addition to terminating the Group Agreement, PacifiCare may terminate a Member's coverage for any of the following reasons:

- The Member no longer meets the eligibility requirements established by the University of California and/or PacifiCare.
- The Member establishes his or her Primary Residence outside the state of California.
- The Member establishes his or her Primary Residence outside the PacifiCare Service Area and does not work inside the PacifiCare Service Area (except for a child subject to a qualified child medical support order, for more information refer to "Qualified Medical Child Support Order" in this section).

Cancellation of the Group Contract for Nonpayment of Premiums

If the Group Contract is cancelled because the University failed to pay the required Premiums when due, then coverage for you and all your Dependents will end retroactively back to the last day of the month for which Premiums were paid; however, this retroactive period will not exceed the 60 days before the date the Plan mails you the Notice Confirming Termination of Coverage.

PacifiCare will mail the University of California a notice at least 15 days before any cancellation of coverage. This Prospective Notice of Cancellation will provide information to your employer regarding the consequences of your employer's failure to pay the Premiums due within 15 days of the date the notice was mailed.

If payment is not received from the University of California within 15 days of the date the Prospective Notice of Cancellation is mailed, PacifiCare will cancel the Group Contract and mail you a Notice Confirming Termination of Coverage, which will provide you with the following information:

- That the University of California Contract has been cancelled for nonpayment of Premiums.
- The specific date and time when your Group coverage ended.
- The Plan telephone number you can call to obtain additional information, including whether your Employer obtained reinstatement of the Group Contract. This confirmation of reinstatement will be available on request 16 days after the date the Notice Confirming Termination of Coverage is mailed.
- An explanation of your options to purchase continuation coverage, including coverage effective as of the retroactive termination date so you can avoid a break in coverage, and the deadline by which you must elect to purchase such continuation coverage, which will be 63 days after the date the Plan mails you the Notice Confirming Termination of Coverage.

Reinstatement of the Contract after Cancellation

If the Group Contract is cancelled for the University's nonpayment of Premiums, the Plan will permit reinstatement of the Group Contract once during any 12-month period if the group pays the amounts owed within 15 days of the date the Notice Confirming Termination.

Other Reasons for Termination of Coverage

In addition to terminating the Group Agreement, PacifiCare may terminate a Member's coverage for any of the following reasons:

- The Member no longer meets the eligibility requirements established by the Group Employer and/or PacifiCare.
- The Member establishes his or her Primary Residence outside the state of California.
- The Members establishes his or her Primary Residence outside the PacifiCare Service Area and does not work inside the PacifiCare Service Area (except for a child subject to a qualified child medical support order, for more information refer to "Qualified Medical Child Support Order" in this section).

Termination for Good Cause

PacifiCare has the right to terminate your coverage under this Health Plan in the following situations:

- **Failure to Pay.** Your coverage may be terminated if you fail to pay any required Copayments, coinsurance or charges owed to a Provider or PacifiCare for Covered Services. To be subject to termination under this provision, you must have been billed by the Provider for two different billing cycles and have failed to pay or make appropriate payment arrangements with the Provider.

  PacifiCare will send you written notice, and you will be subject to termination if you do not pay or make appropriate payment arrangements within the 30-day notice period.
- **Fraud or Misrepresentation.** Your coverage may be terminated if you knowingly provide false information (or misrepresent a meaningful fact) on your enrollment form or fraudulently or deceptively use services or facilities of PacifiCare, its Participating Medical Group or other health care Providers (or knowingly allow another person to do the same), including altering a prescription. Termination is effective immediately on the date PacifiCare mails the notice of termination, unless PacifiCare has specified a later date in that notice.
- **Disruptive Behavior.** Your coverage may be terminated if you threaten the safety of Plan employees, Providers, Members or other patients, or your repeated behavior has substantially impaired PacifiCare's ability to furnish or arrange services for you or other Members, or substantially impaired Provider(s)' ability to provide services to other patients. Termination is effective 15 days after the notice is mailed to the Subscriber.

If coverage is terminated for any of the above reasons, you forfeit all rights to enroll in the PacifiCare

conversion plan (discussed below) or COBRA Plan and lose the right to re-enroll in PacifiCare in the future.

Under no circumstances will a Member be terminated due to health status or the need for health care services. If a Member is Totally Disabled when the Group's coverage ends, coverage for the Totally Disabling condition may be extended (please refer below to "Total Disability"). Any Member who believes his or her enrollment has been terminated due to the Member's health status or requirements for health care services may request a review of the termination by the California Department of Managed Health Care. For more information contact our Customer Service department.

NOTE: If a 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.

Ending Coverage – Special Circumstances for Enrolled Family Members: Enrolled Family Members terminate on the same date of termination as the Subscriber. If there's a divorce, the Spouse loses eligibility at the end of the month in which a final judgment or decree of dissolution of marriage is entered. Dependent children lose their eligibility if they marry or reach the Limiting Age established by the University of California and do not qualify for extended coverage as a student Dependent or as a disabled Dependent. Please refer to the section "Continuing Coverage for Certain Disabled Dependents." It may also end when a qualified student reaches the Limiting Age. Please refer to "Extending Your Coverage" for additional coverage which may be available to you.

Total Disability

If the Group Agreement providing the Subscriber coverage is terminated, and the Subscriber or any enrolled Family Members are Totally Disabled on the date the Group Agreement is terminated, federal law may require the Group's succeeding carrier to provide coverage for the treatment of the condition causing Total Disability. However, in the event that the Subscriber's Group does not contract with a succeeding carrier for health coverage, or in the event that federal law would allow a succeeding carrier to exclude coverage of the condition causing the Total Disability for a period of time, PacifiCare will continue to provide benefits to the Subscriber or any enrolled Family Member for Covered Services directly relating to the condition causing Total Disability existing at the time of termination, for a period of up to 12 successive months after the termination. The extension of benefits may be terminated by PacifiCare at such time the Member is no longer Totally Disabled, or at such time as a succeeding carrier is required by law to provide replacement coverage to the Totally Disabled Member without limitation as to the disabling condition.

Coverage Options Following Termination (Individual Continuation of Benefits)

If your coverage through this *Combined Evidence of Coverage and Disclosure Form* ends, you and your enrolled Family Members may be eligible for additional continuation coverage.

Federal COBRA Continuation Coverage

As the University of California is subject to the federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you may be entitled to temporarily extend your coverage for up to 36 months, based upon 102 percent of your former employer's Health Plan group rates, in certain instances where your coverage under the Health Plan would otherwise end. In the case of a Subscriber who is determined to be disabled under the Social Security Act, the Subscriber will pay 150 percent of the former employer's Health Plan group rate after the first 18 months of continuation coverage and up to the month in which the Subscriber becomes entitled to Medicare, generally 29 months after the disabling event occurred. However, if you are not entitled to Medicare by the 29th month, you may be able to extend your benefits. Please refer to "1401 Extended Continuation Coverage After COBRA".

This discussion is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. However, the University of California is legally responsible for informing you of your specific rights under COBRA. Therefore, please consult with the University of California regarding the availability and duration of COBRA continuation coverage.

COBRA Qualifying Events for Subscribers

If you are a Subscriber covered by this Health Plan, you have a right to choose COBRA continuation coverage for up to 18 months based upon 102 percent of your

former employer's Health Plan group rates if you have a qualifying event described as:

1. You lose your group health coverage because the termination of your employment (for reasons other than gross misconduct on your part) or
2. The number of hours you actually work on a weekly basis are cut back to less than the number of hours required for continued group Health Plan eligibility, as determined by your employer.

If you are determined to be disabled under Title II or Title XVI of the United States Social Security Act within 60 days of your initial qualifying event, you must notify the University of California of this determination prior to the 18th month. You are required to pay to PacifiCare 150 percent of the group rate after the first 18 months and generally up to the 29th month. Your coverage under COBRA will end upon your Medicare entitlement. However, if you are not entitled to Medicare by the 29th month, you may be able to extend your benefits. Please refer to "California Continuation Coverage After COBRA."

COBRA Qualifying Events for Spouses

If you are the Spouse of a Subscriber covered by this Health Plan, you have the right to choose COBRA continuation coverage for up to 36 months based upon 102 percent of the Subscriber's employer's Health Plan group rates (150 percent beginning the 19th month if the Subscriber is determined disabled by the Social Security Administration) for yourself if you lose group health coverage under this Health Plan for any of the following four reasons:

1. The death of the Subscriber;
2. A termination of the Subscriber's employment (for reasons other than gross misconduct) or the number of hours the Subscriber actually works on a weekly basis are cut back to less than the number of hours required for continued group Health Plan eligibility, as determined by the Subscriber's employer;
3. Divorce or legal separation from the Subscriber; or
4. The Subscriber becomes entitled to Medicare. (In the case of a Subscriber who is determined to be disabled under the Social Security Act, the Spouse will pay 150 percent of the former employer's Health Plan group rate after the first 18 months of continuation coverage and up to a combined total of 36 months. In the case of a Subscriber who becomes entitled to Medicare and voluntarily terminates his or her group Health Plan coverage, the Spouse may have up to 36 months based upon 102 percent of the Subscriber's former employer's Health Plan group rates. The length of your COBRA coverage will be determined from the date the Subscriber became entitled to Medicare).

COBRA Qualifying Events for Dependent Children

In the case of a Dependent child of a Subscriber enrolled in this Health Plan, he or she has the right to continuation coverage for up to 36 months based upon 102 percent of the Subscriber's former employer group Health Plan rates (150 percent beginning the 19th month if the Subscriber is determined disabled by the Social Security Administration) if group health coverage under this Health Plan is lost for any of the following five reasons:

1. The death of the Subscriber;
2. A termination of the Subscriber's employment (for reasons other than gross misconduct) or the number of hours the Subscriber actually works on a weekly basis are cut back to less than the number of hours required for continued group Health Plan eligibility, as determined by the Subscriber's former employer;
3. The Subscriber's divorce or legal separation; or
4. The Subscriber becomes entitled to Medicare; (In the case of a Subscriber who is determined to be disabled under the Social Security Act, the Dependent will pay 150 percent of the former employer's group Health Plan rate after the first 18 months of continuation coverage and up to a combined total of 36 months. In the case of a Subscriber who becomes entitled to Medicare and voluntarily terminates his or her group Health Plan coverage, the Dependent may have up to 36 months based upon 102 percent of the Subscriber's former employer's Health Plan group rates. The length of your COBRA coverage will be determined from the date the Subscriber became entitled to Medicare.

5. The Dependent child ceases to be a Dependent eligible for coverage under this Health Plan.

Disability Extension of 18-Month Period of Continuation Coverage

If you or any of your Family Members covered under this Health Plan is determined by the Social Security Administration to be disabled and you notify your Employer Group (or, if applicable, its COBRA administrator) in a timely fashion, you and your entire Family Members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Please consult your Employer Group regarding their plan procedures for providing notice of disability.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If a Family Member experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to your Employer Group (or, if applicable, COBRA administrator). This extension may be available to the Spouse and any Dependent children receiving continuation coverage if the Subscriber dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under this Health Plan as a Dependent child, but only if the event would have caused the Spouse or Dependent child to lose coverage under this Health Plan had the first qualifying event not occurred.

Notification of Qualifying Events

Under COBRA, the Subscriber or enrolled Family Member has the responsibility to inform the Employer Group (or, if applicable, its COBRA administrator) of a divorce, legal separation or a child losing Dependent status under the Health Plan within 60 days of the date of the event. Your former Employer Group has the responsibility to notify its COBRA administrator or PacifiCare of the Subscriber's death, termination, the number of hours the Subscriber actually works on a weekly basis are cut back to less than the number of hours required for continued group Health Plan eligibility or Medicare entitlement. Similar rights may apply to certain retirees, Spouses and Dependent children if your former employer commences a bankruptcy proceeding and these individuals lose coverage. Your former Employer Group or COBRA Administrator is responsible to notify you of your rights when you contact them as a result of one of these qualifying events.

COBRA Enrollment and Premium Information

When your former Employer, the University of California, is notified that one of these events has happened, the University of California will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform the University of California that you want continuation coverage.

If you do not choose continuation coverage on a timely basis, your group health insurance coverage under this Health Plan will end and you will be financially responsible for payment of any health care services that you have received after your terminating event, under the COBRA Health Plan.

If you choose continuation coverage, your Employer Group is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or Family Members. Your Premium may be increased or your benefits decreased each time your former Employer's Group benefit package renews or changes. COBRA permits you to maintain continuation coverage for up to 36 months, unless you lost group health coverage because of a termination of employment or the number of hours you actually work on a weekly basis are cut back to less than the number of hours required for continued group Health Plan eligibility, as determined by the University of California. In that case, the required continuation coverage period is 18 months. This initial 18-month period may be extended for affected individuals up to a combined total of 36 months from termination of employment if other events (such as a death, divorce, legal separation or Medicare entitlement) occur during that initial 18-month period. In addition, the initial 18-month

period may be extended up to a combined total of 29 months if you are determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage. However, if you are not entitled to Medicare by the 29th month, you may be able to extend your benefits. Please refer to "California Continuation Coverage After COBRA." Please contact the University of California for more information regarding the applicable length of COBRA continuation coverage available.

A child who is born to or placed for adoption with the eligible Subscriber during a period of COBRA continuation coverage will be eligible to enroll as a COBRA-qualified beneficiary. These COBRA-qualified beneficiaries can be added to COBRA continuation coverage upon proper notification within 30 calendar days, to the University of California of the birth or adoption. Your new Dependent will be entitled to continue COBRA for only the time period you have remaining which is counted from the date of your initial qualifying event.

Termination of COBRA Continuation Coverage

However, under COBRA, the continuation coverage may be cut short for any of the following five reasons:

1. Your former Employer Group no longer provides group health coverage to any of its employees;
2. The Premium for continuation coverage is not paid on time;
3. The qualified beneficiary becomes covered after the date he or she elects COBRA continuation coverage under another group Health Plan that does not contain any exclusion or limitation with respect to any Pre-Existing Condition he or she may have;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA continuation coverage; or

The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled. However, upon this final determination, you may be able to extend your benefits. Please refer to "California Continuation Coverage After COBRA."

Under the law, you may have to pay all of the Premium for your continuation coverage. Premiums for COBRA continuation coverage are generally 102 percent of the applicable Health Plan Premium. However, if you are on a disability extension, your cost will be 150 percent of the applicable Premium. You are responsible for the timely submission of the COBRA Premium to PacifiCare. At the end of the 18-month, 29-month or 36-month continuation coverage period, qualified beneficiaries may be allowed to enroll in a PacifiCare individual conversion Health Plan. (See the explanation under "Extending Your Coverage: Converting to an Individual Plan.") You may also have additional coverage available under California Continuation Coverage or coverage under HIPAA. (See the explanation under "California Continuation Coverage After COBRA" or "Coverage Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA").) Your new Premiums and benefits through Individual Conversion or HIPAA will be different from your previous group Health Plan coverage and will depend on the type of coverage you select.

If You Have Any Questions About COBRA

If you have any questions about COBRA, please contact the University of California.

1401 Extended Continuation Coverage After COBRA

In the event your COBRA coverage began on or after January 1, 2003, and you have used all of your COBRA benefits, as described above, you may be eligible to continue benefits under California Continuation Coverage at 110 percent of the Premium charged for similarly situated eligible employees currently working at your former employment. A notice will be provided to you by PacifiCare at the time your COBRA benefits will run out, allowing up to 18 more months under California Continuation COBRA. However, your California Continuation COBRA benefits will not exceed a combined total of 36 months from the date COBRA coverage began.

Example: As a result of termination from your former employer (for reasons other than gross misconduct), you applied for and received 18 continuous months of group Health Plan benefits under your federal COBRA benefits. California Continuation COBRA may extend your benefits another 18 consecutive months. Your combined total of benefits between COBRA and California Continuation COBRA is 36 months.

1401 Extended Continuation Coverage Enrollment and Premium Information After COBRA

You must notify PacifiCare within 60 days from the date your COBRA coverage terminated or will terminate because of your qualifying event if you wish to elect this continuation coverage; or within 60 days from the date you received notice from PacifiCare. If you fail to notify PacifiCare within 60 days of the date of your qualifying event, you will lose your rights to elect and enroll on California Continuation Coverage after COBRA. The 60-day period will be counted from the event which occurred last. Your request must be in writing and delivered to PacifiCare by first-class mail, or other reliable means of delivery, including personal delivery, express mail or private courier company. Upon receipt of your written request, an enrollment package to elect coverage will be mailed to you by PacifiCare. You must pay your initial Premiums to PacifiCare within 45 days from the date PacifiCare mails your enrollment package after you notified PacifiCare of your intent to enroll. Your first Premium must equal the full amount billed by PacifiCare. Your failure to submit the correct Premium amount billed to you within the 45-day period, which includes checks returned to PacifiCare by your financial institution for non-sufficient funds (NSF), will disqualify you from this available coverage and you will not be allowed to enroll.

Note: In the event you had a prior qualifying event and you became entitled to enroll on COBRA coverage prior to January 1, 2003, you are not eligible for an extension of these benefits under California Continuation COBRA, even if you enroll in PacifiCare on or after January 1, 2003. Your qualifying event is the first day in which you were initially no longer eligible for your group Health Plan coverage from your former employer, regardless of who your prior insurance carrier may have been at that time.

Termination of 1401 Extended Continuation Coverage After COBRA

Your coverage under California Continuation Coverage will terminate when:

1. You have received 36 months of continuation coverage after your qualifying event date; or
2. If you cease or fail to make timely Premiums; or
3. Your former employer or any successor employer ceases to provide any group benefit plan to his or her employees; or
4. You no longer meet eligibility for PacifiCare coverage, such as moving outside the PacifiCare Service Area.
5. The contract for health care services between your employer and PacifiCare is terminated; or
6. You become entitled for Medicare. **Note:** If you were eligible for the 29-month extension as a result of disability and you are later determined by the Social Security Administration to no longer be disabled, your benefits will terminate the later of 36 months after your qualifying event or the first of the month following 31 days from date of the final Social Security Administration determination, but only if you send the Social Security Administration notice to PacifiCare within 30 days of the determination.
7. If you were covered under a prior carrier and your former employer replaces your prior coverage with PacifiCare coverage, you may continue the remaining balance of your unused coverage with PacifiCare, but only if you enroll with and pay Premiums to PacifiCare within 30 days of receiving notice of your termination from the prior group Health Plan.

If the contract between your former employer and PacifiCare terminates prior to the date your continuation coverage would terminate under California Continuation COBRA, you may elect continuation coverage under your former employer's new benefit plan for the remainder of the time period you would have been covered under the prior group benefit plan.

California Continuation Coverage After COBRA for Certain Former Employees and Their Spouses

California Continuation Coverage option is not available to a Member who does not meet the eligibility requirements for coverage prior to January 1, 2005.

California law also provides that certain former employees and their dependent Spouses (including a Spouse who is divorced from the employee and/or a Spouse who was married to the employee at the time

of that employee's death) may be eligible to continue group coverage beyond the date their COBRA and California Continuation COBRA Coverage is scheduled to end. Prior to you reaching your combined benefit of 36 months, PacifiCare will offer the extended coverage to employees and dependent Spouses of employers that are subject to the existing COBRA and California Continuation COBRA laws and to the former employees' dependent Spouses, including divorced or widowed Spouses as described above.

This coverage is subject to the following conditions:

- The former employee worked for the employer for the prior five (5) years and was 60 years of age or older on the date his or her employment ended and;
- The former employee was eligible for and elected COBRA for himself or herself and his or her dependent Spouse or;
- A former Spouse (i.e., a divorced or widowed Spouse as described above) is also eligible for continuation of group coverage after they have used all of their available COBRA benefit coverage. The former Spouse must elect such coverage by notifying PacifiCare in writing within 30 calendar days prior to the date that the initial COBRA benefits are scheduled to end. A former Spouse or surviving Spouse may continue Continuation COBRA for up to five (5) continuous years upon the coverage prior to the effective date of cancellation. If you are terminated for failing to make timely Premium, you are not eligible for the PacifiCare Individual Conversion Plan described in the section titled, "Extending Your Coverage: Converting to an Individual Conversion Plan."

If elected, this coverage will begin after your 36th month of COBRA coverage and will be administered under the same terms and conditions as if COBRA had remained in force. If you are already a California Continuation COBRA participant or will become eligible as of December 1, 2004, your extended coverage will remain in place until you are automatically terminated per the below section, "Termination of Continuation Coverage After COBRA for Certain Employees and their Spouses as Described in the Above Paragraph." As your former employer's premium is not adjusted for the age of the specific employee or Eligible Dependent, premiums for this coverage will be 213 percent of the current applicable group rate. Your premium may be increased or your benefit package decrease each time the Employer's Group's benefit package renews or changes. Payment is due at the time the Employer Group's payment is due.

For California Continuation Coverage, PacifiCare will bill you directly once we have received your election form. You are responsible for paying the Health Plan Premium directly to PacifiCare on a month basis, and it must be delivered by first-class mail or other reliable means.

The first month's California Continuation COBRA Health Plan Premium payment is due within 45 days of the date that you submit the election form to PacifiCare. This payment must be sufficient to pay all premiums due from the first month after the qualifying event through the current month. Failure to submit the correct premium amount will disqualify you from receiving California Continuation coverage. Please note, you will not be enrolled in California Continuation COBRA until PacifiCare receives both your election form and your first premium payment.

Thereafter, California Continuation Coverage premiums are due on the first day of the coverage month (i.e., January 1st for January coverage). If you fail to pay your premium when the premium payment is due, PacifiCare will send you a 15-day cancellation notice reminding you that your premium is overdue. If premium is received within 15 days of PacifiCare's cancellation notification you will experience no break in coverage and no changes in benefits. However if you do not pay your premium, enrollment will be cancelled effective 15 days after PacifiCare mailed the cancellation notice. A termination notice will be sent to you at this time, and any premium payments received after the 15-day notice period has expired for coverage after the effective date of cancellation will be refunded to you within 20 business days. However, you remain financially responsible for unpaid premium for coverage prior to the effective date of cancellation. If you are terminated for failing to make timely premium, you are not eligible for the PacifiCare Individual Conversion Plan described in the section titled, "Extending Your Coverage: Converting to an Individual Conversion Plan."

Termination of Continuation Coverage After COBRA for Certain Employees and Their Spouses as Described in the Above Paragraph

This coverage will end automatically on the earlier of:

1. The date the former employee, Spouse or former Spouse reaches 65;
2. The date in which the Group Agreement contract is terminated by either your former Employer Group or PacifiCare or the date your former employer ceases to provide coverage for any active employees through PacifiCare;
3. The date the former employee, Spouse or former Spouse is covered by another Health Plan;
4. The date the former employee, Spouse or former Spouse becomes entitled to Medicare;
5. For a Spouse or former Spouse, five (5) years from the date the Spouse's COBRA coverage would end;
6. 15 days after PacifiCare mails notice to the former employee, Spouse or former Spouse that coverage is being cancelled for failure to pay Premium. If Premium is received within 15 days of PacifiCare's cancellation notification you will experience no break in coverage and no change in benefits. However, if you do not pay your Premium, enrollment will be cancelled effective 15 days after PacifiCare mailed the cancellation notice. A termination notice will be sent to you at that time and any Premium payments for coverage after the effective date of cancellation received after the 15-day notice period has expired will be refunded to you within 20 business days. However, you remain financially responsible for unpaid Premium for coverage prior to the effective date of cancellation.

For a Spouse or former Spouse that has used the available California Continuation Coverage period of five (5) years, qualified beneficiaries may be allowed to enroll in a PacifiCare individual conversion Health Plan, unless you are eligible for Medicare. Other exclusions date the full 36 months of COBRA benefits were scheduled to end, regardless of the age or length of employment of the Subscriber.

If elected, this coverage will begin after your 36th month of COBRA coverage and will be administered under the same terms and conditions as if COBRA had remained in force.

As your former employer's Premium is not adjusted for the age of the specific employee or eligible Dependent, Premiums for this coverage will be 213 percent of the current applicable group rate. Your Premium may be increased or benefit package decreased each time your former Employer Group's benefit package renews or changes. Payment is due at the time the Employer Group's payment is due.

For California Continuation Coverage, PacifiCare will bill you directly once we have received your election form. You are responsible for paying the Health Plan Premium directly to PacifiCare on a monthly basis and it must be delivered by first-class mail or other reliable means. The first month's California Continuation COBRA Health Plan Premium payment is due within 45 days of the date that you submit the election form to PacifiCare. This payment must be sufficient to pay all Premiums due from the first month after the qualifying event through the current month. Failure to submit the correct Premium amount will disqualify you from receiving California Continuation Coverage. Please note you will not be enrolled in California Continuation COBRA until PacifiCare receives both your election form and your first Premium payment.

Thereafter, California Continuation Coverage Premiums are due on the first day of the coverage month (i.e., January 1st for January coverage). If you fail to pay your Premium when the Premium payment is due, PacifiCare will send you a 15-day cancellation notice reminding you that your Premium is overdue. If Premium is received within 15 days of the issue date of PacifiCare's cancellation notification to you that your Premium is overdue, you will experience no break in coverage and no change in benefits. However, if you do not pay your Premium, enrollment will be cancelled effective 15 days after PacifiCare mailed the cancellation notice. A termination notice will be sent to you at this time, and any Premium payments received after the 15-day notice period has expired for coverage after the effective date of cancellation will be refunded to you within 20 business days. However, you remain financially responsible for unpaid Premium for may apply. Please see the explanation under "Extending Your Coverage: Converting to an Individual Plan." You may also have additional coverage under HIPAA. Please see the explanation under "Coverage Under the Health

Insurance Portability and Accountability Act of 1996 ("HIPAA").

Notification Requirements

The University of California is solely responsible for notifying former employees or Dependent Spouses (including former Spouses as defined above) of the availability of the coverage at least 90 calendar days before COBRA is scheduled to end. To elect this coverage, the former employee or Spouse must notify PacifiCare in writing at least 30 calendar days before COBRA is scheduled to end."

Extending Your Coverage: Converting to an Individual Conversion Plan

If you have been enrolled in this Health Plan for three or more consecutive months, and you have been terminated by your employer which terminates your group Health Plan coverage, you and your currently enrolled Family Members may apply for the individual conversion plan issued by PacifiCare. The Employer Group is solely responsible for notifying you of the availability, terms and conditions of the individual conversion plan within 15 days of the termination of your group coverage.

An application for the conversion plan must be received by PacifiCare within 63 days of the date of termination of your group coverage. However, if the University of California terminates its Group Agreement with PacifiCare or replaces the PacifiCare group coverage with another carrier within 15 days of the date of termination of the Group coverage or the Subscriber's participation, transfer to the individual conversion Health Plan is not permitted. You also will not be permitted to transfer to the individual conversion Health Plan under any of the following circumstances:

1. You failed to pay any amounts due to the Health Plan;
2. You were terminated by the Health Plan for good cause or for fraud or misrepresentation as described in the section "Termination for Good Cause;"
3. You knowingly furnished incorrect information or otherwise improperly obtained benefits of the Health Plan;
4. You are covered or are eligible for Medicare;
5. You are covered or are eligible for hospital, medical or surgical benefits under state or federal law or under any arrangement of coverage for individuals in a group, whether insured or self-insured*;
6. The Employer Group's hospital, medical or surgical expense benefit program is self-insured; or
7. You are covered for similar benefits under an individual policy or contract.

Please note: If you were not previously eligible under the PacifiCare group Health Plan benefit, as described above, you may not enroll on PacifiCare's Individual Conversion Plan. This includes any future Dependents not currently enrolled as a Member of your PacifiCare group Health Plan under your former employer.

***Note also:** If you elect COBRA or Cal-COBRA Continuation Coverage, you are eligible for guaranteed issuance of a HIPAA individual contract at the time your COBRA or Cal-COBRA Coverage ends. However, if you select Individual Conversion Coverage instead, you will not be eligible for a HIPAA-guaranteed product.

Benefits or rates of an individual conversion plan Health Plan are different from those in your group plan.

An individual conversion Health Plan is also available to:

1. Currently enrolled Dependents, if the Subscriber dies;
2. Dependents who are currently enrolled and are no longer eligible for group Health Plan coverage due either to marriage or exceeding the maximum age for Dependent coverage under the group plan, as determined by the employer;
3. Dependents who are currently enrolled and lose coverage as a result of the Subscriber entering military service;
4. Spouse of the Subscriber who is currently an enrolled Dependent under PacifiCare, if your marriage has terminated due to divorce or legal separation.

Written applications and the first Premium payment for all conversions must be received by PacifiCare within 63 days of the loss of group coverage. This is an additional option to PacifiCare Members. This means you do not need to enroll and use any benefits you may have access to through COBRA or Cal-COBRA

to be eligible. For more details, please contact our Customer Service department.

Individual Conversion Plan Premiums are due on the first day of the coverage month (i.e., January 1st for January coverage). If you fail to pay your Individual Conversion Plan Premium when the Premium payment is due, PacifiCare will send you a 15-day cancellation notice reminding you that your Premium is overdue. If Premium is received within 15 days of PacifiCare's cancellation notification, you will experience no break in coverage and no change in benefits. However, if you do not pay your Premium, enrollment will be cancelled effective 15 days after PacifiCare mailed the cancellation notice. A termination notice will be sent to you at that time and any Premium payments for coverage after the effective date of cancellation received after the 15-day notice period has expired will be refunded to you within 20 business days. However, you remain financially responsible for unpaid Premium for coverage prior to the effective date of cancellation.

Coverage Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

You may be eligible for the PacifiCare HIPAA Guaranteed Issue product, regardless of health status, if you:

1. Have had at least 18 months of prior creditable coverage, with the most recent prior creditable coverage under a group Health Plan, governmental plan or church plan, and with no break in creditable coverage greater than 63 days;
2. Are not currently entitled to coverage under a group Health Plan, Medicare or Medicaid*;
3. Do not currently have other health insurance coverage;
4. Your most recent creditable coverage was not terminated because of nonpayment of Premiums or fraud; and
5. If you were eligible, you elected and have used all federal COBRA continuation coverage available to you.

***Please note:** If you elect COBRA or Cal-COBRA Continuation Coverage, you are eligible for guaranteed issuance of a HIPAA individual contract at the time your COBRA or Cal-COBRA coverage ends. However, if you select Individual Conversion coverage instead, you will not be eligible for a HIPAA-guaranteed product.

HIPAA-eligible individuals need not be under age sixty-five (65) or meet medically underwritten requirements, but must qualify under the criteria for guaranteed issuance under HIPAA. Please contact PacifiCare's Customer Service for more information.

Your Rights Under HIPAA Upon Termination of This Group Contract

HIPAA is the acronym for the federal law known as the Health Insurance Portability and Accountability Act of 1996. HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. California state law provides similar and additional protections.

If you lose your group health insurance coverage and meet certain important criteria, you are entitled to purchase coverage under an individual contract from any Health Plan that sells health insurance coverage to individuals. Significant protections come with the HIPAA individual contract: no Pre-Existing Condition exclusions, guaranteed renewal at the option of the enrollee so long as the Plan offers coverage in the individual market and the enrollee pays the Premiums, and limitations on the amount of the Premium charged by the Health Plan.

Every Health Plan that sells health care coverage contracts to individuals must fairly and affirmatively offer, market, and sell HIPAA individual contracts to all Federally Eligible Defined Individuals. The plan may not reject an application from a Federally Eligible Defined Individual for a HIPAA individual contract if:

1. The Federally Eligible Defined Individual agrees to make the required Premium payments;
2. The Federally Eligible Defined Individual, and his or her Dependents to be covered by the plan contract, work or reside in the Service Area in which the plan operates.

You are a Federally Eligible Defined Individual if, as of the date you apply for coverage:

1. You have 18 or more months of creditable coverage without a break of 63 days or more between any of the periods of creditable coverage or since the most recent coverage has been terminated;
2. Your most recent prior creditable coverage was under a group, government or church plan.

(COBRA and Cal-COBRA are considered employer group coverage);

3. You were not terminated from your most recent creditable coverage due to nonpayment of Premiums or fraud;
4. You are not eligible for coverage under a group Health Plan, Medicare, or Medi-Cal (Medicaid);
5. You have no other health insurance coverage; and
6. You have elected and exhausted fully any continuation coverage you were offered under COBRA or Cal-COBRA.

There are important terms you need to understand, important factors you need to consider, and important choices you need to make in a very short time frame regarding the options available to you following termination of your group health care coverage. For example, if you are offered, but do not elect and exhaust COBRA or CAL-COBRA Continuation Coverage, you are not eligible for guaranteed issuance of a HIPAA individual contract. You should read carefully all of the information set forth in this section. Additional information is available from PacifiCare by calling 1-800-624-8822.

If you believe your HIPAA rights have been violated, you should contact the Department of Managed Health Care at 1-888-HMO-2219 or visit the Department's Web site at **www.dmhc.ca.gov**.

Certificate of Creditable Coverage

According to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a Certificate of Creditable Coverage will be provided to the Subscriber by PacifiCare when the Subscriber or a Dependent ceases to be eligible for benefits under the University of California's health benefit plan. Certificates of Creditable Coverage will also be provided upon request while the Subscriber or Dependent is covered under the Health Plan and up to 24 months after coverage under the Health Plan ceases. A Certificate of Creditable Coverage may be used to reduce or eliminate a Pre-Existing Condition exclusion period imposed by a subsequent Health Plan. Creditable coverage information for Dependents will be included on the Subscriber's *Certificate*, unless the Dependent's address of record or coverage information is substantially different from the Subscriber's. Please contact the PacifiCare Customer Service department if you need a duplicate Certificate of Creditable Coverage. If you meet HIPAA-eligibility requirements, you may be able to obtain individual coverage using your Certificate of Creditable Coverage.

Uniformed Services Employment and Reemployment Rights Act

Continuation of Benefits under USERRA. Continuation coverage under this Health Plan may be available to you through the University of California under the Uniform Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). The continuation coverage is equal to, and subject to the same limitations as, the benefits provided to other Members regularly enrolled in this Health Plan. These benefits may be available to you if you are absent from employment by reason of service in the United States' uniformed services, up to the maximum 24-month period if you meet the USERRA requirements. USERRA benefits run concurrently with any benefits that may be available through the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended. The University of California will provide written notice to you for USERRA continuation coverage. If you are called to active military duty and are stationed outside of the Service Area, you or your eligible Dependents must still maintain a permanent address inside the Service Area and must select a Participating Medical Group within 30 miles of that address. To obtain coverage, all care must be provided or arranged in the Service Area by the designated Participating Medical Group, except for Emergency and Urgently Needed Services.

The Health Plan Premium for USERRA Continuation of benefits is the same as the Health Plan Premium for other PacifiCare Members enrolled through the University of California plus a 2 percent additional surcharge or administrative fee, not to exceed 102 percent of the University of California's active group Premium. Under arrangement with the University, PacifiCare is responsible for billing and collecting Health Plan Premiums from you or your Dependents otherwise due under this Agreement. Additionally, the University of California is responsible to maintain accurate records regarding USERRA Continuation Member Health Plan Premium, qualifying events, terminating events and any other information that may be necessary for PacifiCare to administer this continuation benefit.

Overseeing Your Health Care

Section 9. Overseeing Your Health Care

- **How PacifiCare Makes Important Decisions**
- **New Treatments and Technologies**
- **What to Do if You Have a Problem**
- **Quality of Care Review**
- **Appeals and Grievances**
- **Independent Medical Reviews**

How PacifiCare Makes Important Health Care Decisions

This section explains how PacifiCare authorizes or makes changes to your health care services, how we evaluate new health care technologies and how we reach decisions about your coverage.

You will also find out what to do if you're having a problem with your health care plan, including how to appeal a health care decision by PacifiCare or one of our Participating Providers. You'll learn the process that's available for filing a formal grievance, as well as how to request an expedited decision when your condition requires a quicker review.

Authorization, Modification and Denial of Health Care Services

Medical Necessity reviews may be conducted by PacifiCare, or, in many situations, by a Participating Medical Group. Processes are used to review, approve, modify or deny, based on Medical Necessity, requests by Providers for authorization of the provision of health care services to Members.

The reviewer 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 provided free of charge 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.

The reviewer makes these decisions within at least the following time frame 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 business days from PacifiCare's, or in many situations, the Participating Medical Group's receipt of the information reasonably necessary and requested 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 if lack of timeliness would be detrimental in regaining maximum function or to the Member's life or health, the decision will be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed 72 hours after PacifiCare's or, in many situations, the Participating Medical Group's receipt of the information reasonably necessary and requested by the reviewer to make the determination (an Urgent Request).

If the decision cannot be made within these time frames because (i) PacifiCare or, in many situations, the Participating Medical Group is not in receipt of all of the information reasonably necessary and requested or (ii consultation by an expert reviewer is required, or (iii) the reviewer 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, the reviewer will notify the Provider and the Member, in writing, upon the earlier of the expiration of the required time frame above or as soon as PacifiCare or the Participating Medical Group becomes aware that they will not be able to meet the required time frame.

The notification will specify the information requested but not received or the additional examinations or tests required, and the anticipated date on which a decision may be rendered following receipt of all reasonably necessary requested information. Upon receipt of all information reasonably necessary and requested by PacifiCare or, in many situations, the Participating Medical Group, the reviewer shall approve, modify or deny the request for authorization within the time frame specified above as applicable.

The reviewer will 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. The written decision will include the specific reason(s) for the decision, the clinical reason(s) for modifications or denials based on a lack of Medical Necessity, or reference to the benefit provision on which the denial decision was based, and information about how to file an appeal of the decision with PacifiCare. In addition, the internal criteria or benefit interpretation policy, if any, relied upon in making this decision will be made available upon request by the Member. PacifiCare's Appeals Process is outlined in the "General Information" section of this *Combined Evidence of Coverage and Disclosure Form*.

If the Member requests an extension of a previously authorized and currently ongoing course of treatment, and the request is an "Urgent Request," as defined above, the reviewer will approve, modify or deny the request as soon as possible, taking into account the Member's medical condition, and will notify the Member of the decision within 24 hours of the request, provided the Member made the request to PacifiCare or, in many situations, the Participating Medical Group at least 24 hours prior to the expiration of the previously authorized course of treatment. If the concurrent care request is not an Urgent Request as defined above, the reviewer will treat the request as a new request for a Covered Service under the Health Plan and will follow the time frame for non-urgent requests as discussed above.

If you would like a copy of PacifiCare's policy and procedure, a description of the processes utilized for the authorization, modification or denial of health care services, or are seeking information about the utilization management process and the authorization of care, you may contact the PacifiCare Customer Service department at 1-800-624-8822.

PacifiCare's Utilization Management Policy

PacifiCare distributes its policy on financial incentives to all its Participating Providers, Members and employees. PacifiCare also requires that Participating Providers and staff who make utilization decisions and those who supervise them sign a document acknowledging receipt of this policy. The policy affirms that a utilization management decision is based solely on the appropriateness of a given treatment and service, as well as the existence of coverage. PacifiCare does not specifically reward Participating Providers or other individuals conducting utilization review for issuing denials of coverage. Financial incentives for Utilization management decision-makers do not encourage decisions that result in either the denial or modification of Medically Necessary Covered Services.

Medical Management Guidelines

The Medical Management Guidelines Committee (MMGC), consisting of PacifiCare Medical Directors, provides a forum for the development, review and adoption of medical management guidelines to support consistent, appropriate medical care determinations. The MMGC develops guidelines using evidenced-based medical literature and publications related to medical treatment or service. The Medical Management Guidelines contain practice and utilization criteria for use when making coverage and medical care decisions prior to, subsequent to or concurrent with the provisions of health care services.

Technology Assessment

PacifiCare regularly reviews new procedures, devices, and drugs to determine whether or not they are safe and efficacious for our Members. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a Covered Service, it will be subject to all other terms and conditions of the plan, including Medical Necessity and any applicable Member Copayments, or other payment contributions.

In determining whether to cover a service, PacifiCare uses proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual Member, a PacifiCare Medical Director makes a Medical Necessity determination based on individual Member medical documentation, review of published scientific evidence and, when appropriate, seeks relevant specialty or professional opinion from an individual who has expertise in the technology.

Utilization Criteria

When a Provider or Member requests Preauthorization of a procedure/service requiring Preauthorization, an appropriately qualified licensed health professional reviews the request. The qualified licensed health

professional applies the applicable criteria, including, but not limited to:

- Nationally published guidelines for utilization management (specific guideline information available upon request);
- HCIA-Sachs Length of Stay© Guidelines (average length of Hospital stays by medical or surgical diagnoses);
- Medical Management Guidelines (MMG) and Benefit Interpretation Policies (BIP).

Those cases that meet the criteria for coverage and level of service are approved as requested. Those not meeting the utilization criteria are referred for review to a Participating Medical Group's Medical Director or a PacifiCare Medical Director.

Denial, delay or modification of health care services based on Medical Necessity must be made by a licensed Physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the Provider.

Denials may be made for administrative reasons that include, but are not limited to, the fact that the patient is not a PacifiCare Member or that the service being requested is not a benefit provided by the Member's plan.

Preauthorization determinations are made once the Member's Participating Medical Group Medical Director or designee receives all reasonably necessary medical information. PacifiCare makes timely and appropriate initial determinations based on the nature of the Member's medical condition in compliance with state and federal requirements.

What to Do if You Have a Problem

Sometimes you may have an unexpected problem. When this happens, your first step should be to call our Customer Service department. We'll assist you and attempt to find a solution to your situation.

If you have a concern about your treatment or a decision regarding your medical care, you may be able to request a second medical opinion. You can read more about requesting, as well as the requirements for obtaining a second opinion, in **Section 2. Seeing the Doctor.**

If you feel that your problem is not resolved or that your situation requires additional action, you may also request a formal Appeal or Quality Review. To learn more about this, read the following sections, "Appealing a Health Care Decision" or "Requesting a Quality of Care Review."

Appealing a Health Care Decision

Submitting a Grievance

PacifiCare's Grievance system provides Members with a method for addressing Member dissatisfaction regarding coverage decisions, care or services. Our appeals and quality of care review procedures are designed to resolve your Grievance. This is done through a process that includes a thorough and appropriate investigation. To initiate an appeal or request a quality of care review, call our Customer Service department at 1-800-624-8822, where a Customer Service representative will document your oral appeal. You may also file an appeal using the Online Grievance form at **www.pacificare.com** or write to the Appeals department at:

PacifiCare of California
Appeals and Grievance Department
Mail Stop CA124-0157
5701 Katella Avenue
P.O. Box 6006
Cypress, CA 90630

This request will initiate the following Appeals Quality of Clinical Care and Quality of Service Review Process, except in the case of "expedited reviews," as discussed below. You may submit written comments, documents, records and any other information relating to your appeal, regardless of whether this information was submitted or considered in the initial determination. You may obtain, upon request and free of charge, copies of all documents, records and other information relevant to your appeal. The appeal will be reviewed by an individual who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person.

PacifiCare will review your complaint, and if it 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, a health care professional who has the education, training and relevant expertise in the field of medicine

necessary to evaluate the specific clinical issues that serve as the basis of your appeal.

Quality of Clinical Care and Quality of Service Review

All quality of clinical care and quality of service complaints are investigated by PacifiCare's Health Services department. PacifiCare conducts this quality review by investigating the complaint and consulting with your Participating Medical Group, treating Providers and other PacifiCare internal departments. Medical records are requested and reviewed as necessary, and as such, you may need to sign an authorization to release your medical records. We will respond to your complaint in a manner appropriate to the clinical urgency of your situation. You will also receive written notification regarding the disposition of your quality of clinical care and/or quality of service review complaint within 30 calendar days of PacifiCare's receipt of your complaint. Please be aware that the results of the quality of clinical care review are confidential and protected from legal discovery in accordance with state law.

The Appeals Process

You may submit an appeal for a denial of a service or denied claims within 180 calendar days of your receipt of an initial determination through our Appeals department. PacifiCare's Health Services department will review your appeal within a reasonable period of time appropriate to the medical circumstances and make a determination within 30 calendar days of PacifiCare's receipt of the appeal. For appeals involving the delay, denial or modification of health care services related to Medical Necessity, PacifiCare's written response will include the specific reason for the decision, describe the criteria or guidelines or benefit provision on which the denial decision was based, and notification that upon request the Member may obtain a copy of the actual benefit provision, guideline protocol or other similar criterion on which the denial is based. 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 *Combined Evidence of Coverage and Disclosure Form* that exclude that coverage.

Expedited Review Process

Appeals involving an imminent and serious threat to your health, including, but not limited to, severe pain or the potential loss of life, limb or major bodily function, will be immediately referred to PacifiCare's clinical review personnel. If your case does not meet the criteria for an expedited review, it will be reviewed under the standard appeal process. If your appeal requires expedited review, PacifiCare will immediately inform you of your review status and your right to notify the Department of Managed Health Care (DMHC) of the Grievance.

You and the DMHC will be provided a written statement of the disposition or pending status of the expedited review no later than three calendar days from receipt of the Grievance. You are not required to participate in the PacifiCare appeals process prior to contracting the DMHC regarding your expedited appeal.

Voluntary Mediation and Binding Arbitration

If you are dissatisfied with PacifiCare's Appeal Process determination, you have 60 days to request that PacifiCare submit the appeal to voluntary mediation or binding arbitration before the Judicial Arbitration and Mediation Services (JAMS).

Voluntary Mediation

In order to initiate voluntary mediation, either you or the agent acting on your behalf must submit a written request to PacifiCare. If all parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with the JAMS Mediation Rules and Procedures, unless all parties otherwise agree. Expenses for mediation will be shared equally by the parties. The Department of Managed Health Care will have no administrative or enforcement responsibilities with the voluntary mediation process.

Binding Arbitration

All disputes of any kind, including, but not limited to, claims for medical malpractice between the Member (including any heirs, successors or assigns of Member) and PacifiCare, except for claims subject to ERISA, will be submitted to Binding Arbitration. Medical malpractice includes any issues or allegations that medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligently or incompetently rendered. This means that disputes between the Member and PacifiCare will not be resolved by a lawsuit or by pursuing other court processes and remedies, except to the extent the Federal Arbitration Act provides for judicial review of

arbitration proceedings. Under this provision, neither the Court nor any arbitrator may delay arbitration of disputes or refuse to order disputes to arbitration. The intent of this arbitration provision, and the parties, is to put litigation on hold so that issues can be resolved through the binding arbitration process. Any disputes about the scope of arbitration, about the arbitration itself or about whether an issue falls under this arbitration provision will be resolved by the arbitrator to avoid ambiguities and litigation costs.

The Member and PacifiCare understand and agree that they are giving up their constitutional rights to have disputes decided in a court of law before a jury and are instead accepting the use of Binding Arbitration by a single arbitrator. The arbitration will be performed by JAMS or another arbitration service as the parties may agree in writing. The arbitration will be conducted under the JAMS Comprehensive Arbitration Rules and Procedures. The parties will attempt in good faith to agree to the appointment of an arbitrator, but if agreement cannot be reached within 30 days following the date demand for arbitration is made, the arbitrator will be chosen using the appointment procedures set out in the JAMS Comprehensive Arbitration Rules and Procedures. These rules may be viewed by the Member at the JAMS Web site, **www.jamsadr.com**. If the member does not have access to the Internet, the Member may request a copy of the rules from PacifiCare, and arrangements will be made for the Member to obtain a hard copy of the rules and procedures.

Arbitration hearings will be held in Orange County, California or at a location agreed to in writing by the Member and PacifiCare. The expenses of JAMS and the arbitrator will be paid in equal shares by the Member and PacifiCare. Each party will be responsible for any the expenses related to discovery conducted by them and their own attorney fees. In cases of extreme hardship, PacifiCare may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS and JAMS approves the application. The approval or denial of the hardship application will be determined solely by JAMS. The Member will remain responsible for their own attorney fees, unless an award of attorney fees is allowable under the law and the arbitrator makes an award of attorney fees to the Member. Following the arbitration, the arbitrator will prepare a written award that includes the legal and factual reasons for the decision.

Nothing in this Binding Arbitration provision is intended to prevent the Member or PacifiCare from seeking a temporary restraining order or preliminary injunction or other provisional remedies from a court. However, any and all other claims or causes of action, including, but not limited to those seeking damages, restitution, or other monetary relief, will be subject to this Binding Arbitration provision. Any claim for permanent injunctive relief will be stayed pending completion of the arbitration. The Federal Arbitration Act, 9 U.S.C. Sections 1-16, will apply to the arbitration.

ALL PARTIES 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 BINDING ARBITRATION.

Experimental or Investigational Treatment

A PacifiCare Medical Director may deny a treatment if he or she determines it is Experimental or Investigational, except as described in "Cancer Clinical Trials" under **Section 5. Your Medical Benefits**. If you have a Terminal Illness as defined below, you may request that PacifiCare hold a conference within 30 calendar days of receiving your request to review the denial. For purposes of this paragraph, Terminal Illness means an incurable or irreversible condition that has a high probability of causing death within one year or less. The conference will be held within five (5) days if the treating Physician determines, in consultation with the PacifiCare Medical Director and based on professionally recognized standards of practice, that the effectiveness of the proposed treatment or services would be materially reduced if not provided at the earliest possible date.

Independent Medical Review

IF YOU BELIEVE THAT A HEALTH CARE SERVICE INCLUDED IN YOUR COVERAGE HAS BEEN IMPROPERLY DENIED, MODIFIED OR DELAYED BY PACIFICARE OR ONE OF ITS PARTICIPATING PROVIDERS, YOU MAY REQUEST AN INDEPENDENT MEDICAL REVIEW (IMR) OF THE DECISION. IMR IS AVAILABLE FOR DENIALS, DELAYS OR MODIFICATIONS OF HEALTH CARE SERVICES REQUESTED BY YOU OR YOUR PROVIDER BASED ON A FINDING THAT THE REQUESTED SERVICE IS EXPERIMENTAL

OR INVESTIGATIONAL OR IS NOT MEDICALLY NECESSARY. YOUR CASE ALSO MUST MEET THE STATUTORY ELIGIBILITY CRITERIA AND PROCEDURAL REQUIREMENTS DISCUSSED BELOW. IF YOUR COMPLAINT OR APPEAL PERTAINS TO A DISPUTED HEALTH CARE SERVICE SUBJECT TO INDEPENDENT MEDICAL REVIEW (AS DISCUSSED BELOW), YOU SHOULD FILE YOUR COMPLAINT OR APPEAL WITHIN 180 DAYS OF RECEIVING A DENIAL NOTICE.

Eligibility for Independent Medical Review

Experimental or Investigational Treatment Decisions

If you suffer from a life-threatening or seriously debilitating condition, you may have the opportunity to seek IMR of PacifiCare's coverage decision regarding Experimental or Investigational therapies under California's Independent Medical Review System pursuant to Health and Safety Code Section 1370.4. Life-Threatening means either or both of the following:

a. diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted;

b. 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.

To be eligible for IMR of Experimental or Investigational treatment, your case must meet all of the following criteria:

1. Your Physician certifies that you have a life-threatening or seriously debilitating condition for which:
   - Standard therapies have not been effective in improving your condition; or
   - Standard therapies would not be medically appropriate for you; or
   - There is no more beneficial standard therapy covered by PacifiCare than the proposed Experimental or Investigational therapy proposed by your Physician under the following paragraph.
2. Either (a) your PacifiCare Participating 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 you than any available standard therapies, and he or she has included a statement of the evidence relied upon by the Physician in certifying his or her recommendation; or (b) you or your Non-Contracting Physician – who is a licensed, board-certified or board-eligible Physician qualified to practice in the specialty appropriate to treating your condition – has requested a therapy that, based on two documents of medical and scientific evidence identified in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial than any available standard therapy. To satisfy this requirement, the Physician certification must include a statement detailing 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 Physicians who are not otherwise covered under your PacifiCare benefits.)
3. A PacifiCare Medical Director has denied your request for a treatment or therapy recommended or requested pursuant to the above paragraph.
4. The treatment or therapy recommended pursuant to Paragraph 2 above would be a Covered Service, except for PacifiCare's determination that the treatment, drug, device, procedure or other therapy is Experimental or Investigational.

If you have a life-threatening or seriously debilitating condition, and PacifiCare denies your request for Experimental or Investigational therapy, PacifiCare will send a written notice of the denial within five (5) business days of the decision. The notice will advise you of your right to request IMR, and include a Physician certification form and an application form with a preaddressed envelope to be used to request IMR from the DMHC.

Disputed Health Care Services

You may also request IMR of a Disputed Health Care Service. A Disputed Health Care Service is any health care service eligible for coverage and payment under your Health Plan that has been denied, modified or delayed by PacifiCare or one of its Participating Providers, in whole or in part, due to a finding that the service is not Medically Necessary. (**NOTE**:

Disputed Health Care Services do not encompass coverage decisions. Coverage decisions are decisions that approve or deny health care services substantially based on whether or not a particular service is included or excluded as a covered benefit under the terms and conditions of your health care coverage.)

You are eligible to submit an application to the DMHC for IMR of a Disputed Health Care Service if you meet all of the following criteria:

1. 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 a Participating Provider for the diagnosis or treatment of the medical condition for which you seek IMR;
2. The health care service has been denied, modified or delayed by PacifiCare 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
3. You have filed an appeal with PacifiCare regarding the decision to deny, delay or modify health care services and the disputed decision is upheld or the appeal remains unresolved after 30 days (or three (3) days in the case of an urgent appeal requiring expedited review). (**NOTE**: If there is an imminent and serious threat to your health, the DMHC may waive the requirement that you complete the appeals process or participate in the appeals process for at least 30 days if the DMHC determines that an earlier review is necessary in extraordinary and compelling cases if the DMHC finds that you have acted reasonably.)

You may apply to the DMHC for IMR of a Disputed Health Care Service within six months of any of the events or periods described above, or longer if the DMHC determines that the circumstances of your case warrant an IMR review. PacifiCare will provide you 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.

The IMR process is in addition to any other procedures or remedies that may be available to you.

Independent Medical Review Procedures

Applying for Independent Medical Review

In the case of Experimental or Investigational coverage decisions, if you have a life-threatening or seriously debilitating condition, PacifiCare will include an application for IMR in its notice to you that the requested service has been denied and include a Physician certification form with a preaddressed envelope to the DMHC. Your Physician must provide the Physician certification and medical and scientific documentation required for Experimental and Investigational IMR, which may be included with your application, or mailed or faxed directly to the DMHC by your Physician. Either you or your Physician can provide the letter from PacifiCare or its Participating Provider denying the request for Experimental or Investigational treatment.

In the case of determinations that a Disputed Health Care Service is not Medically Necessary, PacifiCare will provide you with an IMR application form with any disposition letter resolving your appeal of the determination. Your application for IMR of a Disputed Health Care Service may include information or documentation regarding a Provider's recommendation that the service is Medically Necessary, medical information that a service received on an urgent care or emergency basis was Medically Necessary, and any other information you received from or gave to PacifiCare or its Participating Providers that you believe is relevant in support of your position that the Disputed Health Care Service was Medically Necessary.

Completed applications for IMR should be submitted to the DMHC. You pay no fee to apply for IMR. You, your Physician, or another designated representative acting on your behalf may request IMR. If there is any additional information or evidence you or your Physician wish to submit to the DMHC that was not previously provided to PacifiCare, you may include this information with the application for IMR. The DMHC fax number is (916) 229-0465. You may also reach the DMHC by calling 1-888-HMO-2219.

Accepted Applications for Independent Medical Review

Upon receiving your application for IMR, the DMHC will review your request and notify you whether your

case has been accepted. If your case is eligible for IMR, the dispute will be submitted to an Independent Medical Review Organization (IRO) contracted with the DMHC for review by one or more expert reviewers, independent of PacifiCare, who will make an independent determination of whether or not the care should be provided. The IRO selects an independent panel of medical professionals knowledgeable in the treatment of your condition, the proposed treatment and the guidelines and protocols in the area of treatment under review. Neither you nor PacifiCare will control the choice of expert reviewers. PacifiCare must provide the following documents to the IRO within three (3) business days of receiving notice from the DMHC that you have successfully applied for an IMR:

1. The relevant medical records in the possession of PacifiCare or its Participating Providers;
2. All information provided to you by PacifiCare and any of its Participating Providers concerning PacifiCare and Provider decisions regarding your condition and care (including a copy of PacifiCare's denial notice sent to you);
3. Any materials that you or your Provider submitted to PacifiCare and its Participating Providers in support of the request for the health care services;
4. Any other relevant documents or information used by PacifiCare or its Participating Providers in determining whether the health care service should have been provided and any statement by PacifiCare or its Participating Providers explaining the reasons for the decision. The Plan shall provide copies of these documents to you and your Provider unless any information in them is found by the DMHC to be privileged.

If there is an imminent and serious threat to your health, PacifiCare will deliver the necessary information and documents listed above to the IRO within 24 hours of approval of the request for IMR.

After submitting all of the required material to the IRO, PacifiCare will promptly issue you a notification that includes an annotated list of the documents submitted and offer you the opportunity to request copies of those documents from PacifiCare.

If there is any information or evidence you or your Provider wish to submit to the DMHC in support of IMR that was not previously provided to PacifiCare, you may include this information with your application to the DMHC. Also as required, you or your Provider must provide to the DMHC or the IRO copies of any relevant medical records and any newly developed or discovered relevant medical records after the initial documents are provided and respond to any requests for additional medical records or other relevant information from the expert reviewers.

The Independent Medical Review Decision

The independent review panel will render its analysis and recommendations on your IMR case in writing, and in layperson's terms to the maximum extent practical, within 30 days of receiving your request for IMR and supporting information. The time may be adjusted under any of the following circumstances:

- In the case of a review of an Experimental or Investigational determination, if your Physician determines that the proposed treatment or therapy would be significantly less effective if not promptly initiated. In this instance, the analysis and recommendations will be rendered within seven (7) calendar days of the request for expedited review. The review period can be extended up to three (3) calendar days for a delay in providing required documents at the request of the expert. The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practical, within 30 days of the receipt of the application for review and supporting documents, or with less time as prescribed by the director.
- If the health care service has not been provided and your Provider or the DMHC certifies in writing that an imminent and serious threat to your health 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 your health. In this instance, any analyses and recommendations of the experts must be expedited and rendered within three (3) days of the receipt of your application and supporting information.
- If approved by the DMHC, the deadlines for the expert reviewers' analyses and recommendations involving both regular and expedited reviews may be extended for up to three (3) days in extraordinary circumstances or for good cause.

The IRO will provide the DMHC, PacifiCare, you and your 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. In the case of an Experimental or Investigational determination, the experts' analyses will state the reasons the requested Experimental or Investigational therapy is or is not likely to be more beneficial for you than any available standard therapy and the reasons for recommending why the therapy should or should not be provided by PacifiCare, citing your specific medical condition, the relevant documents provided and the relevant medical and scientific evidence supporting the experts' recommendation. In the case of a review of a Disputed Health Care Service denied as not Medically Necessary, the experts' analyses will state whether the Disputed Health Care Service is Medically Necessary and cite your medical condition, the relevant documents in the record and the reviewers' relevant findings.

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 health care service should be provided, the panel's decision will be deemed to be in favor of coverage. If the majority of the experts on the panel does not recommend providing the health care service, PacifiCare will not be required to provide the service.

When a Decision Is Made

The DMHC will immediately adopt the decision of the IRO upon receipt and will promptly issue a written decision to the parties that will be binding on PacifiCare. PacifiCare will promptly implement the decision when received from the DMHC. In the case of an IRO determination requiring reimbursement for services already rendered, PacifiCare will reimburse either you or your Provider – whichever applies – within five (5) business days. In the case of services not yet rendered to you, PacifiCare will authorize the services within five (5) business days of receiving the written decision from the DMHC, or sooner if appropriate for the nature of your medical condition, and will inform you and your Physician of the authorization. PacifiCare will promptly reimburse you for reasonable costs associated with Urgently Needed Services or Emergency Services outside of PacifiCare's Participating Provider network, if:

- The services are found by the IRO to have been Medically Necessary;
- The DMHC finds your decision to secure services outside of PacifiCare's Participating Provider network prior to completing the PacifiCare grievance process or seeking IMR was reasonable under the circumstances; and
- The DMHC finds that the Disputed Health Care Services were a covered benefit under the PacifiCare Subscriber contract.

Health care services required by IMR will be provided subject to the terms and conditions generally applicable to all other benefits under your PacifiCare Health Plan.

For more information regarding the IMR process, or to request an application, please call PacifiCare's Customer Service department.

Review by the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your Health Plan, you should first telephone your Health Plan at **1-800-624-8822** (for HMO Members) or **1-800-442-8833 (TDHI)** and use your Health Plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your Health Plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or Urgent Medical Services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech

impaired. The Department's Internet Web site **www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Complaints Against Participating Medical Groups, Providers, Physicians and Hospitals

Claims against a Participating Medical Group, the group's Physicians, or Providers, Physicians or Hospitals – other than claims for benefits under your coverage – are not governed by the terms of this plan. You may seek any appropriate legal action against such persons and entities deemed necessary.

In the event of a dispute between you and a Participating Medical Group (or one of its Participating Providers) for claims not involving benefits, PacifiCare agrees to make available the Member appeals process for resolution of such dispute. In such an instance, all parties must agree to this resolution process. Any decision reached through this resolution process will not be binding upon the parties except upon agreement between the parties. The Grievance will not be subject to binding arbitration except upon agreement between the parties. Should the parties fail to resolve the Grievance, you or the Participating Medical Group (or its Participating Provider) may seek any appropriate legal action deemed necessary. Member claims against PacifiCare will be handled as discussed above under "Appealing a Health Care Decision."

ERISA Rights

The following is a general description of the claims procedures applicable to Employers subject to the Employee Retirement Income Security Act of 1974, as amended (ERISA). Members should contact their Employer's benefit administrator to determine whether the Employer is subject to ERISA.

1. A description of PacifiCare's claims procedures, including the process for obtaining Preauthorization of a Covered Service, is set forth in this *Combined Evidence of Coverage and Disclosure Form*.
2. PacifiCare or its Participating Medical Group processes initial requests from Members (or their authorized representatives) for Covered Services pursuant to the following time frames:
    a. **Non-Urgent Pre-Service Requests**. Members will be notified of decisions to authorize or deny requests for Covered Services within a reasonable period of time appropriate to the medical condition of the Member but not later than 15 days from the receipt of the request. PacifiCare or its Participating Medical Group may extend the initial time frame for up to 15 days due to circumstances beyond its control. However, if the extension is necessary due to the Member's failure to submit the information necessary for PacifiCare or its Participating Medical Group to make a decision regarding the request, the Member will be notified of the extension, informed of the specific information necessary to make a decision, and provided at least 45 days to provide the specified information. In addition, the time period for making the determination is suspended from the date on which extension notification is received by the Member until the date on which (1) the Member responds with the specified information or (2) the end of the period of time provided to submit the specified information, whichever is earlier.
    b. **Urgent Requests**. A request for Covered Services will be treated as an "urgent request" if making a determination pursuant to the time frames in Section (a) above (i) could seriously jeopardize the life or health of the Member, or (ii) if in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. In the event of an urgent request, PacifiCare or its Participating Medical Group will notify the Member of its determination to authorize or deny as soon as possible, taking into account the Member's medical condition, but not later than 72 hours after receipt of the urgent request. In the event PacifiCare or its Participating Medical Group does not have the information necessary to make a decision regarding the request, PacifiCare or its Participating Medical Group will notify the Member as soon as reasonably possible, but not later than 24 hours after receipt of the request and will inform the Member

of the specific information necessary for PacifiCare or its Participating Medical Group to make a determination regarding the request, and the reasonable time frame (no less than 48 hours) for the Member to provide the specified information. PacifiCare or its Participating Medical Group will make a determination as soon as possible but no later than 48 hours after the earlier of (1) the receipt of the requested information, or (2) the end of the period of time provided to submit the specified information.

c. **Concurrent Care Requests**. If the Member requests an extension of a previously authorized and currently ongoing course of treatment, and the request is an "urgent request," as defined in Section (b) above, PacifiCare or its Participating Medical Group will approve or deny the request as soon as possible, taking into account the Member's medical condition, and will notify the Member of the decision within 24 hours of the request, provided the Member made the request to PacifiCare or its Participating Medical Group at least 24 hours prior to the expiration of the previously authorized course of treatment. If the concurrent care request is not an "urgent request," as defined in Section (b) above, PacifiCare or its Participating Medical Group will treat the request as a new request for a Covered Service under the Health Plan and will follow the time frame for non-urgent requests, as discussed in Section (a) above.

d. **Post-Service Claim.** Members will be notified of denials (in whole or in part) of an initial post-service claim within a reasonable period of time, but not later than 30 days after receipt of the claim. PacifiCare or its Participating Medical Group may extend the initial time frame for up to 15 days due to circumstances beyond its control. However, if the extension is necessary due to the Member's failure to submit the information necessary for PacifiCare or its Participating Medical Group to make a decision regarding the request, the Member will be notified of the extension, informed of the specific information necessary to make a decision, and provided at least 45 days to provide the specified information. In addition, the time period for making the determination is suspended from the date on which extension notification is received by the Member until the date on which (1) the Member responds with the specified information or (2) the end of the period of time provided to submit the specified information, whichever is earlier.

3. **Appeal.** Members have up to 180 days following receipt of an adverse determination within which to appeal the determination. Members are entitled to a full and fair appeals process. Members may submit written comments, documents, records and information in support of their appeal. PacifiCare will notify the Member of its decision regarding the appeal no later than:
   - 72 hours for an urgent request
   - 30 days for a non-urgent pre-service request (the denial of an initial request for a service not yet provided)
   - 60 days for a post-service claim (the denial of a claim for services already provided but not yet paid for)
4. The Member agrees that their Provider will be their "authorized representative" (pursuant to ERISA) regarding the receipt of approvals of requests for Covered Services for purposes of medical management.
5. ERISA provides for a maximum of two (2) mandatory appeal levels. Members enrolled in employee welfare benefit plans subject to ERISA may have the right to bring civil action under Section 502(a) of ERISA if all required reviews of their claim have been completed and the claim has not been approved.
6. A Member's participation in a voluntary appeal level does not effect their legal rights provided under ERISA. Any statute of limitations applicable to pursing civil action will be tolled during the period of a voluntary level of appeal.
7. Binding Arbitration of claims, as described in this section of this *Combined Evidence of Coverage and Disclosure Form*, will be limited to claims that are not subject to ERISA.

Section 10. General Information

- **How to Replace Your Card**
- **Translation Assistance**
- **Speech- and Hearing-Impaired Assistance**
- **Coverage in Extraordinary Situations**
- **Compensation for Providers**
- **Organ and Tissue Donation**
- **Public Policy Participation**

What follows are answers to some common and uncommon questions about your coverage. If you have any questions of your own that haven't been answered, please call our Customer Service department.

What should I do if I lose or misplace my membership card?

If you should lose your card, simply call our Customer Service department. Along with sending you a replacement card, they can make sure there is no interruption in your coverage.

Does PacifiCare offer a translation service?

PacifiCare uses a telephone translation service for almost 140 languages and dialects. That's in addition to select Customer Service representatives who are fluent in Spanish.

Does PacifiCare offer hearing- and speech-impaired telephone lines?

PacifiCare has a dedicated telephone number for the hearing- and speech-impaired. This phone number is 1-800-442-8833.

How is my coverage provided under 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 later provide appropriate reimbursement.

How does PacifiCare compensate its Participating Providers?

PacifiCare itself is not a Provider of health care. PacifiCare typically contracts with independent medical groups to provide medical services to its Members and with hospitals to provide Hospital Services. Once they are contracted, they become PacifiCare Participating Providers.

Participating Medical Groups in turn employ or contract with individual Physicians. None of the Participating Medical Groups or Participating Hospitals or their Physicians or employees are employees or agents of PacifiCare. Likewise, neither PacifiCare nor any employee of PacifiCare is an employee or agent of any Participating Medical Group, Participating Hospital or any other Participating Provider.

Most of our Participating Medical Groups receive an agreed-upon monthly payment from PacifiCare to provide services to our 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, or referred and authorized, by the Participating Medical Group.

Some of PacifiCare's Participating Hospitals receive similar monthly payments in return for providing Hospital Services for Members. Other Participating Hospitals are paid on a discounted fee-for-service or fixed charge per day of hospitalization. Most acute care, Subacute and Transitional Care and Skilled Nursing Facilities are paid on a fixed charge per day basis for inpatient care.

At the beginning of each year, PacifiCare and its Participating Medical Groups agree on a budget for the cost of services for all PacifiCare Members assigned to 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 Participating Hospital and Participating Medical Group typically participate in programs for Hospital Services similar to what is described above.

Stop-loss insurance protects Participating Medical Groups and Participating Hospitals from large financial expenses for health care services. PacifiCare provides stop-loss protection to our Participating Medical Groups and Participating Hospitals that receive the monthly payments described above. If any Participating Hospital or Participating Medical Group does not obtain stop-loss protection from PacifiCare, it must obtain stop-loss insurance acceptable to PacifiCare.

PacifiCare arranges with additional Providers or their representatives for the provision of Covered Services that cannot be performed by your assigned Participating Medical Group or Participating Hospital. Such services include authorized Covered Services that require a specialist not available through your Participating Medical Group or Participating Hospital or Emergency and Urgently Needed Services. PacifiCare or your Participating Medical Group pays these Providers at the lesser of the Provider's reasonable charges or agreed-to rates. Your responsibility for Covered Services received from these Providers is limited to payment of applicable Copayments. (For more about Copayments, see **Section 7. Payment Responsibility.**) You may obtain additional information on PacifiCare's compensation arrangements by contacting PacifiCare or your Participating Medical Group.

How do I become an organ and tissue donor?

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.

There are many resources that can provide the information you need to make a responsible decision. If you do decide to become a donor, 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 can I learn more about being an organ and tissue donor?

To get your donor card and information on organ and tissue donation call 1-800-355-SHARE or 1-800-633-6562. You can also request donor information from your local Department of Motor Vehicles (DMV).

On the Internet, contact:

- All About Transplantation and Donation (**www.transweb.org**)
- Department of Health and Human Services (**www.organdonor.gov**)
- Once you get a donor card, be sure to sign it in your family's presence. Have your family sign as witnesses and pledge to carry out your wishes, then 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.

How can I participate in PacifiCare's Public Policy Participation?

PacifiCare gives 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 our Customer Service department.

Section 11. Definitions

PacifiCare is dedicated to making its services easily accessible and understandable. To help you understand the precise meanings of many terms used to explain your benefits, we have provided the following definitions. These definitions apply to the capitalized terms used in your *Combined Evidence of Coverage and Disclosure Form*, as well as the *Schedule of Benefits*.

Annual Copayment Maximum – The maximum amount of Copayments a Member is required to pay for certain Covered Services in a calendar year. (Please refer to your *Schedule of Benefits*.)

Binding Arbitration – The submission of a dispute to one or more impartial persons for a final and binding decision, except for fraud or collusion on the part of the arbitrator. This means that once the arbitrator has issued a decision, neither party may appeal the decision. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings.

Biofeedback – Biofeedback therapy provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition. Biofeedback therapy often uses electrical devices to transform bodily signals indicative of such functions as heart rate, blood pressure, skin temperature, salivation, peripheral vasomotor activity, and gross muscle tone into a tone or light, the loudness or brightness of which shows the extent of activity in the function being measured.

Case Management – A collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's health care needs based on the health care benefits and available resources in order to promote a quality outcome for the individual Member.

Chronic Condition – A medical condition that is continuous or persistent over an extended period of time and requires ongoing treatment for its management.

Claim Determination Period – A calendar year.

Cognitive Behavioral Therapy – Psychotherapy where the emphasis is on the role of thought patterns in moods and behaviors.

Cognitive Rehabilitation Therapy – Cognitive Rehabilitation Therapy is therapy for the treatment of functional deficits as a result of traumatic brain injury and cerebral vascular insult. It is intended to help in achieving the return of higher-level cognitive ability. This therapy is direct (one-on-one) patient contact.

Complementary and Alternative Medicine – Defined by the National Center for Complementary and Alternative Medicine as the broad range of healing philosophies (schools of thought), approaches and therapies that Conventional Medicine does not commonly use, accept, study or make available. Generally defined, these treatments and health care practices are not taught widely in medical schools and not generally used in hospitals. These types of therapies used alone are often referred to as "alternative." When used in combination with other alternative therapies or in addition to conventional therapies, these therapies are often referred to as "complementary."

Conventional Medicine – Defined by the National Center for Complementary and Alternative Medicine as medicine as practiced by holders of M.D. (medical doctor) or D.O. (doctor of osteopathy) degrees. Other terms for conventional medicine are allopathic, Western, regular and mainstream medicine.

Completion of Covered Services – Covered Services for the Continuity of Care Condition under treatment by the Terminated Provider or Non-Participating Provider will be considered complete when (i) the Member's Continuity of Care Condition under treatment is medically/clinically stable, and (ii) there are no clinical contraindications that would prevent a medically/clinically safe transfer to a Participating Provider as determined by a PacifiCare Medical Director in consultation with the Member, the Terminated Provider or Non-Participating Provider, and as applicable, the Member's assigned Participating Provider.

Continuity of Care Condition(s) – The Completion of Covered Services will be provided by: (i) a Terminated Provider to a Member who, at the time of the Participating Provider's contract Termination, was receiving Covered Services from that Participating Provider, or (ii) Non-Participating Provider for newly enrolled Member who, at the time of his or her coverage became effective with PacifiCare, was receiving Covered Services from the Non-Participating

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Provider, for one of the Continuity of Care Conditions, as limited and described below:

1. **An Acute Condition** – a medical condition, including medical and Mental Health[1], that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services will be provided for the duration of the Acute Condition.
2. **A Serious Chronic Condition** – a medical condition due to disease, illness, or other medical or mental health problem[2] or medical or mental health[2] disorder that is serious in nature, and that persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services will be provided for the period of time necessary to complete the active course of treatment and to arrange for a clinically safe transfer to a Participating Provider, as determined by a PacifiCare Medical Director in consultation with the Member, and either (i) the Terminated Provider or (ii) the Non-Participating Provider and, as applicable, the receiving Participating Provider, consistent with good professional practice. Completion of Covered Services for this condition will not exceed twelve (12) months from the agreement's Termination date or twelve (12) months from the effective date of coverage for a newly enrolled Member.
3. **A pregnancy** diagnosed and documented by (i) the Terminated Provider prior to Termination of the agreement, or (ii) by the Non-Participating Provider prior to the newly enrolled Member's effective date of coverage with PacifiCare. Completion of Covered Services will be provided for the duration of the pregnancy and the immediate postpartum period.
4. **A Terminal Illness** – an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services will be provided for the duration of the Terminal Illness, not to exceed twelve (12) months, provided that the prognosis of death was made by the:
    i. Terminated Provider prior to the agreement Termination date or
    ii. Non-Participating Provider prior to the newly enrolled Member's effective date of coverage with PacifiCare.
5. **The Care of a Newborn** – Services provided to a child between birth and age thirty-six (36) months. Completion of Covered Services will not exceed twelve (12) months from the: (i) Provider agreement Termination date, or (ii) the newly enrolled Member' s effective date of coverage with PacifiCare, or (iii) extend beyond the child's third (3rd) birthday.
6. **Surgery or Other Procedure** – Performance of a surgery or Other Procedure that has been authorized by PacifiCare or the Member's assigned Participating Provider as part of a documented course of treatment and has been recommended and documented by the: (i) Terminating Provider to occur within 180 calendar days of the agreement's Termination date, or (ii) Non-Participating Provider to occur within 180 calendar days of the newly enrolled Member's effective date of coverage with PacifiCare.

Copayments – The fee that a Member is obligated to pay, if any, at the time he or she receives a Covered Service. Copayments may be a specific dollar amount or a percentage of the cost of the Covered Services. Copayments are fees paid by the Member in addition to the Premium paid by the University of California and any payroll contributions required by the University of California from your paycheck.

[1] Except pursuant to the CA Health and Safety Code 1374.72, inpatient coverage for Behavioral Health is not a covered benefit under the PacifiCare HMO/POS Commercial core coverage.

[2] PacifiCare Behavioral Health, Inc. (PBH) will coordinate Continuity of Care for Members whose employer has purchased supplemental benefits and for Members requesting continued care with a terminated or Non-Participating Provider for "Serious Mental Illnesses" and "Serious Emotional Disturbances of a Child" as defined in CA Health and Safety Code, Section 1374.72. special diets; and supervision of medication that usually can be self-administered. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing. Custodial Care does not require the continuing attention of trained medical or paramedical personnel.

Covered Services – Medically Necessary services or supplies provided under the terms of this *Combined Evidence of Coverage and Disclosure Form*, your *Schedule of Benefits* and supplemental benefit materials.

Custodial Care – Care and services that assist an individual in the activities of daily living. Examples include: assistance in walking, getting in or out of bed, bathing, dressing, feeding and using the toilet; preparation of special diets; and supervision of medication that usually can be self-administered. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing. Custodial Care does not require the continuing attention of trained medical or paramedical personnel. The mere provision of Custodial Care by a medical professional, such as a Physician, licensed nurse or registered therapist, does not mean the services are not custodial in nature. If the nature of the services can be safely and effectively performed by a trained nonmedical person, the services will be considered Custodial Care.

Dependent – A Member of a Subscriber's family who is enrolled with PacifiCare after meeting all of the eligibility requirements of the University of California and PacifiCare and for whom applicable Health Plan Premiums have been received by PacifiCare.

Developmental and Neurodevelopmental Testing – Developmental and Neurodevelopmental Testing is a battery of diagnostic tests for the purpose of determining a child's developmental status and need for early intervention services. This may include, but is not limited to, psychological and behavioral developmental profiles.

Domestic Partner is a person who meets the eligibility requirements, as defined by the Employer Group, and the following:

- Is eighteen (18) years of age or older;
- Is mentally competent to consent to contract;
- Resides with the Subscriber and intends to do so indefinitely;
- Is jointly responsible with the Subscriber for their common welfare and financial obligations;
- Is unmarried or not a member of another domestic partnership; and
- Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

Emergency Medical Condition – 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;
- 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 – 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. If this condition exists, Emergency Services include 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. (For a detailed explanation of Emergency Services, see **Section 3. Emergency and Urgently Needed Services**.)

Employer Group – The University of California through which you enrolled for coverage.

Enteral Feeding – Provision of nutritional requirements through a tube into the stomach or bowel. It may be administered by syringe, gravity or pump.

Experimental or Investigational – Defined in the "Exclusions and Limitations of Benefits" section of this *Combined Evidence of Coverage and Disclosure Form*.

Family Member – The Subscriber's Spouse or Domestic Partner and any person related to the Subscriber, Spouse or Domestic Partner by blood, marriage, adoption or guardianship. An enrolled Family Member is a Family Member who is enrolled with PacifiCare, meets all the eligibility requirements of the

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University of California and PacifiCare, and for whom Premiums have been received by PacifiCare. An eligible Family Member is a Family Member who meets all the eligibility requirements of University of California and PacifiCare.

Grievance (Complaint) – A written or oral expression of dissatisfaction regarding the plan and/or Provider, including quality of care concerns, and shall include a Complaint, dispute, request for reconsideration or appeal made by a Member or the Member's representative.

Group Agreement – The Medical and Hospital Group Subscriber Agreement entered into between PacifiCare and the University of California through which you enroll for coverage.

Health Plan – Your benefit plan as described in this *Combined Evidence of Coverage and Disclosure Form*, *Schedule of Benefits* and supplemental benefit materials.

Health Plan Premiums (or Premiums) – Amounts established by PacifiCare to be paid to PacifiCare by Employer on behalf of Subscriber and his or her Dependents in consideration of the benefits provided under this Health Plan.

Home Health Aide – A person who has completed Home Health Aide training as required by the state in which the individual is working. Home Health Aides must work under a plan of care ordered by a physician and under the supervision of a licensed nurse or licensed therapist.

Home Health Aide Services – Medically Necessary personal care such as bathing, exercise assistance and light meal preparation, provided by trained individuals and ordered along with skilled nursing and/or therapy visits.

Home Health Care Visit – Defined as up to two (2) hours of skilled services by a registered nurse or licensed vocational nurse or licensed therapist or up to four (4) hours of Home Health Aide Services.

Hospice – Specialized form of interdisciplinary health care for a Member with a life expectancy of a year or less due to a terminal illness. Hospice programs or services are designed to provide palliative care; alleviate the physical, emotional, social and spiritual discomforts of a Member who is experiencing the last phase of life due to the existence of a terminal disease; and provide supportive care to the primary caregiver and family of the Member receiving Hospice Services.

Hospital Services – Services and supplies performed or supplied by a licensed Hospital on an inpatient or outpatient basis.

Hospitalist – A Physician whose sole practice is the management of acutely and/or chronically ill patients' health services in a hospital setting.

Hypnotherapy – Medical Hypnotherapy is treatment by hypnotism or inducing sleep.

Infertility – Either: (1) 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 (2) the presence of a demonstrated condition recognized by a licensed Physician who is a Participating Provider as a cause of Infertility.

Intramuscular – Injection into the muscle.

Intravenous – Injection into the vein.

Late Enrollee – An employee who declined enrollment in the PacifiCare Health Plan when offered and who subsequently requests enrollment outside the designated Open Enrollment Period.

Learning Disability – A Learning Disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psychosocial deprivation, psychiatric disorder, or sensory loss.

Limiting Age – The age established by the University of California when a Dependent is no longer eligible to be an enrolled Family Member under the Subscriber's coverage.

Medically Necessary (or Medical Necessity) refers to an intervention, if, as recommended by the treating Physician and determined by the Medical Director of PacifiCare or the Participating Medical Group, it is all of the following:

a. A health intervention for the purpose of treating a medical condition;

b. The most appropriate supply or level of service, considering potential benefits and harms to the Member;

c. Known to be effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.

   For new interventions, effectiveness is determined by scientific evidence; and

d. If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner that may be provided safely and effectively to the Member. "Cost-effective" does not necessarily mean lowest price.

A service or item will be covered under the PacifiCare Health Plan if it is an intervention that is an otherwise covered category of service or item, not specifically excluded, and Medically Necessary.

An intervention may be medically indicated yet not be a covered benefit or meet the definition of Medical Necessity.

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

i. *Treating Physician* means a Physician who has personally evaluated the patient.

ii. A *health intervention* is an item or service delivered or undertaken primarily to *treat* (that is, prevent, diagnose, detect, treat or palliate) a medical condition or to maintain or restore functional ability. A *medical condition* is a disease, illness, injury, genetic or congenital defect, pregnancy or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation. A health intervention is defined not only by the intervention itself but also by the medical condition and the patient indications for which it is being applied.

iii. *Effective* means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

iv. *Health outcomes* are outcomes that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

v. *Scientific evidence* consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases. For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of Medical Necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence.

   Existing interventions can meet the definition of Medical Necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.

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

vii. An intervention is considered *cost-effective* if the benefits and harms relative to costs represent

an economically efficient use of resources for patients with this condition.

In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

Medicare (Original Medicare) – The Hospital Insurance Plan (Part A) and the supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.

Medicare Eligible – Those Members who meet eligibility requirements under Title XVIII of the Social Security Act, as amended.

Member – The Subscriber or any Dependent who is eligible, enrolled and covered by PacifiCare.

Mental Retardation and Related Conditions – An individual is determined to have mental retardation based on the following three criteria: Intellectual functioning level (IQ) is below 70-75, significant limitations exist in two or more adaptive skill areas, and the condition is present from childhood (defined as age 18 or less).

National Preferred Transplant Network Facility – A network of transplant Facilities that are:

- Licensed in the State of California;
- Certified by Medicare as a transplant facility for a specific organ transplant;
- Designated by PacifiCare as a transplant facility for a specific organ program;
- Satisfies PacifiCare's quality of care standards to be designated by PacifiCare as a transplant facility for a specific organ program.

Non-Participating Providers – A Hospital or other health care entity, a Physician or other health care professional, or a health care vendor that has not entered into a written agreement to provide Covered Services to PacifiCare's Members.

Non-Physician Health Care Practitioners – Include, but are not limited to, psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists and nurse midwives.

Open Enrollment Period – The time period determined by PacifiCare and the University of California when all eligible employees and their eligible Family Members may enroll in PacifiCare.

PacifiCare-Designated Pharmacy – PacifiCare participating pharmacy designated to dispense injectable medications. A PacifiCare-Designated Pharmacy may include Prescription Solutions® mail service pharmacy or alternative specialty injectable vendor as determined by PacifiCare.

Participating Hospital – Any general acute care Hospital licensed by the State of California that has entered into a written agreement with PacifiCare to provide Hospital Services to PacifiCare's Members. Participating Hospitals are independent contractors and are not employees of PacifiCare.

Participating Medical Group – An independent practice association (IPA) or medical group of Physicians that has entered into a written agreement with PacifiCare to provide Physician services to PacifiCare's Members. An IPA contracts with independent contractor Physicians who work at different office sites. A medical group employs Physicians who typically all work at one or several physical locations. Under certain circumstances, PacifiCare may also serve as the Member's Participating Medical Group. This includes, but is not limited to, when the Member's Primary Care Physician contracts directly with PacifiCare and there is no Participating Medical Group. Participating Medical Groups are independent contractors and are not employees of PacifiCare.

Participating Provider – A Hospital or other health care entity, a Physician or other health care professional or a health care vendor that has entered into a written agreement to provide Covered Services to PacifiCare's Members. A Participating Provider may contract directly with PacifiCare, with a Participating Medical Group or with another Participating Provider. Participating Providers are independent contractors and are not employees of PacifiCare.

Physician – Any licensed allopathic or osteopathic Physician.

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

Primary Care Physician – A Participating Provider who is a Physician trained in internal medicine, general practice, family practice, pediatrics or obstetrics/gynecology and who has accepted primary responsibility for coordinating a Member's health care services. Primary

Care Physicians are independent contractors and are not employees of PacifiCare.

Primary Residence – The home or address where the Member actually lives most of the time. A residence will no longer be considered a Primary Residence if: (1) the Member moves without intent to return; (2) the Member is absent from the residence for 90 consecutive days; or (3) the Member is absent from the residence for more than 100 days in any six-month period.

Primary Workplace – The facility or location where 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.

Private-Duty Nursing Services – Private-Duty Nursing Services encompass nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or Skilled Nursing Facility.

Provider – A person, group, facility or other entity that is licensed or otherwise qualified to deliver any of the health care services described in this *Combined Evidence of Coverage and Disclosure Form* and supplemental benefit materials.

Prudent Layperson – A person without medical training who reasonably draws on practical experience when making a decision regarding whether Emergency Services are needed.

Psychological Testing – Psychological Testing includes the administration, interpretation, and scoring of tests such as WAIS-R, Rorschach, MMPI and other medically accepted tests for evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation, and other factors influencing treatment and prognosis.

Regional Organ Procurement Agency – An organization designated by the federal government and responsible for procurement of organs for transplantation and the promotion of organ donation.

Rehabilitation Services – The combined and coordinated use of medical, social, educational and vocational measures for training or retraining individuals disabled by disease or injury.

Schedule of Benefits – An important part of your *Combined Evidence of Coverage and Disclosure Form* that provides benefit information specific to your Health Plan, including Copayment information.

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

1. Has one or more Mental Disorders as defined by the *Diagnostic and Statistical Manual IV (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;
2. Is under the age of 18 years old; and
3. Meets one or more of the following criteria:
    a. 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
    b. The child displays one of the following: psychotic features, risk of suicide or risk or violence due to a Mental Disorder; or
    c. The child meets special education eligibility requirement 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.

Service Area – A geographic region in the state of California where PacifiCare is authorized by the California Department of Managed Health Care to provide Covered Services to Members.

Skilled Nursing Care – The care provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a home health aide.

Skilled Nursing Facility – A comprehensive free-standing rehabilitation facility or a specially designed unit within a Hospital licensed by the state of California to provide Skilled Nursing Care.

Skilled Rehabilitation Care – The care provided directly by or under the direct supervision of licensed nursing personnel or a licensed physical, occupational or speech therapist.

Spouse – The Subscriber's husband or wife who is legally recognized as a husband or wife under the laws of the state of California.

Subacute and Transitional Care – Care provided to a Member as an inpatient of a Skilled Nursing Facility that is more intensive than is provided to the majority of the patients in a Skilled Nursing Facility.

Subcutaneous – Injection under the skin.

Subscriber – The person enrolled in the Health Plan for whom the appropriate Premiums have been received by PacifiCare and whose employment or other status, except for family dependency, is the basis for enrollment eligibility.

Totally Disabled or Total Disability – 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 will 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.

Telehealth – A health service, other than a Telemedicine, delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification who does not perform a Telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

1. Compressed digital interactive video, audio, or data transmission;
2. Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
3. Other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine – The use of interactive audio, video, or other electronic media to deliver health care. This includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. This term does not include services performed using a telephone or facsimile machine.

Urgently Needed Services – Covered Services that are provided when the Member's Participating Medical Group is temporarily unavailable or inaccessible. This includes when the Member is temporarily absent from the geographic area served by their Participating Medical Group. These services must be Medically Necessary and cannot be delayed because of an unforeseen illness, injury or condition.

Usual and Customary Charges (U&C) means charges for medical services or supplies for which PacifiCare is legally liable and which do not exceed the average charged rate charged for the same or similar services or supplies in the geographic region where the services or supplies are received. Usual and Customary Charges are determined by referencing the 80th percentile of the most current survey published by Medical Data Research (MDR) for such services or supplies. The MDR survey is a product of Ingenix, Inc., formerly known as Medicode.

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

Vocational Rehabilitation – The process of facilitating an individual in the choice of or return to a suitable vocation. When necessary, assisting the patient to obtain training for such a vocation. Vocational Rehabilitation can also mean preparing an individual regardless of age, status (whether U.S. citizen or immigrant), or physical condition to cope emotionally, psychologically, and physically with changing circumstances in life, including remaining at school or returning to school, work or work equivalent (homemaker).

NOTE: THIS *COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM* CONSTITUTES ONLY A SUMMARY OF THE PACIFICARE HEALTH PLAN. THE GROUP AGREEMENT BETWEEN PACIFICARE AND THE UNIVERSITY OF CALIFORNIA MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. A COPY OF THE GROUP AGREEMENT WILL BE FURNISHED UPON REQUEST AND IS AVAILABLE AT PACIFICARE AND FROM THE BENEFIT REPRESENTATIVE AT THE UNIVERSITY OF CALIFORNIA'S LAB OR CAMPUS THAT YOU WORK.

Answering Questions

Answering Questions

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

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

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

PacifiCare's Customer Service –

We're Here for You

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

Count on Us for Efficient Service

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

We'll Expedite Your Requests

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

We're Here to Answer Your Questions

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

Need a replacement ID card or up-to-date information?

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

Concerns, Comments, Suggestions?

That's what we're here for.

1-800-624-8822 or 1-800-442-8833 TDHI
(Telecommunications Device for the Hearing Impaired)
Monday – Friday
7:00 a.m. – 9:00 p.m.