



CALIFORNIA

Subscriber Agreement/Combined Evidence of Coverage
and Disclosure Form (HMO)
Individual

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NOTE: THIS INFORMATION IN THE SUBSCRIBER AGREEMENT/EVIDENCE OF COVERAGE IS SUBJECT TO THE APPROVAL OF THE CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE.

Welcome to PacifiCare of California (PacifiCare)

PacifiCare is pleased that you are enrolling in this Health Plan and looks forward to meeting your health-care needs. PacifiCare is a health-care service plan (HMO) licensed by the State of California to arrange for health-care services on a managed care basis.

PacifiCare arranges for services through a network of contracting hospitals, physicians and other health care providers which serve PacifiCare Members in an organized and cost-effective manner. 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 7 – Member Eligibility.

What is this publication?

This publication is called an Individual HMO Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form (*Agreement and EOC*). It is a legal document that explains your health-care plan and should answer many important questions about your benefits. The words and terms that are capitalized in this *Agreement and EOC* have specific meanings. Because these meanings may differ from the usual meanings of these words or phrases, please refer to **Section 11 – Definitions** to be sure you understand what these words and phrases mean.

Whether you are the Subscriber of this coverage or enrolled as a Family Member, your *Agreement and EOC* is a 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, your Pharmacy Schedule of Benefits and your Behavioral Health-Care Supplement. 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 (800) 624-8822 or (800) 442-8833 (TDHI).

Note: Your *Agreement and EOC* and Schedule of Benefits provide the terms and conditions of your coverage with PacifiCare, and all applicants have a right to view these documents prior to Enrollment. This *Agreement and EOC* 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, CA 90630
PacifiCare's Web site is: www.pacificare.com

By enrolling in and accepting health services under this Health Plan, Members agree to abide by all terms and conditions of this *Agreement and EOC*.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

Section 1 – Getting Started: Your Primary Care Physician

- What is a Primary Care Physician?
- What is a Subscriber?
- What is a Participating Medical Group?
- Your Provider Directory
- Choosing Your Primary Care Physician

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 Participating Medical Groups 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 *Agreement and EOC* along with the *Pharmacy Schedule of Benefits* and the *Behavioral Health Care Supplement*. 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. At times, others may participate in the coordination of your health-care services, such as a Hospitalist (Please refer to **Section 2 - Seeing Your Doctor** for information on Hospitalist programs.)

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 any necessary Hospital Services. Either your Primary Care Physician or a Hospitalist may provide the coordination of 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 after meeting the eligibility requirements of PacifiCare. A Subscriber pays the Premiums to PacifiCare for his or her health-care coverage for him or herself and any enrolled Family Members. An enrolled Family Member is someone such as a Spouse, Domestic Partner 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

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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 a 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 on next page, "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 or Nonphysician Health-Care Practitioner, you will generally be referred to a doctor, Nonphysician Health-Care Practitioner or service within this group. Since Participating Medical Groups are independent contractors not employed by PacifiCare, each has its own unique network of affiliated specialists and Providers. Only if a specialist, Nonphysician Health-Care Practitioner 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 where you will find addresses and phone numbers, and other important information, about hospital affiliations, or any restrictions limiting the availability of certain 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 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 a 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 on next page to learn how to choose a Primary Care Physician for the newborn.)

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

If You Are Pregnant

Every Member of PacifiCare needs a Primary Care Physician, including your newborn. Newborns are assigned to the mother's Participating Medical Group from birth until discharge from the Hospital. You may request to reassign your newborn to 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. In order for coverage to continue beyond the first 30 days of life, the Subscriber must submit a request to add the baby to PacifiCare prior to the expiration of the 30-day period to continue coverage beyond the first 30 days of life.

If your newborn has not been discharged from the Hospital, is being followed by the Case Management or is receiving acute institutional 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 7 - 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 and that you or your Family Member might need: family planning, contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic, or call the PacifiCare Health Plan Customer Service department at (800) 624-8822 or (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, please call our Customer Service department.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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.

This section will help you begin taking advantage of your health-care coverage. It will also answer common questions about seeing a specialist or Nonphysician Health-Care Practitioner and receiving medical services that are not Emergency Services or Urgently Needed Services. (For information on Emergency Services or Urgently Needed Services, please turn to **Section 3**.)

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 next page, "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 6 – Payment Responsibility**.

Referrals to Specialists and Nonphysician 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 Nonphysician 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 on the next page in "Direct Access to OB/GYN Services.")

(Your plan may not cover services provided by all Nonphysician Health-Care Practitioners. Please refer to the Medical Benefits and Exclusions and Limitations section in this *Agreement and EOC* for further information regarding Nonphysician Health-Care Practitioner services excluded from coverage or limited under this Health Plan.)

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

This referral may also be reviewed by, and may be subject to the approval of, the Primary Care Physician's Utilization Review Committee. For more information regarding the role of the Utilization

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 Nonphysician 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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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.

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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 business days after the request is received by the Participating Medical Group or PacifiCare. Please refer to “How PacifiCare Makes Important Health-Care Decisions” for utilization management time frames.

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 medical 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 medical opinion believes are appropriate. If this second medical opinion includes our commendation 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 8 – 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

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

What is PacifiCare's Case Management Program?

PacifiCare has licensed registered nurses who, in collaboration with the Member, Member's designated family and the Member's Participating Medical Group may 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. Not every Member will be assigned a case manager.

Prearranging Hospital Stays

Your Primary Care Physician will prearrange any Medically Necessary hospital or facility care. Your Primary Care Physician or Hospitalist will prearrange and Medically Necessary inpatient Transitional Care or care provided in a Sub acute/Skilled Nursing Facility. If you've been referred to a specialist and the specialist determines you need hospitalization, your Primary Care Physician will work together with the specialist 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 or Hospitalist may discharge you from the hospital to a Subacute/Skilled Nursing Facility. He or she can also arrange for Home Health-Care Visits.

Please Note: If a Hospitalist program applies, a Hospitalist may direct your inpatient hospital or facility care in consultation with 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, coordinate and consult with specialists, and communicate with you, 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.

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.

What To Do When You Require Emergency Services

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. 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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 (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 (800) 762-8456.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 non-business hours, and a Physician is not immediately available, ask to have the Physician-on-call paged. A Physician should call you back shortly. Explain your situation and follow 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, injury or complication of an existing condition, including pregnancy, 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, or if the Member is pregnant, the serious deterioration of the health of the Member's fetus, 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 above 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 non business hours, and a Physician is not immediately available, ask to have the Physician-on-call paged. A Physician should call you back shortly. Explain your situation and follow 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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 6** in this *Agreement and EOC*.

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 or Participating Medical Group

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 to change doctors within your Participating Medical Group if the Primary Care Physician you've selected is accepting new patients and meets the other criteria in **Section 1– Getting Started**.

If you 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 wish to transfer out of your Participating Medical Group entirely, and you are not an inpatient in a hospital, a Skilled Nursing Facility or other medical institution, PacifiCare will approve your request if the Primary Care Physician within the new Participating Medical Group you've selected is accepting new patients and meets the other criteria in **Section 1– Getting Started**. This includes being located within a 30-miles of your Primary Residence or Primary Workplace. The effective date of transfer will be the same as referred to above when requesting a transfer within your Participating Medical Group.

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 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 **Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).**

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 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 Provider

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 your Health 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 (PMGs/IPAs) 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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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** in this *Agreement and EOC* 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 *Agreement and EOC*.

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 30 calendar days of the Provider's effective date of termination. Exceptions to the 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, CA 90630-9938
Fax Number: (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 non-urgent requests will be made within five 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 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 8 – 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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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.

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. PacifiCare's Commercial HMO Benefit Interpretation Policy Manual and Medical Management Guidelines Manual are available at www.pacificare.com.

Your Medical Benefits

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 Agreement and EOC. The fact that a Physician has ordered a particular service, supply or treatment will not make it covered under the health plan. A service, supply or treatment must be both Medically Necessary and not excluded from coverage in order to a Covered Service.

With the exception of Emergency or Urgently Needed Services, a Member will only be admitted to acute 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.
- 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/Hospital.
- 4. Bone Marrow and Stem Cell Transplants** – Non-Experimental/Non-Investigational autologous and allogeneic bone marrow and stem cell transplants and transplant services are covered when the recipient is a Member and the bone marrow or stem cell services are performed at a Designated Facility. 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 Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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. A Designated 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.

A six-month Pre-Existing Condition Exclusion Period will apply to all Members enrolling for the first time in the Health Plan for all covered transplant services.

Enrolled newborns are exempt from the six-month Pre-Existing Exclusion Period. Children under the age of 18 who have been adopted or placed for adoption may be exempt or partially exempt from the six-month Pre-Existing Condition Exclusion Period. The Exclusion Period will be reduced or eliminated based on prior creditable coverage, which must be continuous and with no lapse greater than 63 days. Every month of creditable coverage will reduce the six-month Exclusion Period by one month.

The Exclusion Period will be reduced or eliminated based on prior creditable coverage, which must be continuous with no lapse greater than 63 days. Every month of creditable coverage will reduce the six-month Exclusion Period by one month.

Credit for prior creditable coverage will be given if transplant services were covered under the prior creditable coverage, without regard to the level or use of coverage in the prior plan.

Creditable coverage must be continuous with no lapse greater than 63 days. Prior coverage credit toward the Exclusion Period is applied on the basis of elapsed time in the prior coverage. For example, given a six-month Exclusion Period and the individual had creditable coverage for three months, the applicable Exclusion Period would be three months. Every month of applicable creditable coverage will reduce the six-month Exclusion Period by one month.

- 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 or a Member who is diagnosed with cancer and whose Participating Treating Physician recommend 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.

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 non-clinical 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 endpoints defined exclusively to test toxicity is not an approved clinical trial.

All services must be preauthorized by PacifiCare's Medical Director or designee. Additionally, services must be provided by a PacifiCare Participating Provider in PacifiCare's Service Area. In the event a PacifiCare Participating Provider does not offer a clinical trial with the same protocol as the one 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

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 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 individual or combined and coordinated use of medical, physical, occupational, and speech therapy 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.
This benefit does not include drug, alcohol or other substance abuse rehabilitation
- 10. 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

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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.

11. 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/Certified 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.

12. Morbid Obesity (Surgical Treatment) – PacifiCare covers bariatric surgical procedures when Medically Necessary and preauthorized. 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. Please refer to your Schedule of Benefits for copayment information of this benefit or you may call PacifiCare’s Customer Service Department for additional information.

13. Newborn Care – Postnatal Hospital Services are covered, including circumcision 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.

14. 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 Designated Facility. Listing of the Member at a second Designated Facility is a covered benefit unless the Regional Organ Procurement Agency is the same for both facilities.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

Organ transplant listing is limited to two Designated Facilities. If the Member is listed at two facilities, PacifiCare will only cover 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 will be responsible for any duplicated diagnostic costs for a transplant evaluation 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 non-clinical 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 “Designated Facility.”)

A six-month Pre-Existing Condition Exclusion Period will apply to all Members enrolling for the first time in the Health Plan for all covered transplant services.

Enrolled newborns are exempt from the six-month Pre-Existing Exclusion Period. Children under the age of 18 who have been adopted or placed for adoption may be exempt or partially exempt from the six-month Pre-Existing Condition Exclusion Period. The Exclusion Period will be reduced or eliminated based on prior creditable coverage, which must be continuous, and with no lapse greater than 63 days. Every month of creditable coverage will reduce the six-month Exclusion Period by one month.

The Exclusion Period will be reduced or eliminated based on prior creditable coverage, which must be continuous with no lapse greater than 63 days. Every month of creditable coverage will reduce the six-month Exclusion Period by one month.

Credit for prior creditable coverage will be given if transplant services were covered under the prior creditable coverage, without regard to the level or use of coverage in the prior plan.

Creditable coverage must be continuous with no lapse greater than 63 days. Prior coverage credit toward the Exclusion Period is applied on the basis of elapsed time in the prior coverage. For example, given a six-month Exclusion Period and the individual had creditable coverage for three months, the applicable Exclusion Period would be three months. Every month of applicable creditable coverage will reduce the six-month Exclusion Period by one month.

- 15. 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.
- 16. 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. Subacute and Transitional Care are levels of care provided by a Skilled Nursing Facility to a Member who does not require Hospital acute care, but who requires more intensive licensed Skilled Nursing Facility care than is provided to the majority of the patients in a Skilled Nursing Facility.

Skilled Nursing Facility room and board charges are excluded after 100 consecutive days per admission. Days spent out of a Skilled Nursing Facility when transferred to an acute hospital

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setting are not counted toward the 100 consecutive days when the Member is transferred back to a Skilled Nursing Facility. Such days spent in an acute hospital setting 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 may not have received Skilled Nursing Care or Skilled Rehabilitation Care for 60 days.

17. 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 Agreement and EOC. The fact that a Physician has ordered a particular service, supply or treatment will not make it covered under the health plan. A service, supply or treatment must be both Medically Necessary and not excluded from coverage in order to be a Covered Service.

- 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 Serum** - 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 Testing and 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 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 Services 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. This benefit does not include non-crisis mental health counseling or behavior modification programs. For additional information regarding covered Mental Services please refer to the "Mental Health Services" benefit description in this section.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 above 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 on previous page 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 the circumcision is performed within 90 days of that determination.

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

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

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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 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 and 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. Please refer to the Pharmacy Schedule of Benefit, “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

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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/or car modifications to accommodate the Member's physical condition.

For a detailed listing of covered Durable Medical Equipment, please contact the PacifiCare Customer Service department at (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 (800) 624-8822, or visit the PacifiCare.com 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 Visits** – A Member is eligible to receive Home Health-Care Visits if the Member: (1) 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); (2) needs Medically Necessary skilled nursing visits or needs physical, speech or occupational therapy; and (3) 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*.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 consecutive days at a time.

- 22. Immunizations** – Immunizations for children (through age 18 years) are covered only if the immunizations are consistent with the most current version of the Recommended Childhood and Adolescent Immunization Schedule/United States¹. 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 only if the immunizations are consistent with the most current recommendations of the Recommended Adult Immunization Schedule/United States². For children under two 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.

¹As adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Family Physicians.

²As approved by the Advisory Committee on Immunization Practices (ACIP), the American College of Obstetricians and Gynecologists and the American Academy of Family Physicians.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

23. Injectable Drugs (Infusion Therapy, 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 immunizations, 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 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, the Member’s Participating Medical Group or PacifiCare-Designated Pharmacy 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.

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

25. 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.

26. 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.

27. Mental Health Services – Only services to treat Severe Mental Illness (SMI) for adults and children, and Serious Emotional Disturbances (SED) of a Child are covered. (See your Supplement to this *Agreement and EOC* for a description of this coverage.)

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

28. OB/GYN Physician Care – See “Physician OB/GYN Care.”

29. 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 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 work-up 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, are not covered except for services covered by PacifiCare under this outpatient benefit “Oral Surgery and Dental Services.”

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

30. 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 a 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 seven 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.”

31. 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.

32. Outpatient Services – Medically Necessary services, treatments or procedures performed in a hospital outpatient services department setting or a free-standing facility that is not a certified ambulatory surgical center or outpatient surgery department of an acute hospital are covered. Examples include, but are not limited to: endoscopies, hyperbaric oxygen and wound care.

33. Outpatient Surgery – Short stay, same day or other similar outpatient surgery facilities and professional services are covered when provided as a substitute for inpatient care.

34. 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 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.
- **Prostate Screening** – Evaluation 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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

- 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 two, preventive health services are covered (including immunizations) when provided by the child’s Participating Medical Group.
- Well-Woman Care – Medically Necessary services, including annual cervical cancer screening tests. Annual cervical cancer screening tests include a Pap smear (cytology), a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration, and the option of any cervical cancer screening test approved by the federal Food and Drug Administration, 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.

- 35. 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 one gram of protein per serving.
- 36. 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.
- 37. 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.
- 38. Prescription Drugs** – Prescription Drugs are covered when Medically Necessary as determined by the Member’s Participating Medical Group or PacifiCare. Refer to your Pharmacy Schedule of Benefits for prescription drugs coverage details.
- 39. 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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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, myoelectric, microprocessor-controlled and computerized prosthetics are not covered.

- Deluxe upgrades that are not Medically Necessary are not covered.
- Replacements, repairs and adjustments to corrective appliances and prosthetics coverage are covered when Medically Necessary. Repair or replacement must be authorized by the Member's Participating Medical Group or PacifiCare.
- An artificial larynx or electronic speech aid is covered post laryngectomy or for a Member with permanently inoperative larynx condition.

Refer to "Footwear" in Outpatient Benefits.

For a detailed listing of covered Prosthetics and Corrective Appliances, please contact the PacifiCare Customer Service department at (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), conformal photon beam radiation and IMRT. (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 (1) pair of eyeglasses when prescribed following a cataract surgery with an intraocular 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 include conventional plain film X-rays, oral and rectal contrast gastrointestinal studies (such as upper GIs, barium enemas, and oral cholecystograms), mammograms, obstetrical ultrasounds, and bone mineral density studies (including ultrasound and DEXA scans). See "Specialized Scanning and Imaging Procedures" in *Outpatient Benefits* for coverage and examples of specialized scanning and imaging procedures.

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

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(see “Standard X-rays”, item number 43, in *Outpatient Benefits*), 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 procedures: CT, PET, SPECT, MRI, MRA, EEG, EMG and nuclear scans, angiograms (includes heart catheterization), arthrograms, myelograms, and non-obstetrical ultrasounds .

III. Exclusions and Limitations of Benefits

Unless described as a Covered Service in a benefit supplement purchased by the Subscriber, all services and benefits described below are excluded from coverage or limited under this Health Plan. (Note: Additional exclusions and limitations may be included with the explanation of your benefits in the additional materials.)

General Exclusions

1. Services that are not Medically Necessary, as defined in the Definitions section of this *Agreement and EOC*, are not covered. Payment for these services will be your financial responsibility. When a service is denied or is not covered based on Medically Necessity, you may appeal the decision through the PacifiCare appeals process and the Independent Medical Review (IMR) process outlined in **Section 8**.
2. Services not specifically included in this *Agreement and EOC* are not covered. Payment for these services will be your financial responsibility.
3. 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 *Agreement and EOC*, 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 except for Emergency Services and out-of-area Urgently Needed Services.
4. Services obtained from Non-Participating Providers or Participating Providers who are not affiliated with the Member’s Participating Medical Group, without authorization from PacifiCare or the Participating Medical Group, are not covered except for Emergency Services and out-of-area Urgently Needed Services.
5. Services rendered prior to the Member’s effective date of Enrollment or after the effective date of disenrollment are not covered.
6. 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.
7. Services performed by immediate relatives or members of your household are not covered.
8. Services obtained outside the Service Area are not covered except for Emergency Services or Urgently Needed Services.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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.

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 apart of parole or probation, or instead of incarceration.
4. **Ambulance** – Ambulance service is not covered when used only for the Member’s convenience or when another available form of transportation would be more appropriate. Wheelchair transportation services (e.g., a specifically designed van or taxi) and personal transportation costs such as gasoline costs for a private vehicle or taxi fare are also not covered.

Please refer to “Ambulance” in the Outpatient Benefits section and “Organ Transplants” in the 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 **8**.

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 evaluation encourages a multidisciplinary team approach that includes medical, surgical, psychological, and nutritional expertise for those who are seeking surgical weight-loss. After surgery the Member participates in a multi-disciplinary program of diet, exercise, and behavior modification.

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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 urinary incontinence, fecal incontinence or constipation for Members with organic neuromuscular impairment when part of an authorized treatment plan.
9. **Bloodless Surgery Services** – Bloodless surgery services are only covered to the extent available within the Member's Participating Medical Group.
10. **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 8** of this *Agreement and EOC* under the caption "Independent Medical Review Procedures." 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. Unrelated Donor Searches must be performed at a PacifiCare-approved transplant center. (See "Designated Facility" in Definitions.)

A six-month Pre-Existing Condition Exclusion Period will apply to all Members enrolling for the first time in the Health Plan for all covered transplant services.

Enrolled newborns are exempt from the six-month Pre-Existing Exclusion Period. Children under the age of 18 who have been adopted or placed for adoption may be exempt or partially exempt from the six-month Pre-Existing Condition Exclusion Period. The Exclusion Period will be reduced or eliminated based on prior creditable coverage, which must be continuous, and with no lapse greater than 63 days.

Every month of creditable coverage will reduce the six-month Exclusion Period by one month. The Exclusion Period will be reduced or eliminated based on prior creditable coverage, which must be continuous with no lapse greater than 63 days. Every month of creditable coverage will reduce the six-month Exclusion Period by one month.

Credit for prior creditable coverage will be given if transplant services were covered under the prior creditable coverage, without regard to the level or use of coverage in the prior plan. Creditable coverage must be continuous with no lapse greater than 63 days. Prior coverage credit toward the Exclusion Period is applied on the basis of elapsed time in the prior coverage. For example, given a six-month Exclusion Period and the individual had creditable coverage for three months, the applicable Exclusion Period would be three months. Every month of applicable creditable coverage will reduce the six-month Exclusion Period by one month.

- 11. Chiropractic Care** – Care and treatment provided by a chiropractor are not covered.
- 12. Communication Devices** – Computers, personal digital assistants and any speech-generating devices (except for artificial larynxes) are not covered. Please also refer to “Durable Medical Equipment” and “Prosthetic and Corrective Appliances.” For a detailed listing of covered durable medical equipment and Prosthetic and Corrective Appliances, please contact the PacifiCare Customer Service department at (800) 624-8822.
- 13. Complementary and Alternative Medicine** – Complementary and Alternative Medicine are not covered. Religious non-medical health care is not covered. (See the definition for Complementary and Alternative Medicine.)
- 14. 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. Surgeries or services that would ordinarily be classified as cosmetic, will not be reclassified as reconstructive, based on a Member’s dissatisfaction with his/her appearance, as influenced by that Member’s underlying psychologic makeup or psychiatric condition.
- 15. 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 the Medical Benefits section of this *Agreement and EOC*. Custodial Care does not require the continuing attention of trained medical or paramedical personnel.
- 16. 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.
- 17. 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.”
- 18. 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.
- 19. 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.

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- 20. Drugs and Prescription Medication (Outpatient)** – 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.
- 21. 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/or car modifications to accommodate the Member’s physical condition.
- 22. 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*.
- 23. Elective Enhancements** – Procedures, technologies, services, drugs, devices, items and supplies for elective, non-Medically Necessary improvements, alterations, enhancements or augmentation of appearance, skills, performance capability, physical or mental attributes or competencies are not covered. This exclusion includes, but is not limited to, elective improvements, alterations, enhancements, augmentation or genetic manipulation related to hair growth, aging, athletic performance, intelligence, height, weight or cosmetic appearance. Please refer to “Reconstructive Surgery” for a description of Reconstructive Surgery services covered by your Health Plan.
- 24. 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 captions “*Phenylketonuria (PKU) Testing and Treatment*.” Pumps and tubing are covered under the “*Durable Medical Equipment*” *Outpatient Benefits*.
- 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. 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 8** of this *Agreement and EOC*. 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 *Agreement and EOC*, procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/guidelines is met:

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- 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 8 – Overseeing Your Health-Care Decisions**, "Experimental or Investigational Treatment Decisions."

- 27. 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.
- 28. Family Planning** – Family planning benefits, other than those specifically listed in the Schedule of Benefits that accompanies this document, are not covered.
- 29. 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.
- 30. 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.
- 31. 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.
- 32. 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.
 - Non-medical 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.

- 33. Government Services and Treatment** – Any services that the Member receives from a local, state or federal governmental agency are not covered, except when coverage under this Health Plan is expressly required by federal or state law or as noted below:
- **Services While Confined** – Services required for injuries or illnesses experienced while under arrest, detained, imprisoned, incarcerated or confined pursuant to federal, state or local law are not covered. However, PacifiCare will reimburse Members their out-of-pocket expenses for services received while confined in a city or county jail, or, if a juvenile, while detained in any

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facility, if the services were provided or authorized by your Primary Care Physician or Participating Medical Group in accordance with the terms of this Health Plan or were Emergency Services or Urgently Needed Services. This exclusion does not restrict PacifiCare's liability with respect to expenses for Covered Services solely because the expenses were incurred in a state hospital; however, PacifiCare's liability with respect to expenses for Covered Services provided in a state hospital is limited to the rate PacifiCare would pay for those Covered Services if provided by a Participating Hospital.

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

34. Hearing Aids and Hearing Devices – Hearing aids and non-implantable 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).

35. Hospice Services – Hospice services are not covered for:

- 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.
- Hospice services that are not reasonable and necessary for the management of a terminal illness (e.g., care provided in a non-certified 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.

36. Human Growth Hormone – Human growth hormone injections for the treatment of idiopathic short stature are covered only when determined Medically Necessary by a PacifiCare Medical Director or designee.

37. Immunizations – Immunizations and vaccinations solely for international travel and/or required work, 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 Immunizations Schedule – United States and Recommended Adult Immunization Schedule – United States are not covered.

38. Implants – The following implants and services are not covered:

- Surgical implantation or removal of breast implants for non-medical reasons.
- Replacement of breast implants when the initial surgery was done for non-medical reasons, such as for cosmetic breast augmentation.

PacifiCare will cover Medically Necessary services directly related to non-Covered Services when complications exceed routine follow-up care.

39. Infertility Reversal – Reversals of sterilization procedures are not covered.

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- 40. Infertility Services** – Infertility services are not covered.
- 41. 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 *Agreement and EOC* in the sections entitled “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.
- 42. 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.
- 43. 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.
- 44. Mental Health and Nervous Disorders** – Mental health services are not covered except for diagnosis and treatment of severe mental illness (SMI) for adults and children and for diagnosis and treatment of serious emotional disturbances (SED) of children. Please refer to the Behavioral Health Care supplement to this *Agreement and EOC* 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.
- 45. Nonphysician Health-Care Practitioners** – This plan may not cover services of all Nonphysician Health-Care Practitioners. Treatment by Nonphysician Health-Care Practitioners, such as acupuncturists, psychologists, chiropractors, licensed clinical social workers, and marriage and family therapists, may be available if purchased as a supplemental benefit. (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.”).
- 46. Nursing Services, Private Duty** – Private-Duty Nursing Services are not covered. 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.
- 47. Nurse Midwife Services** – Licensed/Certified nurse midwife services are covered only when available within the Member’s Participating Medical Group. Elective home deliveries at home are not covered.
- 48. Nursing, Private Duty** – Private Duty Nursing is not covered.
- 49. 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.”

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50. 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 this *Agreement and EOC*. 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:

- The drug is approved by the FDA;
- The drug is prescribed by a participating licensed health-care professional;
- The drug is Medically Necessary to treat the medical condition;
- The drug has been recognized for treatment of the medical condition by one of the following: *The American Hospital Formulary Service Drug Information, The United States Pharmacopoeia Dispensing Information* or in two articles from major peer-reviewed medical journals that present data supporting the proposed Off-Label Drug Use or Uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

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 than the use for which that drug has been approved for marketing by the FDA. Denial of a drug as Experimental or Investigational will allow the Member to use the Independent Medical Review System as defined in this *Agreement and EOC*.

51. 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.

52. 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.”)

53. 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 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. Organ donor searches are only covered when performed by a Provider in a Designated Facility.

54. Organ Transplants – All organ transplants must be preauthorized by PacifiCare and performed in a Designated Facility.

- Transportation is limited to the transportation of the Member and one escort to a Designated Facility greater than 60 miles from the Member’s Primary Residence as preauthorized by PacifiCare. Transportation and other non-clinical 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 “Designated Facility.”)
- Food and housing is not covered unless the Designated Facility is located more than 60 miles from the Member’s Primary Residence, in which case food and housing is limited to \$125 a day to cover both the Member and escort, if any (excludes alcohol and tobacco), as

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preauthorized by PacifiCare. 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 Designated Facility is a covered benefit unless the Regional Organ Procurement Agency (the agency that obtains the organ) is the same for both facilities. Organ transplant listing is limited to two Designated 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 “Designated Facility.”)
- Artificial heart implantation and non-human organ transplantation are considered experimental and are therefore excluded. Please refer to the exclusion entitled “Experimental and/or Investigational Procedures, Items and Treatment” and to the “Independent Medical Review” process outlined in **Section 8**.

A six-month Pre-Existing Condition Exclusion Period will apply to all Members enrolling for the first time in the Health Plan for all covered transplant services.

Enrolled newborns are exempt from the six-month Pre-Existing Exclusion Period. Children under the age of 18 who have been adopted or placed for adoption may be exempt or partially exempt from the six-month Pre-Existing Condition Exclusion Period. The Exclusion Period will be reduced or eliminated based on prior creditable coverage, which must be continuous, and with no lapse greater than 63 days. Every month of creditable coverage will reduce the six-month Exclusion Period by one month.

The Exclusion Period will be reduced or eliminated based on prior creditable coverage, which must be continuous with no lapse greater than 63 days. Every month of creditable coverage will reduce the six-month Exclusion Period by one month.

Credit for prior creditable coverage will be given if transplant services were covered under the prior creditable coverage, without regard to the level or use of coverage in the prior plan.

Creditable coverage must be continuous with no lapse greater than 63 days. Prior coverage credit toward the Exclusion Period is applied on the basis of elapsed time in the prior coverage. For example, given a six-month Exclusion Period and the individual had creditable coverage for three months, the applicable Exclusion Period would be three months. Every month of applicable creditable coverage will reduce the six-month Exclusion Period by one month.

- 55. 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.
- 56. Phenylketonuria (PKU) Testing and Treatment** – Food products naturally low in protein are not covered.
- 57. Physical or Psychological Examinations** – Physical or psychological examinations for court hearings, travel, premarital, pre-adoption, employment or other non-preventive health reasons are not covered. Court-ordered or other statutorily allowed psychological evaluation, testing, and treatment are not covered unless Medically Necessary and pre authorized by PacifiCare.

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- 58. Private Rooms and Comfort Items** – Personal or comfort items and non-Medically Necessary private rooms during inpatient hospitalization are not covered.
- 59. Prosthetics and Corrective Appliances** – Replacement of prosthetics or corrective appliances are covered when determined Medically Necessary by the Member’s Participating Medical Group or PacifiCare. Bionic, myoelectric, microprocessor-controlled and computerized prosthetics are not covered. Deluxe upgrades that are not Medically Necessary are not covered. For a detailed listing of covered durable medical equipment and prosthetics and corrective appliances, please contact the PacifiCare Customer Service department at (800) 624-8822.
- 60. Pulmonary Rehabilitation Programs** – Pulmonary rehabilitation programs are covered only when determined to be Medically Necessary by a PacifiCare Medical Director or designee.
- 61. 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.
- 62. Recreational, Lifestyle, Educational or Hypnotic Therapy** – Recreational, lifestyle, educational or hypnotherapy, and any related diagnostic testing, are not covered.
- 63. Rehabilitation Services and Therapy** – Rehabilitation services and therapy will be provided only as Medically Necessary and 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 a Participating 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 limitations, 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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 Testing beyond initial diagnosis other than for pervasive developmental disorder.
- Hypnotherapy.
- Psychological Testing.
- Vocational Rehabilitation.

- 64. 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 consecutive days at a time.
- 65. 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.
- 66. 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.”
- 67. 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.
- 68. Sexual Dysfunction or Inadequacy Medications** – Sexual dysfunction or inadequacy medications/drugs, procedures, services and supplies, including penile implants/prosthesis except testosterone injections for documented low testosterone levels, are not covered.
- 69. Sex Transformations** – Procedures, services, medications and supplies related to sex transformations are not covered.
- 70. 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 a 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. Such days spent in an acute hospital setting 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 may not have received Skilled Nursing Care or Skilled Rehabilitation Care for 60 days.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

- 71. 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.
- 72. Transportation**– Transportation is not a covered benefit except for ambulance transportation as defined in this *Agreement and EOC*. Also see “Organ Transplants” listed in Exclusions and Limitations.
- 73. Vision Care** – See “Eyewear and Corrective Refractive Procedures” listed in Exclusions and Limitations.
- 74. Vision Training** – Vision therapy rehabilitation and ocular training programs (orthoptics) are not covered.
- 75. Visual Aids** – Visual aids are not covered, except as specified under the outpatient benefit for (Diabetic Self-Management Items). Electronic and non-electronic magnification devices are not covered.
- 76. 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 gain , except as described under Inpatient Benefits, “Morbid Obesity (Surgical Treatment),” are not covered. For the treatment of anorexia nervosa and bulimia nervosa, please refer to the behavioral health supplement of this *Agreement and EOC*.

Section 6 – Payment Responsibility

- Premiums and Co-payments
- What to Do if You Receive a Bill
- Workers' Compensation Eligibility

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 Workers' compensation coverage.

What are Premiums (Prepayment Fees)?

Premiums are fees a Subscriber pays to cover the basic costs of the health care package for himself or herself and any enrolled Family Members. A Subscriber shall pay the Health Plan Premiums directly to PacifiCare when due. Health Plan Premiums must be received by PacifiCare by the first business day of the coverage month (i.e., January 1st for January coverage). All payments are to be made payable to PacifiCare of California and mailed to:

PacifiCare of California
Mail Stop CY24-5975701
Katella Avenue
Cypress, CA 90630

Health Care Premiums are due in full on a monthly basis by check or by electronic transfer. Contact PacifiCare's Membership Accounting Department at (800) 624-8822 for further information and an authorization form.

Failure to provide payment by the due date may result in termination or nonrenewal of Subscriber, as set forth in **Section 7**.

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.

Copayments are a Member's share of costs for Covered Services that are paid to the Participating Provider at the time services are rendered. A Member must always be prepared to pay the Copayment during a visit to the Member's Primary Care Physician or to any Participating Provider upon referral. Failure to pay a Copayment may result in termination of a Member's coverage under this Health Plan. A schedule of applicable Copayments is set forth in the Schedule of Benefits, which is made part of this *Agreement and EOC*.

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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

It is the Member's responsibility to inform PacifiCare when the Member has satisfied the Annual Copayment Maximum. Accordingly, it is important to keep all receipts for Copayments which the Member has actually paid. 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—
Annual Copayment Maximum
P.O. Box 6006
Cypress, CA 90630

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. Copayments paid for certain Covered Services are not applicable to a Member's Annual Copayment Maximum; these exceptions are specified in the *Schedule of Benefits*.

Note: The calculation of your Annual Copayment Maximum will not include supplemental benefits that may be offered (e.g., coverage for outpatient prescription drugs). However, the Annual Copayment Maximum includes coverage for Severe Mental Illnesses (SMI) of adults and children and Serious Emotional Disturbances of a Child (SED).

Effect of Payment

Except as otherwise provided in this *Agreement and EOC*, only Members for whom Health Plan Premiums are received by PacifiCare are entitled to health-care benefits as described in this *Agreement and EOC*, and then only for the period for which such payment is received. Subscriber agrees to pay Premium to PacifiCare for the first month of coverage for newborn or adopted children who become eligible as provided in this *Agreement and EOC*.

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:

- Call the Provider, then let them know you have received a bill in error and you will be forwarding the bill to PacifiCare.
- 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

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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 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

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 45 working days from the date PacifiCare receives a claim containing all information reasonably necessary to decide the claim. PacifiCare will not pay any claim from a Non-Participating Provider that is filed more than 180 calendar days 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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 above: "Bills from Non-Participating Providers."

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% 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.

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

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 THIS AGREEMENT AND EOC 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.

Section 7 – Member Eligibility

- Membership Requirements
- Limitations on Subscriber Eligibility
- Adding Family Members (Dependents)
- Updating Your Enrollment Information
- Rescission
- Termination of Enrollment

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.

If you and your dependents have been covered under this individual plan for at least 18 months, you and any applicable dependents have the right to transfer at least once a year without medical underwriting to any other individual plan that we offer that provides equal or lesser benefits, as determined by us. "Without medical underwriting" means that we will not deny you coverage or impose any preexisting condition period on you or any applicable dependents when you transfer to another individual plan with equal or lesser benefits. We will notify you in writing of our right to transfer whenever the premium rates for your present plan coverage are changed. The notice will also provide information on other individual contracts available to you and how to apply for a transfer. You may also contact Member Services for further information as how to change your Plan.

Application Form

A properly completed, signed application for Enrollment on a form provided by PacifiCare must be submitted to PacifiCare by Subscriber on behalf of the eligible and/or prospective Subscriber and any Eligible Dependents. PacifiCare may, in its discretion and subject to specific protocols, accept Enrollment through an electronic submission. The Enrollment application includes medical review questionnaires and other forms or statements that PacifiCare may reasonably request. The Subscriber must notify PacifiCare of any changes to the information requested or provided on the Enrollment application prior to the approved effective date. This information includes, but is not limited to, each applicant's health status, addresses, marital status and Dependent status. Failure to disclose material information on the application form or to disclose changes to material information prior to the effective date of coverage could result in termination or rescission of coverage for the Member. Please see the "Termination of Enrollment" and "Rescission" sections.

Enrollment is conditional upon acceptance and approval by PacifiCare and the timely payment of applicable Health Plan Premiums. Your effective date of Enrollment in PacifiCare will depend on when and how you enroll. These circumstances are explained below.

Note: PacifiCare enrolls applicants in the order that they become eligible and up to our capacity for accepting new Members.

Commencement of Coverage

The commencement date of coverage under this Health Plan shall generally be the first day of the month following PacifiCare's approval of Member's Enrollment application and verification of Member's eligibility in accordance with the terms of this *Agreement and EOC* and PacifiCare's Enrollment application form. PacifiCare's acceptance of each Member's Enrollment is contingent upon receipt of the applicable Health Plan Premium payment.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

Who is a PacifiCare Member?

There are two kinds of PacifiCare Members: Subscriber and enrolled Family Members (also called Dependents). The Subscriber is the Member who enrolls after meeting the eligibility requirements of PacifiCare. A Subscriber pays the Premiums to PacifiCare for his or her healthcare coverage for him- or herself and any enrolled Family Members.

The following Family Members are eligible to enroll in PacifiCare:

1. The Subscriber's Spouse or Domestic Partner;
2. The unmarried biological children of the Subscriber, the Subscriber's Spouse or the Domestic Partner (step-children) who are under the Limiting Age (for an explanation of "Limiting Age," see Definitions);
3. Children who are legally adopted or placed for adoption with the Subscriber, the Subscriber's Spouse or Domestic Partner who are under the Limiting Age;
4. Children for whom the Subscriber, the Subscriber's Spouse or Domestic Partner has assumed permanent legal guardianship. Legal evidence of the guardianship, such as a certified copy of a court order, must be furnished to PacifiCare upon request; and
5. Children for whom the Subscriber, the Subscriber's Spouse or Domestic Partner is required to provide health insurance coverage pursuant to a qualified medical child support order assignment order or medical support order, in this section.

Your Dependent children cannot be denied Enrollment or eligibility due to the following:

- Was born to a single person or unmarried couple;
- Is not claimed as a Dependent on a Federal Income Tax Return;
- Does not reside with the Subscriber or within the PacifiCare Service Area.

Eligibility

All Members must meet all eligibility requirements established by PacifiCare (except as otherwise required by the Health Insurance Portability and Accountability Act (HIPAA)). See below for more details). PacifiCare's eligibility requirements are:

- Be a United States citizen or lawful permanent resident of the United States;
- Be a resident of the State of California for at least six months prior to applying for coverage;
- Have a Primary Residence within PacifiCare's Service Area; and
- Select a Primary Care Physician within a 30-miles of his or her Primary Residence or Primary Workplace (except children enrolled as a result of a qualified medical child support order).

Please Note: Failure to comply with the above Eligibility requirements may result in loss of your membership in this Health Plan.

Limitations on Subscriber Eligibility

Individuals who are for any reason eligible for Medicare benefits (Part A and/or Part B) are not eligible to enroll in this Health Plan. Upon request, a Member shall provide PacifiCare with any information necessary to determine the Member's eligibility for Medicare. Member shall also provide PacifiCare with information regarding coverage under any other governmental or private health-care program. Medicare-eligible persons may be eligible for Enrollment in PacifiCare's Secure Horizons Health Plan.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

Eligibility Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

HIPAA eligible individuals need not meet medically underwritten requirements but must qualify under the criteria for guaranteed issuance under HIPAA. An individual will be eligible for this Health Plan, regardless of health status, if he or she meets the Subscriber Eligibility requirements set forth in this section and all of the following criteria:

- The individual has at least 18 months prior creditable coverage with the most recent coverage under a group Health Plan, governmental plan or church plan, with no break in coverage greater than 62 consecutive calendar days;
- The individual is not currently eligible for group coverage, Medicare or Medi-Cal;
- The individual does not currently have other health insurance coverage;
- The individual's most current coverage was not terminated because of non-payment of Premiums or fraud; and
- If eligible, the individual elected and exhausted Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage.

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.

Open Enrollment for Specific Participating Medical Groups

Certain Participating Medical Groups accept new Members only during specified Open Enrollment Periods. As a newly eligible Individual Plan Member, your Open Enrollment Period occurs at the time you enroll in the Plan. As a current Individual Plan Member, your annual Open Enrollment Period will take place during the month of December of each calendar year. After December, current Individual Plan Members will not be able to select a Primary Care Physician from these select groups until the next Open Enrollment Period. Because these groups may change from time-to-time, please visit our Provider Directory on our Web site at www.pacificare.com or contact Customer Service if you would like additional information.

Adding Family Members to Your Coverage

If you have a new Dependent as a result of birth, adoption or placement for adoption, you may enroll your Dependents, provided that you request Enrollment within 30 days after the birth, adoption or placement for adoption. A Change Request Form must be submitted prior to the expiration of 30 days or proof of good health will be required.

Newborns, New Adoptions and Guardianships

Having a Baby. Newborns are covered for the first 30 days of life under an existing Subscriber's membership, provided that the Subscriber is the parent. Newborns may not be added to any other Member's plan, including, but not limited to, siblings. You must notify PacifiCare's Membership Accounting Department in writing or by telephone at (800) 861-6611. In order for coverage to continue beyond the first 30 days of life, the Subscriber must submit a Change Request Form, signed by the Subscriber, to PacifiCare, prior to the expiration of the 30-day period. In addition, before processing the Change Request Form, PacifiCare requires that all additional Premiums as a result of adding coverage for your newborn be paid. Failure to submit the completed and signed Change Request Form and the additional Premiums within the first 30 days of life will result in the newborn being considered a late applicant, and PacifiCare will require the newborn to reapply for

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

coverage, subject to full medical review by PacifiCare's Underwriting Department, with no guarantee of coverage.

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 or 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. A Change Request Form must be received within 30 days of the adoption placement.

Guardianship. To enroll a Dependent child for whom the Subscriber has assumed legal guardianship, the Subscriber must submit an Enrollment application to PacifiCare, along with a certified copy of a court order granting guardianship, within 30 days of when the Subscriber assumed legal guardianship. Please note that the Dependent will be required to meet PacifiCare's underwriting criteria prior to PacifiCare approving coverage. Coverage will be retroactively effective to the date the Subscriber assumed legal guardianship.

Spouses, Domestic Partners and Other Dependents

If the Subscriber wishes to apply for coverage for a Spouse, Domestic Partner or any other Dependent not currently covered by this plan, he or she may submit a completed Enrollment application to PacifiCare. PacifiCare's approval of the Member's Enrollment application is contingent upon underwriting approval and receipt of the applicable Health Plan Premium payment. The commencement date of coverage under this Health Plan shall generally be the first day of the month following PacifiCare's approval of Member's Enrollment application and verification of Member's eligibility in accordance with the terms of this *Agreement and EOC*.

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.

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, *Agreement and EOC* 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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

Continuing Coverage for Student and Disabled Dependents

Certain Dependents who would otherwise lose coverage under the Health Plan due to their attainment of the Limiting Age of 19 may extend their coverage under the following circumstances:

Continuing Coverage for Student Dependents

An unmarried Dependent who is registered on a full-time basis (at least 12 semester units or the equivalent as determined by PacifiCare) at an accredited school or college may continue as an eligible Dependent to the Limiting Age of 24, if proof of such status is provided to PacifiCare on a periodic basis as requested by PacifiCare. If the Dependent student resides outside of the Service Area, the student must maintain a permanent address inside the Service Area with the Subscriber and the student must select a Participating Medical Group within 30 miles of that address. All health care coverage must be provided or arranged for in the Service Area by the designated Participating Medical Group, except for Emergency and Urgently Needed Services.

Continuing Coverage for Certain Disabled Dependents

Unmarried enrolled Dependents who attain the Limiting Age of 24 may continue Enrollment in the Health Plan beyond the Limiting Age if the unmarried Dependent meets all of the following:

1. The unmarried Dependent resides within the Service Area with the Subscriber or the Subscriber's separated or divorced Spouse or the terminated Domestic Partner;
2. The unmarried Dependent is incapable of self-sustaining employment by reason of Mental Retardation or physical handicap;
3. The unmarried Dependent is chiefly dependent upon the Subscriber for support and maintenance; and
4. The mental or physical condition existed continuously prior to reaching the Limiting Age.

In order to continue coverage under this section for qualifying disabled Dependents, proof of such disability and dependency must be provided to PacifiCare by the Member within 31 days of the onset of the disability, attainment of the Limiting Age or at the time of the Subscriber's initial Enrollment in PacifiCare.

PacifiCare may require ongoing proof of a Dependent's disability and dependency, but not more frequently than annually after the two-year period following the Dependent's attainment of the Limiting Age of 24. This proof may include supporting documentation from a state or federal agency or a written statement by a licensed psychologist, psychiatrist or other Physician to the effect that such disabled Dependent is incapable of self-sustaining employment by reason of Mental Retardation or physical handicap.

Notifying You of Changes in Your Plan

The Health Plan Premium rates, the benefits set forth in this *Agreement and EOC* and its attachments, including, but not limited to, the Schedule of Benefits, may be modified by PacifiCare in its sole discretion upon 30 days prior written notice mailed postage prepaid to Subscriber. Any such modification shall take effect commencing on the first day of the first full month following the expiration of the 30-day notice period.

Renewal and Reinstatement (Renewal Provisions)

This *Agreement and EOC* with PacifiCare is renewable, subject to all the terms and conditions of the *Agreement and EOC*. PacifiCare may change your Health Plan benefits and Premium at renewal upon

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

30 days prior written notice to Subscriber. If PacifiCare terminates this *Agreement and EOC*, reinstatement is subject to all the terms and conditions of the *Agreement and EOC*.

Updating Your Enrollment Information

You must notify PacifiCare 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 (800) 624-8822 or (800) 442-8833 (TDHI).

About Your PacifiCare Identification (ID) Card

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, to 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 ID card by any other person, PacifiCare may immediately terminate that Member’s membership.

Ending Coverage (Termination of Benefits)

Rescission

PacifiCare may rescind coverage if the Subscriber or any Dependent intentionally provides incomplete or incorrect material misstatements, omission or false information (or intentionally misrepresents a material fact) on the Enrollment application form or intentionally does not inform PacifiCare of changes to material information before coverage becomes effective. Rescinding coverage means that the *Agreement and EOC* is void and that no coverage existed at any time. (Alternatively, PacifiCare may choose to terminate your coverage upon mailing of written notice. Please see “Termination and Nonrenewal for Good Cause, Fraud or Misrepresentation” in this section).

Termination by Subscriber

Subscriber may terminate this *Agreement and EOC* on his or her behalf or on behalf of a Dependent by giving a minimum of 30 days advance written notice of termination to PacifiCare. Subscriber’s termination must always be effective on the first day of the month. Subscriber shall continue to be liable for Health Plan Premiums for all Members enrolled in this Health Plan until the effective date of termination.

Termination and Nonrenewal for Ceasing to Meet Eligibility Requirements

PacifiCare may terminate or not renew a Member’s coverage if the Member no longer meets the eligibility requirements established by PacifiCare.

Termination and Nonrenewal for Good Cause

PacifiCare has the right to terminate or not renew your coverage under this Health Plan in the following situations:

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

Nonpayment of Health Plan Premiums. If this *Agreement and EOC* is canceled because you 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 Health Plan mails you the Notice Confirming Termination of Coverage. If your Premium is not received when due, the Health Plan will notify you with a Prospective Notice of Cancellation. This notice will be mailed to you at least 15 days before any cancellation of coverage and will provide you with the following information:

- That Premiums due have not been paid and that the this *Agreement and EOC* will be canceled for nonpayment if you do not pay the required Premiums within 15 days from the date the Prospective Notice of Cancellation was mailed.
- The specific date and time when coverage for you and all of your Dependents will end if Premiums are not paid.

If payment is not received within 15 days of the date the Prospective Notice of Cancellation was mailed, the Health Plan will cancel the *Agreement and EOC* and will mail you a Notice Confirming Termination of Coverage, which will this *Agreement and EOC* inform you of the following:

- That this *Agreement and EOC* has been canceled for non-payment of Premiums.
- The specific date and time when coverage for you and all your Dependents ended.
- Information explaining whether or not you can reinstate this *Agreement and EOC*.

Nonpayment of Health Plan Premiums includes, but is not limited to, payments returned due to non-sufficient funds (NSF) and postdated checks.

Note: PacifiCare charges a \$25 administrative fee for all returned payments.

- **Reinstatement Following Nonpayment of Premium.** If the *Agreement and EOC* is canceled for nonpayment of Premiums, the Health Plan will permit reinstatement of the *Agreement and EOC* twice during any 12-month period, without a change in Premiums and without consideration of the medical condition of you or any Dependent, if the amounts owed are paid within 15 days of the date the Notice Confirming Termination of Coverage is mailed to you, along with a \$50 reinstatement fee. Only payment in the form of a cashier's check or money order will be accepted for reinstatement. If you do not obtain reinstatement of the canceled *Agreement and EOC* within the required 15 days, or if the *Agreement and EOC* is canceled for nonpayment of Premiums more than twice during a contract year, then the Health Plan is not required to reinstate you, and you will need to reapply for coverage. In this case, the Health Plan may impose different Premiums and consider the medical condition of you and your Dependents.

In the event PacifiCare receives untimely payments after Subscriber has been terminated, the deposit or application of such funds by PacifiCare does not constitute acceptance of such funds or reinstate Subscriber, and such funds may be refunded by PacifiCare at its sole discretion. Please note that if the *Agreement and EOC* is canceled for nonpayment of Premiums more than twice during a contract year, Subscriber must submit a new Enrollment application for membership and comply with all applicable eligibility requirements. Approval is not guaranteed and is subject to medical underwriting criteria.

- **Failure to Pay Other Applicable Charges.** Your coverage may be terminated or not renewed 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 or nonrenewal 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

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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.** PacifiCare may terminate coverage if the Subscriber or any Dependent intentionally provides incomplete or incorrect material misstatements, omission or false information (or intentionally misrepresents a material fact) on the Enrollment application form (this includes adding dependent that do not meet the eligibility requirements of PacifiCare as defined in this document and proof of eligibility may be requested at any time PacifiCare deems necessary); or intentionally does not inform PacifiCare of changes to material information before coverage becomes effective. PacifiCare may terminate or not renew coverage if the Subscriber or any Dependent fraudulently or deceptively uses services or facilities of PacifiCare, its Participating Medical Groups or other health care Providers (or allows another person to do the same), including altering a prescription. Termination for fraud or misrepresentation as set forth in this section is effective immediately on the date PacifiCare mails the notice of termination, unless PacifiCare has specified a later date in that notice. (Alternatively, PacifiCare may choose to rescind your coverage. Please see “Rescission” in this section.)
- **Disruptive Behavior.** Your coverage may be terminated or not renewed if you or any of your Dependents 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.
- **Member Never Eligible for Membership.** If a person who has never been eligible for membership in this Health Plan has received the benefits of membership in this Health Plan for reasons other than the fraud or deception of the person or another person through whom the person is enrolled as a Dependent, such person’s benefits shall be terminated effective the first of the month following 15 days from the date the notice is mailed to the Subscriber.
- **Member Permits Misuse of Identification Card.** Your membership in this Health Plan shall be terminated or not renewed if you or any of your Dependents permits the use of your PacifiCare Identification Cards by any other person. Termination is effective immediately on the date PacifiCare mails the notice of termination to the Subscriber.
- **Payments Made in Error.** If PacifiCare pays to a Member any fees for services which were not authorized by Member’s Primary Care Physician (and which were not Emergency or Urgently Needed Services as described in this Agreement and EOC, or obstetrical or 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), you shall reimburse PacifiCare for such payment. Failure to reimburse PacifiCare, or to reach reasonable accommodations with PacifiCare within 30 days after PacifiCare mails you a request for reimbursement, shall be grounds for termination or nonrenewal. Termination is effective 15 days after the date PacifiCare mails a notice of termination to the Subscriber. The exercise of PacifiCare’s termination rights shall not affect PacifiCare’s right to collect reimbursement from the Member.

To obtain coverage after termination, Subscriber must submit a new Enrollment application for membership and comply with all applicable eligibility requirements, including being subject to medical underwriting.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

Under no circumstances will a Member be terminated due to health status or the need for health-care services. 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.

Written Notice of Termination

When a written notice of termination or nonrenewal is sent to the Subscriber pursuant to this section, it shall be dated, sent to the last known address of the Subscriber and state:

- a) The cause of termination or nonrenewal with specific reference to the section of this *Agreement and EOC* giving rise to the right of termination or nonrenewal;
- b) That the cause for termination or nonrenewal was not the Member's health status or requirements for health-care services;
- c) The effective date of termination or nonrenewal; and
- d) That notwithstanding the Member Appeals (Grievance) procedure set forth in this *Agreement and EOC*, if Member believes that his or her Health Plan membership has been terminated because of his or her health status or requirements for health-care services, Member may request a review before the Director of the Department of Managed Health-Care for the State of California.

NOTE: IF A SUBSCRIBER IS TERMINATED BY PACIFICARE, NOTICE TO THE SUBSCRIBER IS SUFFICIENT IF SENT TO SUBSCRIBER'S LAST KNOWN ADDRESS.

Ending Coverage: Special Circumstances for Enrolled Family Members

Enrolled Family Members terminate on the same date of termination as the Subscriber except:

- **Death.** If the Subscriber dies, coverage for all Dependents will continue, provided that monthly Premiums continue to be received by PacifiCare.
- **Divorce.** If there's a divorce, the Spouse, along with all of the Spouse's Dependents who are not also Dependents of the Subscriber, lose coverage at the end of the month in which a final judgment or decree of dissolution of marriage is entered. (See below "Continuing Coverage for Dependents.")
- **Termination of Domestic Partnership.** If there's a termination of a domestic partnership, the Domestic Partner, along with all of the Domestic Partner's Dependents who are not also Dependents of the Subscriber, lose coverage at the end of the month in which a termination of Domestic partnership occurs. (See "Continuing Coverage for Dependents).
- **Limiting Age.** Dependent children lose their eligibility if they marry or reach the Limiting Age of 19 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 of 24. Please refer to "Extending Your Coverage" for additional coverage which may be available to you.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

Continuing Coverage for Dependents

Should a Dependent lose coverage under this Health Plan due to a Subscriber's loss of eligibility for any reason set forth in this section, the Dependent shall be eligible to enroll in this Health Plan without regard to health status, provided the Dependent notifies PacifiCare within 30 days of the Subscriber's loss of eligibility and the Subscriber's loss of eligibility was not due to fraud or misrepresentation by the Dependent. If a Dependent loses eligibility because he or she reached the age of 19 or no longer meets the definition of a student Dependent, the Dependent shall be eligible to enroll in this Health Plan without regard to health status, provided the Dependent notifies PacifiCare within 30 days of the Dependent's loss of eligibility.

Return of Prepayment Premium Fees Following Termination

In the event of termination by PacifiCare (except in the case of fraud or deception in the use of PacifiCare services or facilities, or knowingly permitting such fraud or deception by another), PacifiCare will, within 30 days, return to Subscriber the pro rata portion of money paid to PacifiCare which corresponds to any unexpired period for which payment has been received, together with amounts due on claims, if any, less any amounts due to PacifiCare.

Non-Liability After Termination

Upon termination of this *Agreement and EOC*, PacifiCare shall have no further liability to provide benefits to any former Member, including, but not limited to, former Members hospitalized or undergoing treatment for an ongoing condition. An individual's rights to receive benefits under this Health Plan shall cease at 12:01 a.m. upon the effective date of termination.

Subscriber's Termination Rights and Responsibilities

The Subscriber shall immediately inform PacifiCare of any event which would give rise to PacifiCare's right to terminate this *Agreement and EOC* or to terminate the coverage of any Dependent.

Former Members are responsible for payment for any services received after termination of this *Agreement and EOC* at the Provider's Prevailing Rates for non-Members. This also applies to individuals who are hospitalized or undergoing treatment for an ongoing condition on the termination date of this *Agreement and EOC*.

Section 8 – Overseeing Your Health Care Decisions

- How PacifiCare Makes Important Health Care Decisions
- What to Do if You Have a Problem
- Quality of Care Review
- Appeals and Grievances
- Independent Medical Reviews
- New Treatments and Technologies

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 a show to request an expedited decision when your condition requires a quicker review.

How PacifiCare Makes Important HealthCare Decisions

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 frames required by state law:

- Decisions to approve, modify or deny requests for authorization of health-care services, based on Medical Necessity, will be made in a timely fashion appropriate for the nature of the Member's condition, not to exceed five 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 his or her 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) PacifiCare, or in many situations, the Participating Medical Group has asked that an additional examination or test be

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 frames above or as soon as the reviewer becomes aware that it will not be able to meet the required time frames.

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 timeframes specified above as applicable.

PacifiCare and Participating Medical Groups 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 *Agreement and EOC*.

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, PacifiCare or its Participating Medical Group 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 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 above, PacifiCare 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 on previous page.

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 (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

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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 criteria 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).
- PacifiCare Medical Management Guidelines (MMG) and Benefit Interpretation Policies (BIP). (PacifiCare's Medical Management Guidelines Manual and Commercial HMO Benefit Interpretation Policy Manual are available at www.pacificare.com.)

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 or modification of health-care services based on Medical Necessity must be made by an appropriately qualified licensed Physician or a qualified licensed health 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 reasons other than Medical Necessity 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 PacifiCare or 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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 will 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 submit a Grievance requesting an Appeal or Quality Review. To learn more about this, read the following section: “Appealing a Health Care Decision or Requesting a Quality of Care Review.”

Appealing a Health Care Decision or Requesting a Quality of Care Review

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 grievances. This is done through a process that includes an appropriate investigation. To initiate an appeal or request a quality of care review, you may 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 by using the Online Grievance format www.pacificare.com or write to the Appeals Department at:

PacifiCare
Appeals & Grievances
P.O. Box 6107
Mailstop CA124-0160
Cypress, CA 90630-9972

This request will initiate the following Appeals 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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 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 denying or modifying health care services based on a finding that the services are not Covered Services, the response will specify the provisions in this *Agreement and EOC* that exclude that coverage.

Expedited Review Appeals 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 appeals 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 contacting the DMHC regarding your expedited appeal.

Voluntary Mediation and Binding Arbitration

If you are dissatisfied with PacifiCare's Appeals Process determination, you can request that PacifiCare submit the appeal to voluntary mediation or Binding Arbitration before 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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 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 IMR (AS DISCUSSED BELOW), YOU MUST FILE YOUR COMPLAINT OR APPEAL WITHIN 180 CALENDAR 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 IMR 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

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 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 pre-addressed 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 healthcare 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
 - a. You have received Urgently Needed Services or Emergency Services that a Provider determined were Medically Necessary; or
 - b. 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; 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 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 calendar 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.)

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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. 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 pre-addressed 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 (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 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;

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 calendar 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 calendar days of the request for expedited review. The review period can be extended up to three 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 practicable, within 30 days of the receipt of the application for review and supporting documentation, or within less time as prescribed by the director.
- If the disputed health-care service has not been provided and the enrollee's Provider or the DMHC certifies in writing that an imminent and serious threat to the health of the enrollee may exist, including, but not limited to, serious pain, the potential loss of life, limb or major bodily function or the immediate and serious deterioration of the health of the enrollee, the analysis and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information.
- Subject to the approval of the DMHC, the deadlines for analysis and determinations involving both regular and expedited reviews may be extended by the director for up to three days in extraordinary circumstances or for good cause.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

The IRO will provide the DMHC, PacifiCare, you and your Physician with each of the experts' analysis 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 there viewer is called to testify and in response to court orders. In the case of an Experimental or Investigational determination, the experts' analysis 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 Services denied as not Medically Necessary, the experts' analysis 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 do 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 business days. In the case of services not yet rendered to you, PacifiCare will authorize the services within five 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 **(800) 624-8822** or **(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

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 **(888) HMO-2219** and a TDD line **(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.

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."

Section 9 – 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
- Nondiscrimination Notice

What follows are answers to some common and uncommon questions about your Health Plan. If you have any questions of your own that haven't been answered, please call our Customer Service department. If you have special needs, this document may be available in other formats.

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: (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.

Nondiscrimination Notice

PacifiCare does not exclude, deny Covered Benefits to, or otherwise discriminate against any Member on the ground of race, color, or national origin, or on the basis of disability or age in participation in, or receipt of the Covered Services under, any of its Health Plans, whether carried out by PacifiCare directly or through a Participating Medical Group or any other entity with which PacifiCare arranges to carry out Covered Services under any of its Health Plans.

This statement is in accordance with the provisions of Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and Regulations of the U.S. Department of Health and Human Services issued pursuant to these statutes at Title 45 Code of Federal Regulations Parts 80, 84, and 91.

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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 6 – 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

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 (800) 355-SHARE or (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 the establishment of PacifiCare’s public policy?

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 10 – Miscellaneous Provisions

Governing Law

This *Agreement and EOC* is subject to the laws of the State of California and the United States of America, including the Knox-Keene Health-Care Service Plan Act of 1974, as amended (codified at Chapter 2.2 of Division 2 of the California Health and Safety Code), and the regulations promulgated there under by the California Department of Managed Health Care (codified at Chapter 1 of Division 1 of Title 28 of the California Code of Regulations); the Health Maintenance Organization Act of 1973, as amended (codified at Subchapter XI of Chapter 6A of Title 42 of the United States Code) and the regulations promulgated there under by the Center for Medicare and Medicaid Services (codified at Part 417 of Chapter IV of Title 42 of the Code of Federal Regulations); and the Health Insurance Portability and Accountability Act of 1996, Public law 104-1910 (codified at Section 8.1, Title II, subtitle F, section 261-264). Any provisions required to be in this *Agreement and EOC* by any of the above laws and regulations shall bind PacifiCare and Member whether or not expressly provided in this *Agreement and EOC*.

PacifiCare Names, Logos and Service Marks

PacifiCare reserves the right to control all use of its name, product names, symbols, logos, trademarks and service marks currently existing or later established. Subscriber shall not use PacifiCare's name, product names, symbols, logos, trademarks or service marks without obtaining the prior written approval of PacifiCare.

Assignment

This *Agreement and EOC* and the rights, interests and benefits hereunder shall not be assigned, transferred, pledged or hypothecated in any way by either party and shall not be subject to execution, attachment or similar process, nor shall the duties imposed herein be subcontracted or delegated without the approval of the other party. Notwithstanding the above, if PacifiCare assigns, sells or otherwise transfers substantially all of its assets and business to another corporation, firm or person, with or without recourse, this *Agreement and EOC* will continue in full force and effect as if such corporation, firm or person were a party to this *Agreement and EOC*, provided such corporation, firm or person continues to provide prepaid health services.

Validity

The unenforceability or invalidity of any part of this *Agreement and EOC* shall not affect the enforceability and validity of the balance of this *Agreement and EOC*.

Confidentiality

PacifiCare agrees to maintain and preserve the confidentiality of any and all medical records of Member in accordance with all applicable state and federal laws. However, Member authorizes the release of information and access to any and all of Member's medical records for purposes of utilization review, quality review, processing of any claim, financial audit, coordination of benefits or for any other purpose reasonably related to the provision of benefits under this *Agreement and EOC* to PacifiCare, its agents and employees, Member's participating medical group and appropriate governmental agencies.

Use of Gender

The use of masculine gender in this *Agreement and EOC* includes the feminine gender and the singular includes the plural.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

Waiver of Default

The waiver by PacifiCare of any one or more defaults by Member shall not be construed as a waiver of any other or future defaults under the same or different terms, conditions or covenants contained in this Agreement and EOC.

Notices

Any notice required or permitted under this *Agreement and EOC* shall be in writing and either delivered personally or by regular, registered or certified mail, U.S. Postal Service Express Mail or overnight courier, postage prepaid, or by facsimile transmission at the addresses set forth below:

If to PacifiCare: PacifiCare of California

Attention: President
P.O. Box 6006
Cypress, CA 90630-0006

If to Member: at Member's last address known to PacifiCare.

Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. If sent by regular mail, the notice shall be deemed given 48 hours after the notice is addressed and mailed with postage prepaid. Notices delivered by U.S. Postal Service Express mail or overnight courier that guarantees next day delivery shall be deemed given 24 hours after delivery of the notice to the United State Postal Service or courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

Acceptance of Agreement and EOC

Member accepts the terms, conditions and provisions of this *Agreement and EOC* upon completion and execution of the Enrollment form and by making his or her initial payment to PacifiCare of Health Plan Premiums at the time of submission of the Enrollment form.

Entire Agreement

This Agreement and EOC, including all exhibits, attachments and amendments, contains the entire understanding of Subscriber and PacifiCare with respect to the subject matter hereof, and it incorporates all of the covenants, conditions, promises and agreements exchanged by the parties hereto with respect to such matter. This Agreement supersedes any and all prior or contemporaneous negotiations, agreements, representations or communications, whether written or oral, between Subscriber and PacifiCare with respect to the subject matter of this Agreement and EOC.

Headings

The headings of the various sections of this *Agreement and EOC* are inserted merely for the purpose of convenience and do not expressly, or by implication, limit or define or extend the specific terms of the section so designated.

No Third-Party Beneficiaries

Except as otherwise expressly indicated in this Agreement and EOC, this *Agreement and EOC* shall not create any rights in any third parties who have not entered into this Agreement and EOC, nor shall this *Agreement and EOC* entitle any such third party to enforce any rights or obligations that may be possessed by such third party.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 this Agreement and EOC, as well as the Schedule of Benefits.

Agreement and EOC – This *Agreement and EOC* and all Enrollment applications, health questionnaires, information submitted by the Subscriber and his or her Dependents applying for coverage, the Schedule of Benefits, the Pharmacy Schedule of Benefits and the Behavioral Health-Care Supplement, other appropriate attachments and addenda and any amendments thereto.

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 use selectrical 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.

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.”

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 a newly enrolled Member who, at the time of his or her coverage became effective with PacifiCare, was receiving Covered Services from the Non-Participating 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 health³, 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 problem⁴ or medical or mental health 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 12 months from the agreement’s termination date or 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 year or less. Completion of Covered Services will be provided for the duration of the Terminal Illness, not to exceed 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.

³ Except pursuant to California Health and Safety Code Section 1374.72, inpatient coverage for Behavioral Health is not a covered benefit under the PacifiCare HMO Commercial core coverage.

⁴ PacifiCare Behavioral Health, Inc. will coordinate Continuity of Care 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 California Health and Safety Code Section 1374.72.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

5. **The care of a newborn:** Services provided to a child between birth and age 36 months. Completion of Covered Services will not exceed 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 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.

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.

Copayments – Fees payable to and retained by a healthcare Provider paid by the Member at the time of provision of services which are in addition to the Health Plan Premiums paid. Such fees may be a specific dollar amount or a percentage of total fees as specified herein, depending on the type of services provided.

Covered Services – Medically Necessary services and supplies provided under the terms of this *Agreement and EOC*, your Schedule of Benefits and supplemental benefit materials, and subject to the exclusions and limitations set forth in this *Agreement and EOC*.

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.

Dependent – Any Spouse, Domestic Partner or unmarried child (including a stepchild or adopted child) of a Subscriber who is enrolled hereunder, who meets all the eligibility requirements set forth in this *Agreement and EOC* and for whom applicable Health Plan Premiums are received by PacifiCare.

Designated Facility – A facility that has entered into an agreement with PacifiCare, or with an organization contracting on PacifiCare's behalf, to render Covered Services for the treatment of specified diseases or conditions. The fact that a hospital is a Participating Hospital does not mean that it is a Designated Facility.

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 is eligible for coverage under this *Agreement and EOC* on the same basis as if the Domestic Partner were the Subscriber's lawful spouse under the laws of the

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Subscriber's state of residence. To qualify for coverage, both the Subscriber and his/her Domestic Partner must meet the following eligibility requirements:

- i. Is eighteen (18) year of age or older;
- ii. Is mentally competent to consent to contract;
- iii. Resides with the Subscriber and intends to do so indefinitely;
- iv. Is jointly responsible with the Subscriber for their common welfare and financial obligations;
- v. Is unmarried or not a member of another domestic partnership and
- vi. 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.**)

Enrollment – The execution of a PacifiCare Enrollment form by the Subscriber on behalf of the Subscriber and his or her Dependents and acceptance and approval thereof by PacifiCare and the timely payment of applicable Health Plan Premiums by Subscriber. In its discretion and subject to specific protocols, PacifiCare may accept Enrollment through an electronic submission.

Enrollment Packet – The packet of information supplied by PacifiCare to prospective Members which discloses plan policy and procedure and provides information about plan benefits and exclusions. The PacifiCare Enrollment Packet contains the PacifiCare Enrollment form.

Enteral Feeding – Provision of nutritional requirements through a tube into the stomach or bowel. It may be administered by syringe, gravity, or pump.

Exclusion Period – A period during which specified treatments or services are excluded from coverage.

Experimental or Investigational – Defined in **Section 5** under the "Other Exclusions and Limitations of Benefits" section of this *Agreement and EOC*.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

Family Member – The Subscriber’s Spouse or Domestic Partner and any person related to the Subscriber or 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 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 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.

Health Plan – The Health Plan described in this *Agreement and EOC* and attachments, subject to modification pursuant to the terms of this *Agreement and EOC*.

Health Plan Premiums (or Premiums) – Amounts established by PacifiCare to be paid to PacifiCare by Subscriber on behalf of Subscriber and his or her Dependents in consideration of the benefits provided under this Health Plan, such amounts are set forth in the Enrollment Packet.

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 hours of skilled services by a registered nurse or licensed vocational nurse or licensed therapist or up to four hours of Home Health Aide Services.

Hospice – Specialized form of interdisciplinary healthcare 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.

Hospitalist – A Physician whose sole practice is the management of acutely and/or chronically ill patients’ health services in a hospital setting.

Hospital Services – Services and supplies performed or supplied by a licensed hospital on an inpatient or outpatient basis.

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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 psycho-social deprivation, psychiatric disorder or sensory loss.

Limiting Age – Age 19 for non-student Dependents and age 24 for Dependents who are full-time students. Disabled Dependents may be eligible for Dependent coverage beyond the Limiting Age.

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 maybe 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

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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).

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.

Nonphysician 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 when all Eligible Subscribers and their eligible Family Members may enroll in certain Participating Medical Groups. Please contact Customer Service for additional information.

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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 with the network of providers from whom the Member is entitled to receive Covered Services. Participating Providers are independent contractors and are not employees of PacifiCare.

Physician – Any licensed allopathic or osteopathic Physician.

Pre-Existing Condition – means any condition, other than pregnancy, for which medical advice, diagnosis, care or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the six months immediately preceding the effective date of coverage.

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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 *Agreement and EOC* 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 – is an organization designated by the federal government and responsible for procurement of organs for transplantation and the promotion of organ donation.

Rehabilitation Services – The individual or combined and coordinated use of medical, physical, occupational and speech therapy for training or retraining individuals disabled by disease or injury.

Schedule of Benefits – An important part of your *Agreement and EOC* 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 (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 occurs:
 - 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.

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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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, 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.

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 licensed Skill Nursing Care than is provided to the majority of the patients in a Skilled Nursing Facility.

Subcutaneous – Injection under the skin.

Subscriber – The individual enrolled in the Health Plan and who meets all eligibility requirements stated in the *Agreement and EOC* and for whom the appropriate Health Plan Premium has been received by PacifiCare.

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.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

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 necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member returns to the Health Plan's Service Area. Urgently Needed Services includes maternity services necessary to prevent serious deterioration of the health of the Member or the Member's fetus, based on the Member's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the Member returns to the Health Plan's Service Area.

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,

Section 12. Member/Enrollee Rights and Responsibilities

As a Member/enrollee you have the right to receive information about, and make recommendations regarding, your rights and responsibilities.

You have the right to:

- Receive information about PacifiCare and the Covered Services under your Health Plan/policy.
- Submit complaints regarding PacifiCare or Participating Providers or request appeals for denied service.
- Be treated with dignity and respect and have your right to privacy recognized in accordance with state and federal laws.
- Discuss and actively participate in decision-making with your Participating Provider regarding the full range of appropriate or Medically Necessary treatment options for your conditions, regardless of cost or benefit coverage.
- Refuse any treatment or leave a medical facility, even against the advice of a Participating Provider. Your refusal in no way limits or otherwise precludes you from receiving other Medically Necessary Covered Services for which you consent.
- Complete an advance directive, living will or other directive and provide it to your Participating Provider to include in your medical record. Treatment decisions are not based on whether or not an individual has executed an advance directive.
- Exercise these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your health care.

Your responsibilities are to:

Review information regarding your benefits, Covered Services, any exclusions, limitations, deductibles or Copayments, and the rules you need to follow as stated in your Combined Evidence of Coverage and Disclosure Form.

Provide PacifiCare and Participating Providers, to the degree possible, the information needed to provide care to you.

Follow treatment plans and care instructions as agreed upon with your Participating Provider. Actively participate, to the degree possible, in understanding and improving your own medical and behavioral health condition and in developing mutually agreed upon treatment goals.

Accept your financial responsibility for Health Plan Premiums, and any other charges owed, and any Copayment or coinsurance associated with services received while under the care of a Participating Provider or while a patient in a facility.

If you have questions or concerns about your rights, please call Customer Service at the phone number listed on the back of your membership card. If you need help with communication, such as help from a language interpreter, Customer Services representatives can assist you.

Questions? Call our Customer Service Department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

**P.O. Box 6006
Cypress, CA 90603**

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

www.pacificare.com

PacifiCare[®]

A UnitedHealthcare Company

PACIFICARE SIGNATUREVALUE 10-35/250D
HMO SCHEDULE OF BENEFITS

EFFECTIVE FEBRUARY 1, 2008

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 (2 individual maximums per family)	\$2500/individual
PCP Office Visits	\$10 Copayment
Specialist/Nonphysician Health Care Practitioner Office Visits ² (Member required to obtain referral to specialist or Nonphysician Health Care Practitioner, except for OB/GYN Physician services and Emergency/Urgently Needed Services.)	\$35 Copayment
Hospital Benefits (Only one hospital Copayment per day is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment for that day.) (Autologous (self-donated) blood limited up to \$120.00 per unit.)	\$250 Copayment per day Copayment applies to a maximum of 4 days per stay
Emergency Services (Copayment waived if admitted)	\$100 Copayment
Urgently Needed Services (Medically Necessary services required outside the 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 day Copayment applies to a maximum of 4 days per stay
Bone Marrow Transplants (Donor searches limited to \$15,000 per procedure)	\$250 Copayment per day Copayment applies to a maximum of 4 days per stay
Cancer Clinical Trials ³	Paid at contracting rate Balance (if any) is the responsibility of the Member.
Hospice Services (Prognosis of life expectancy of one year or less.)	\$250 Copayment per day Copayment applies to a maximum of 4 days per stay
Hospital Benefits (Only one hospital Copayment per day is applicable. If a transfer to another facility is necessary, you are not responsible for the additional hospital admission Copayment for that day.) (Autologous (self-donated) blood limited up to \$120.00 per unit.)	\$250 Copayment per day Copayment applies to a maximum of 4 days per stay
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	\$250 Copayment per day Copayment applies to a maximum of 4 days per stay
Maternity Care	\$250 Copayment per day Copayment applies to a maximum of 4 days per stay

Benefits Available While Hospitalized as an Inpatient (Continued)

Mental Health Services Severe Mental Illness (SMI) and Serious Emotional Disturbances of Children (SED) (As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and the treatment of Serious Emotional Disturbance of Children (SED). Please refer to your Supplement to the Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form (HMO) for a description of this coverage.)	\$250 Copayment per day Copayment applies to a maximum of 4 days per stay
Newborn Care ⁴	\$250 Copayment per day Copayment applies to a maximum of 4 days per stay
Physician Care	Paid in full
Reconstructive Surgery	\$250 Copayment per day Copayment applies to a maximum of 4 days per stay
Rehabilitation Care (Including physical, occupational and speech therapy)	\$250 Copayment per day Copayment applies to a maximum of 4 days per stay
Skilled Nursing Facility Care (Up to 100 consecutive calendar days from the first treatment per disability.)	\$50 Copayment per day
Voluntary Termination of Pregnancy (Medical/medication and surgical)	
– 1st trimester	\$125 Copayment
– 2nd trimester (12-20 weeks)	\$200 Copayment
– After 20 weeks, not covered unless mother's life is in jeopardy or fetus is not viable.	

Benefits Available on an Outpatient Basis

Alcohol, Drug or Other Substance Abuse Detoxification	\$35 Office Visit Copayment
Allergy Testing/Treatment (Serum is covered)	
PCP Office Visit	\$10 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	\$35 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.)	\$50 Copayment
Cancer Clinical Trials ³	Paid at contracting rate Balance (if any) is the responsibility of the Member
Cochlear Implants Device (Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply.)	\$35 Copayment
Crisis Intervention	Not covered
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply.)	\$35 Copayment
Dialysis (Physician office visit Copayment may apply.)	\$35 Copayment per treatment
Durable Medical Equipment ¹ (\$2,000 annual benefit maximum per calendar year. The annual DME benefit does not apply to nebulizers, masks, tubing and peak flow meters for the treatment of asthma for Dependent children under the age of 19. Also, the DME benefit maximum does not apply to diabetic supplies.)	\$50 Copayment per item ⁵

Benefits Available on an Outpatient Basis (Continued)

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. Does not apply to the annual Durable Medical Equipment benefit maximum.)	Paid in Full
Family Planning/Voluntary Interruption of Pregnancy	
Vasectomy	\$50 Copayment
Tubal Ligation ⁶	\$100 Copayment
(Additional Copayment for inpatient hospital benefits may apply if performed on an inpatient basis.)	
Insertion/Removal of Intra-Uterine Device (IUD)	
PCP Office Visit	\$10 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visits	\$35 Office Visit Copayment
Intra-Uterine Device (IUD)	\$50 Copayment
Removal of Norplant	
PCP Office Visit	\$10 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visits	\$35 Office Visit Copayment
Depo-Provera Injection	
PCP Office Visit	\$10 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visits	\$35 Office Visit Copayment
Depo-Provera Medication (Limited to one Depo-Provera injection every 90 days)	\$35 Copayment
Voluntary Termination of Pregnancy (Medical/medication and surgical)	
1st trimester	\$125 Copayment
2nd trimester (12-20 weeks)	\$200 Copayment
After 20 weeks, not covered unless mother's life is in jeopardy or fetus is not viable.	
Health Education Services	Paid in full
Hearing Screening	
PCP Office Visit	\$10 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit ²	\$35 Office Visit Copayment
Home Health Care Visits (Up to 100 visits per calendar year)	\$10 Copayment per visit
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)	
PCP Office Visit	\$10 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	\$35 Office Visit Copayment
Infertility Services	Not Covered
Infusion Therapy (Infusion therapy is a separate Copayment in addition to a home health or an office visit Copayment. Copayment applies per 30 days or treatment plan, whichever is shorter.)	\$100 Copayment ⁵
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 Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form (HMO) for more information on these benefits, if any. Office Visit Copayment may apply.)	\$150 Copayment per visit ⁵

Benefits Available on an Outpatient Basis (Continued)

Laboratory Services (When available through or authorized by your Participating Medical Group.)	Paid in full
Maternity Care, Tests and Procedures	\$10 Copayment per visit
Mental Health Services Severe Mental Illness (SMI) and Serious Emotional Disturbance of Children (SED) (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.) PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit	\$10 Office Visit Copayment \$35 Office Visit Copayment
Oral Surgery Services	Paid In Full ⁵
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy.)	\$35 Office Visit Copayment
Outpatient Prescription Drug Benefits ¹ (Copayment applies per Prescription Unit or up to 30 days. Please refer to your Supplement to the PacifiCare Combined Evidence of Coverage and Disclosure Form for coverage details.) Generic Formulary Brand-Name Formulary	\$10 Copayment \$35 Copayment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	\$250 Copayment per day
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.)	\$10 Office Visit Copayment
Physician Care (For children under two years of age, refer to Well-Baby Care.) PCP Office Visit Specialist/Nonphysician Health Care Practitioner Office Visit	\$10 Office Visit Copayment \$35 Office Visit Copayment
Prosthetics and Corrective Appliances	\$50 Copayment per item ⁵
Radiation Therapy Standard: (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.)	Paid in Full \$100 Copayment ⁵
Radiology Services Standard: Specialized scanning and imaging procedures: (Examples include but are not limited to CT, SPECT, PET, MRA and MRI – with or without contrast media.)	Paid in full \$50 Copayment per procedure ⁵
Specialized Footwear for Foot Disfigurement	Paid In Full

Benefits Available on an Outpatient Basis (Continued)

Vision Screening/Refraction	
PCP Office Visit	\$10 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	\$35 Office Visit Copayment
Well-Baby Care	Paid in full
(Preventive health service, including immunizations 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 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	
(Includes Pap smear (by your Primary Care Physician or an OB/GYN in your Participating Medical Group) and referral by the Participating Medical Group for screening mammography as recommended by the U.S. Preventive Services Task Force.)	
PCP Office Visit	\$10 Office Visit Copayment

¹Annual Copayment Maximum does not include Copayments for Diabetic Supplies, Durable Medical Equipment (except for nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma), Pharmacy and Supplemental Benefits.

²Copayments for audiologist and podiatrist visits will be the same as for the PCP.

³Cancer Clinical 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 Provider's billed charges and the rate negotiated by PacifiCare with Participating Providers, in addition to any applicable Copayments, coinsurance or deductibles.

⁴The 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 Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form (HMO) for more details.

⁵In instances where the negotiated rate is less than your Copayment, you will pay only the negotiated rate.

⁶Copayment applies regardless of whether this benefit is performed on an inpatient or outpatient basis. If performed on an inpatient basis, additional inpatient copayment, if any, will apply.

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 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 constitute only a summary of the Health Plan.

The Individual Health Plan HMO Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form and additional benefit materials must be consulted to determine the exact terms and conditions of coverage.

PacifiCare's most recent audited financial information is also available upon request.

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37255CA-P-1107
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PACIFICARE SIGNATUREVALUE 20-35/80
HMO SCHEDULE OF BENEFITS
EFFECTIVE FEBRUARY 1, 2008

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 2 individual maximums per family	\$2,500/individual
PCP Office Visits	\$20 Copayment
Specialist/Nonphysician Health Care Practitioner Office Visits ² (Member required to obtain referral to specialist or Nonphysician Health Care Practitioner, except for OB/GYN Physician services and Emergency/Urgently Needed Services.)	\$35 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.)	20% of cost Copayment ³
Emergency Services (Copayment waived if admitted)	\$100 Copayment
Urgently Needed Services (Medically Necessary services required outside the 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	20% of cost Copayment ³
Bone Marrow Transplants (Donor searches limited to \$15,000 per procedure)	20% of cost Copayment ³
Cancer Clinical Trials ⁴	Paid at contracting rate Balance (if any) is the responsibility of the Member.
Hospice Services (Prognosis of life expectancy of one year or less.)	20% of cost Copayment ³
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.)	20% of cost Copayment ³
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	20% of cost Copayment ³
Maternity Care	20% of cost Copayment ³

Benefits Available While Hospitalized as an Inpatient (Continued)

Mental Health Services Severe Mental Illness (SMI) and Serious Emotional Disturbances of Children (SED) (As required by state law, coverage includes treatment for Severe Mental Illness (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.)	20% of cost Copayment ³
Newborn Care ⁵	20% of cost Copayment ³
Physician Care	Paid in full
Reconstructive Surgery	20% of cost Copayment ³
Rehabilitation Care (Including physical, occupational and speech therapy)	20% of cost Copayment ³
Skilled Nursing Facility Care (Up to 100 consecutive calendar days from the first treatment per disability.)	20% of cost Copayment ³
Voluntary Termination of Pregnancy (Medical/medication and surgical)	
— 1st trimester	\$125 Copayment
— 2nd trimester (12-20 weeks)	\$200 Copayment
— After 20 weeks, not covered unless mother's life is in jeopardy or fetus is not viable.	

Benefits Available on an Outpatient Basis

Alcohol, Drug or Other Substance Abuse Detoxification	
PCP Office Visit	\$20 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	\$35 Office Visit Copayment
Allergy Testing/Treatment (Serum is covered)	
PCP Office Visit	\$20 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	\$35 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.)	\$50 Copayment
Cancer Clinical Trials ⁴	Paid at contracting rate Balance (if any) is the responsibility of the Member
Cochlear Implants Device (Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply.)	\$35 Copayment
Crisis Intervention	Not covered
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply.)	\$35 Copayment
Dialysis (Physician office visit Copayment may apply.)	\$35 Copayment per treatment
Durable Medical Equipment ¹ (\$2,000 annual benefit maximum per calendar year. The annual DME benefit does not apply to nebulizers, masks, tubing and peak flow meters for the treatment of asthma for Dependent children under the age of 19. Also, the DME benefit maximum does not apply to diabetic supplies.)	\$50 Copayment per item ⁶

Benefits Available on an Outpatient Basis (Continued)

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. Does not apply to the annual Durable Medical Equipment benefit maximum.)	Paid in Full
Family Planning/Voluntary Interruption of Pregnancy	
Vasectomy	\$50 Copayment
Tubal Ligation	\$100 Copayment
(Additional Copayment ⁷ for inpatient hospital benefits may apply if performed on an inpatient basis.)	
Insertion/Removal of Intra-Uterine Device (IUD)	
PCP Office Visit	\$20 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visits	\$35 Office Visit Copayment
Intra-Uterine Device (IUD)	\$50 Copayment
Removal of Norplant	
PCP Office Visit	\$20 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visits	\$35 Office Visit Copayment
Depo-Provera Injection	
PCP Office Visit	\$20 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visits	\$35 Office Visit Copayment
Depo-Provera Medication (Limited to one Depo-Provera injection every 90 days)	\$35 Copayment
Voluntary Termination of Pregnancy (Medical/medication and surgical)	
1st trimester	\$125 Copayment
2nd trimester (12-20 weeks)	\$200 Copayment
After 20 weeks, not covered unless mother's life is in jeopardy or fetus is not viable.	
Health Education Services	Paid in full
Hearing Screening	
PCP Office Visit	\$20 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit ²	\$35 Office Visit Copayment
Home Health Care Visits (Up to 100 visits per calendar year)	\$10 Copayment per visit
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)	
PCP Office Visit	\$20 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	\$35 Office Visit Copayment
Infertility Services	Not Covered
Infusion Therapy (Infusion therapy is a separate Copayment in addition to a home health or an office visit Copayment. Copayment applies per 30 days or treatment plan, whichever is shorter.)	\$100 Copayment ⁶
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 Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form (HMO) for more information on these benefits, if any. Office Visit Copayment may apply.)	\$150 Copayment per visit ⁶
Laboratory Services (When available through or authorized by your Participating Medical Group.)	Paid in full

Benefits Available on an Outpatient Basis (Continued)

Maternity Care, Tests and Procedures	\$20 Copayment per visit
Mental Health Services Severe Mental Illness (SMI) and Serious Emotional Disturbance of Children (SED) (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.)	
PCP Office Visit	\$20 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	\$35 Office Visit Copayment
Oral Surgery Services	\$100 Copayment ⁶
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy.)	
PCP Office Visit	\$20 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	\$35 Office Visit Copayment
Outpatient Prescription Drug Benefits ¹ (Copayment applies per Prescription Unit or up to 30 days. Please refer to your Supplement to the PacifiCare Combined Evidence of Coverage and Disclosure Form for coverage details.)	
Generic Formulary	\$20 Copayment
Brand-Name Formulary (\$100 Brand Deductible)	\$35 Copayment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	20% of cost Copayment ³
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.)	\$20 Office Visit Copayment
Physician Care (For children under two years of age, refer to Well-Baby Care.)	
PCP Office Visit	\$20 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	\$35 Office Visit Copayment
Prosthetics and Corrective Appliances	\$50 Copayment per item ⁶
Radiation Therapy Standard: (Photon beam radiation therapy.)	Paid in Full
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.)	\$100 Copayment ⁶
Radiology Services Standard:	Paid in full
Specialized scanning and imaging procedures: (Examples include but are not limited to CT, SPECT, PET, MRA and MRI – with or without contrast media.)	\$150 Copayment per procedure ⁶
Specialized Footwear for Foot Disfigurement	Paid In Full

Benefits Available on an Outpatient Basis (Continued)

Vision Screening/Refraction	
PCP Office Visit	\$20 Office Visit Copayment
Specialist/Nonphysician Health Care Practitioner Office Visit	\$35 Office Visit Copayment
Well-Baby Care	Paid in full
(Preventive health service, including immunizations 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 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	
(Includes Pap smear (by your Primary Care Physician or an OB/GYN in your Participating Medical Group) and referral by the Participating Medical Group for screening mammography as recommended by the U.S. Preventive Services Task Force.)	
PCP Office Visit	\$20 Office Visit Copayment

¹Annual Copayment Maximum does not include Copayments for Diabetic Supplies, Durable Medical Equipment (except for nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma), Pharmacy and Supplemental Benefits.

²Copayments for audiologist and podiatrist visits will be the same as for the PCP.

³Percentage Copayment amounts are based upon the PacifiCare negotiated rate.

⁴Cancer Clinical 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 Provider's billed charges and the rate negotiated by PacifiCare with Participating Providers, in addition to any applicable Copayments, coinsurance or deductibles.

⁵The 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 Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form (HMO) for more details.

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

⁷Copayment applies regardless of whether this benefit is performed on an inpatient or outpatient basis. If performed on an inpatient basis, additional inpatient copayment, if any, will apply.

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 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 constitute only a summary of the Health Plan.

The Individual Health Plan HMO Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form and additional benefit materials must be consulted to determine the exact terms and conditions of coverage.

PacifiCare's most recent audited financial information is also available upon request.

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PACIFICARE SIGNATUREVALUE 35/70
HMO SCHEDULE OF BENEFITS

EFFECTIVE FEBRUARY 1, 2008

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 No family maximum	\$5,000/individual
Office Visits	\$35 Copayment
Hospitalization (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.)	30% of cost Copayment ²
Emergency Services (Copayment not waived if admitted)	\$100 Copayment
Urgently Needed Services (Medically Necessary services required outside the geographic area served by your Participating Medical Group. Please consult your brochure for additional details. Copayment not waived if admitted.)	\$100 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	30% of cost Copayment ²
Bone Marrow Transplants (Donor searches limited to \$15,000 per procedure)	30% of cost Copayment ²
Cancer Clinical Trials ³	Paid at contracting rate Balance (if any) is the responsibility of the Member.
Hospice Services (Prognosis of life expectancy of one year or less.)	30% of cost Copayment ²
Hospital Benefits (Autologous (self-donated) blood up to \$120.00 per unit.)	30% of cost Copayment ²
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	30% of cost Copayment ²
Maternity Care	30% of cost Copayment ²
Mental Health Services Severe Mental illness (SMI) and Serious Emotional Disturbance of Children (SED) (As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and the treatment of Serious Emotional Disturbance of Children (SED). Please refer to your Supplement to the Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form (HMO) for a description of this coverage.)	30% of cost Copayment ²
Newborn Care ⁶	30% of cost Copayment ²

Benefits Available While Hospitalized as an Inpatient (continued)

Physician Care	Paid in full
Reconstructive Surgery	30% of cost Copayment ²
Rehabilitation Care (including physical, occupational and speech therapy)	30% of cost Copayment ²
Skilled Nursing Care (Up to 100 consecutive calendar days from the first treatment per admission.)	30% of cost Copayment ²
Voluntary Termination of Pregnancy (Medical/medication and surgical)	
– 1st trimester	\$125 Copayment
– 2nd trimester (12–20 weeks)	\$200 Copayment
After 20 weeks, not covered unless mother's life is in jeopardy or fetus is not viable.	

Benefits Available on an Outpatient Basis

Alcohol, Drug or Other Substance Abuse - Detoxification	\$35 Office Visit Copayment
Allergy Testing/Treatment (Serum is covered)	\$35 Office Visit Copayment
Ambulance (Only one ambulance Copayment per trip may be applicable. If a subsequent ambulance transfer to another facility is necessary, the Member is not responsible for the additional ambulance Copayment.)	\$50 Copayment
Cancer Clinical Trials ³	Paid at contracting rate Balance (if any) is the responsibility of the member
Cochlear Implant Device (Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply.)	\$35 Copayment ⁴
Crisis Intervention	Not covered
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply.)	\$35 Copayment
Dialysis (Physician office visit Copayment may apply.)	\$35 Copayment per treatment
Durable Medical Equipment ¹ (\$2,000 annual benefit maximum per calendar year. The annual DME benefit does not apply to nebulizers, masks, tubing and peak flow meters for the treatment of asthma for Dependent children under the age of 19. Also, the DME benefit maximum does not apply to diabetic supplies.)	\$50 Copayment ⁴
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. Does not apply to the annual Durable Medical Equipment benefit maximum.)	Paid in Full

Benefits Available on an Outpatient Basis (Continued)

Family Planning/Voluntary Interruption of Pregnancy	
Vasectomy	\$50 Copayment
Tubal Ligation ⁵	\$100 Copayment
(Additional Copayment for inpatient hospital benefits may apply if performed on an inpatient basis.)	
Insertion/Removal of Intra-Uterine Device (IUD)	\$35 Office Visit Copayment
Intra-Uterine Device (IUD)	\$50 Copayment
Removal of Norplant	\$35 Office Visit Copayment
Depo-Provera Injection	\$35 Office Visit Copayment
Depo-Provera Medication (Limited to one Depo-Provera injection every 90 days)	\$35 Copayment
Voluntary Termination of Pregnancy(Medical/medication and surgical)	
1st trimester	\$125 Copayment
2nd trimester (12–20 weeks)	\$200 Copayment
After 20 weeks, not covered unless mother's life is in jeopardy or fetus is not viable.	
Health Education Services	Paid in full
Hearing Screening	\$35 Office Visit Copayment
Home Health Care Visits (Up to 100 visits per calendar year)	\$10 Copayment per visit
Hospice Care (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)	\$35 Office Visit Copayment
Infertility Services	Not Covered
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.)	\$100 Copayment ⁴
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 Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form (HMO) for more information on these benefits, if any. Office Visit Copayment may apply.)	\$100 Copayment per visit ⁴
Laboratory Services (When available through or authorized by your Participating Medical Group.)	Paid in full
Maternity Care, Tests and Procedures	\$35 Office Visit Copayment
Mental Health Services Severe Mental Illness (SMI) and Serious Emotional Disturbance of Children (SED) (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.)	\$35 Office Visit Copayment
Oral Surgery Services	\$200 Copayment ⁴
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy.)	\$35 Office Visit Copayment

Benefits Available on an Outpatient Basis (Continued)

<p>Outpatient Prescription Drug Benefits¹ (Copayment applies per Prescription Unit or up to 30 days. Please refer to your Supplement to the Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form (HMO) for coverage details.)</p> <p>Generic Formulary \$20 Copayment Brand-Name Formulary \$35 Copayment</p>
<p>Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Center 30% of cost Copayment⁴</p>
<p>Periodic Health Evaluations \$35 Office Visit Copayment (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.)</p>
<p>Physician Care \$35 Copayment (For children under two years of age, refer to Well-Baby Care.)</p>
<p>Prosthetics and Corrective Appliances \$50 Copayment per item⁴</p>
<p>Radiation Therapy</p> <p>Standard: Paid in full (Photon beam radiation therapy.)</p> <p>Complex: \$400 Copayment⁴ (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; GammaKnife and stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount, if any.)</p>
<p>Radiology Services</p> <p>Standard: Paid in full Specialized scanning and imaging procedures: \$200 Copayment per procedure⁴ (Examples include but are not limited to CT, SPECT, PET, MRA and MRI – with or without contrast media.)</p>
<p>Specialized Footwear for Foot Disfigurement Paid In Full</p>
<p>Vision Screening/Refractions \$35 Office Visit Copayment</p>
<p>Well-Baby Care Paid in full (Preventive health service, including immunizations 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 for children under two years of age. The applicable office visit Copayment applies to infants that are ill at time of services.)</p>
<p>Well-Woman Care \$35 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 U.S. Preventive Services Task Force.)</p>

¹Annual Copayment Maximum does not include Copayments for Diabetic Supplies, Durable Medical Equipment (except for nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma), Pharmacy and Supplemental Benefits.

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

³Cancer Clinical 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.

⁴In instances where the negotiated rate is less than your Copayment, you will pay only the negotiated rate.

⁵Copayment applies regardless of whether this benefit is performed on an inpatient or outpatient basis. If performed on an inpatient basis, additional inpatient copayment, if any, will apply.

⁶The 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 Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form (HMO) for more details.

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 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 constitute only a summary of the Health Plan.

The Individual Health Plan HMO Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form and additional benefit materials must be consulted to determine the exact terms and conditions of coverage.

P.O. Box 6006
Cypress, CA 90630

Customer Service:
(800) 624-8822
(800) 442-8833 (TDHI)
www.pacificare.com

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PACIFICARE SIGNATUREVALUE 35/50
HMO SCHEDULE OF BENEFITS

EFFECTIVE FEBRUARY 1, 2008

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 No family maximum	\$5,000/individual
Office Visits	\$35 Copayment
Hospitalization (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.)	50% of cost Copayment ²
Emergency Services (Copayment not waived if admitted)	\$100 Copayment
Urgently Needed Services (Medically Necessary services required outside the geographic area served by your Participating Medical Group. Please consult your brochure for additional details. Copayment not 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 and Detoxification	50% of cost Copayment ²
Bone Marrow Transplants (Donor searches limited to \$15,000 per procedure)	50% of cost Copayment ²
Cancer Clinical Trials ³	Paid at contracting rate Balance (if any) is the responsibility of the Member.
Hospice Services (Prognosis of life expectancy of one year or less.)	50% of cost Copayment ²
Hospital Benefits (Autologous (self-donated) blood up to \$120.00 per unit.)	50% of cost Copayment ²
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	50% of cost Copayment ²
Maternity Care	50% of cost Copayment ²
Mental Health Services Severe Mental illness (SMI) and Serious Emotional Disturbance of Children (SED). (As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and the treatment of Serious Emotional Disturbance of Children (SED). Please refer to your Supplement to the Subscriber Agreement /Combined Evidence of Coverage and Disclosure Form (HMO) for a description of this coverage.)	50% of cost Copayment ²
Newborn Care ⁶	50% of cost Copayment ²

Benefits Available While Hospitalized as an Inpatient (continued)

Physician Care	Paid in full
Reconstructive Surgery	50% of cost Copayment ²
Rehabilitation Care (including physical, occupational and speech therapy)	50% of cost Copayment ²
Skilled Nursing Care (Up to 100 consecutive calendar days from the first treatment per admission.)	50% of cost Copayment ²
Voluntary Termination of Pregnancy (Medical/medication and surgical)	
— 1st trimester	\$125 Copayment
— 2nd trimester (12–20 weeks)	\$200 Copayment
After 20 weeks, not covered unless mother's life is in jeopardy or fetus is not viable.	

Benefits Available on an Outpatient Basis

Alcohol, Drug or Other Substance Abuse - Detoxification	\$35 Office Visit Copayment
Allergy Testing/Treatment (Serum is covered)	\$35 Office Visit Copayment
Ambulance (Only one ambulance Copayment per trip may be applicable. If a subsequent ambulance transfer to another facility is necessary, the Member is not responsible for the additional ambulance Copayment.)	\$50 Copayment
Cancer Clinical Trials ³	Paid at contracting rate Balance (if any) is the responsibility of the member
Cochlear Implant Device (Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply.)	\$100 Copayment ⁴
Crisis Intervention	Not covered
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply.)	\$35 Copayment
Dialysis (Physician office visit Copayment may apply.)	\$100 Copayment per treatment
Durable Medical Equipment ¹ ((\$2,000 annual benefit maximum per calendar year. The annual DME benefit does not apply to nebulizers, masks, tubing and peak flow meters for the treatment of asthma for Dependent children under the age of 19. Also, the DME benefit maximum does not apply to diabetic supplies.)	\$50 Copayment ⁴
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. Does not apply to the annual Durable Medical Equipment benefit maximum.)	Paid in Full

Benefits Available on an Outpatient Basis (continued)

Family Planning/Voluntary Interruption of Pregnancy	
Vasectomy	\$50 Copayment
Tubal Ligation ⁵	\$100 Copayment
(Additional Copayment for inpatient hospital benefits may apply if performed on an inpatient basis.)	
Insertion/Removal of Intra-Uterine Device (IUD)	\$35 Office Visit Copayment
Intra-Uterine Device (IUD)	\$50 Copayment
Removal of Norplant	\$35 Office Visit Copayment
Depo-Provera Injection	\$35 Office Visit Copayment
Depo-Provera Medication (Limited to one Depo-Provera injection every 90 days)	\$35 Copayment
Voluntary Termination of Pregnancy(Medical/medication and surgical)	
1st trimester	\$125 Copayment
2nd trimester (12–20 weeks)	\$200 Copayment
After 20 weeks, not covered unless mother’s life is in jeopardy or fetus is not viable.	
Health Education Services	Paid in full
Hearing Screening	\$35 Office Visit Copayment
Home Health Care Visits (Up to 100 visits per calendar year)	\$10 Copayment per visit
Hospice Care (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)	\$35 Office Visit Copayment
Infertility Services	Not Covered
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.)	\$100 Copayment ⁴
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 Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form (HMO) for more information on these benefits, if any. Office Visit Copayment may apply.)	\$150 Copayment per visit ⁴
Laboratory Services (When available through or authorized by your Participating Medical Group.)	Paid in full
Maternity Care, Tests and Procedures	\$35 Office Visit Copayment
Mental Health Services Severe Mental Illness (SMI) and Serious Emotional Disturbance of Children (SED) (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.)	\$35 Office Visit Copayment
Oral Surgery Services	\$200 Copayment ⁴
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy.)	\$35 Office Visit Copayment

Benefits Available on an Outpatient Basis (continued)

<p>Outpatient Prescription Drug Benefits¹ (Copayment applies per Prescription Unit or up to 30 days. Please refer to your Supplement to the Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form (HMO) for coverage details.)</p> <p>Generic Formulary \$20 Copayment Brand-Name Formulary \$35 Copayment</p>
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³Cancer Clinical 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.

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⁵Copayment applies regardless of whether this benefit is performed on an inpatient or outpatient basis. If performed on an inpatient basis, additional inpatient copayment, if any, will apply.

⁶The 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 Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form (HMO) for more details.

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 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 constitute only a summary of the Health Plan.

The Individual Health Plan HMO Subscriber Agreement/Combined Evidence of Coverage and Disclosure Form and additional benefit materials must be consulted to determine the exact terms and conditions of coverage.

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MANAGED TIERED
HMO PHARMACY SCHEDULE OF BENEFITS

Summary of Benefits	Generic Formulary	Brand-Name Formulary
Retail Pharmacy Copayment per Prescription Unit or up to 30 days	\$10	\$35
Mail Service Pharmacy Copayment up to 3 Prescription Units or up to 90 days	\$20	\$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 Copayment of just \$10. Contact PacifiCare’s Customer Service department for Formulary information.

Preauthorization for all Non-Formulary Drugs

All non-Formulary drugs must be Preauthorized by PacifiCare as Medically Necessary in order to be covered under this pharmacy benefit. If approved, you will pay the applicable generic or brand-name Copayment. Non-Formulary drugs that are not otherwise excluded from coverage may be Preauthorized as Medically Necessary in the following instances. (See “Exclusions and Limitations” section of this *Pharmacy Schedule of Benefits* for those medications that are excluded from coverage):

- No Formulary alternative is appropriate and the drug is Medically Necessary for patient care, as determined by PacifiCare and consistent with professional practice.
- The Formulary alternative has failed after a therapeutic trial. Your Participating Physician will be asked to provide a copy of the medical chart notes specifically stating treatment failure with the Formulary alternative.
- The Formulary alternative is not appropriate as determined by a review of Physician chart notes.

- You have been under treatment and remain stable on a non-Formulary prescription drug previously approved by PacifiCare as Medically Necessary that is not excluded from coverage and changing to a Formulary drug is medically inappropriate.
- Your Participating Physician provides evidence in the form of documents, records or clinical trials which establishes that use of the requested non-Formulary drug over the Formulary drug is Medically Necessary, as determined by PacifiCare.

Preauthorization for Selected Formulary Drugs

Selected Formulary drugs must also be Preauthorized by PacifiCare to determine that they are Medically Necessary and being prescribed according to treatment guidelines consistent with standard professional practice to be eligible for coverage. If approved, you will pay the applicable generic or brand-name Copayment. For a list of the Formulary medications that require PacifiCare’s Preauthorization, please contact PacifiCare’s Customer Service department.

Please note: If you are prescribed a non-Formulary or Selected Formulary medication for acute treatment that requires immediate use upon Hospital discharge, an urgent care or emergency room visit after normal business hours, you may receive a one-time authorization for coverage. You will need to obtain Preauthorization before refilling this prescription.

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. For brand-name drugs that have Food and Drug Administration (FDA)-approved equivalents, a prescription may be filled with a generic drug unless a specific brand-name drug is Medically Necessary and Preauthorized by PacifiCare, or is on PacifiCare's Selected Brands List. Preauthorization is necessary even if your Physician writes "Dispense as Written" or "Do Not Substitute" on your prescription. 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. If you choose to use a medication not included on the Formulary and not Preauthorized by PacifiCare, you will be responsible for the full retail price of the medication. However, you have the option of selecting a non-Formulary brand-name drug that has a generic equivalent on the Formulary at a cost that is generally lower than retail. The cost is the generic Copayment plus the difference between PacifiCare's contracted rate for the generic and brand-name drugs. You will not pay a rate higher than PacifiCare's contracted rate for the brand-name drug. If the brand-name drug with the generic equivalent is Medically Necessary, it may be Preauthorized by PacifiCare. If it is approved, you will only pay your brand-name Copayment.
- **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.
- **State Restricted Drugs:** Any medicinal substance that may be dispensed by prescription only, according to state law.

Exclusions and Limitations

While the prescription drug benefit covers most medications, there are some Drugs 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 under your medical benefit.

- **Administered Drugs:** Drugs or medicines delivered or administered to the Member by the prescriber or the prescriber's staff is 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* entitled "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 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, sexual performance, 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 Investigation 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 upon the purpose for which they are prescribed, as part of the home health or durable medical equipment benefit. Refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* for additional information.
- **Sexual Dysfunction Medication:** All forms of medications when prescribed for the treatment of sexual dysfunction, which includes, but is not limited to, erectile dysfunction, impotence, anorgasmia or hyporgasmia, are not covered. An example of such medications includes Viagra.
- **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, entitled "Your Medical Benefits" under "Outpatient Benefits" located, for example, in subsections titled "Diabetic Self Management," "Durable Medical Equipment," "Home Health Care" or "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.

Questions? Call the HMO Customer Service department at 1-800-624-8822 or TDHI 1-800-442-8833.

OUTPATIENT PRESCRIPTION DRUG BENEFIT

Supplement to the Combined Evidence of Coverage and Disclosure Form

Understanding Your Outpatient Prescription Drug Benefit

This brochure contains important information for our Members about the PacifiCare outpatient prescription drug benefit. As part of PacifiCare's commitment to you, we want to provide you with the tools that will help you better understand and utilize your Pharmacy and Prescription Drug Plan. In an effort to eliminate confusion, PacifiCare has provided you with answers for your pharmacy questions such as:

- What is a Formulary?
- What is the difference between a brand-name and generic drug?
- Who can write my prescription?
- What happens in emergency situations?
- What is the Mail Service Pharmacy program?
- What is Preauthorization?

What else should I read to understand my pharmacy benefits?

We want our Members to get the most from their prescription drug benefit plan, so please read this Supplement to the Combined Evidence of Coverage and Disclosure Form ("Supplement") carefully. You need to become familiar with the terms used for explaining your coverage because understanding these terms is essential to understanding your benefit. Along with reading this publication, be sure to review your Pharmacy Schedule of Benefits. Your Pharmacy Schedule of Benefits provides the details of your particular pharmacy benefit plan, including the exclusions and limitations, applicable Copayments and PacifiCare's Preauthorization process. Together, these documents explain your outpatient pharmacy coverage. These documents should be read completely and carefully for a comprehensive understanding of your outpatient pharmacy benefits.

Your medical Combined Evidence of Coverage and Disclosure Form and Schedule of Benefits together with this Supplement to the Combined Evidence of Coverage and Disclosure Form and the Pharmacy Schedule of Benefits provide the terms and conditions of your benefit coverage. All applicants have a right to view these documents prior to enrollment.

What is covered, what is not?

PacifiCare covers Medically Necessary drugs that are not otherwise excluded from coverage by PacifiCare, and Preauthorization may be required. Refer to your Pharmacy Schedule of Benefits for a description of covered medications as well as the limitations and exclusions for certain medications.

Formulary Drugs

What is a Formulary?

A Formulary is a list that contains a broad range of Food-and-Drug-Administration (FDA)-approved generic and some brand-name medications that are covered under your prescription drug benefit. Please refer to your Pharmacy Schedule of Benefits to determine how the Formulary applies to your prescription drug benefit.

Why are Formularies necessary?

Medication costs continue to rise. Formularies list those medications that offer value while maintaining quality of care to help reduce health care and premium costs.

Who decides which medications are on the Formulary?

Medications are added or deleted from the Formulary only after careful review by a committee of practicing Physicians and pharmacists. This committee, called a Pharmacy and Therapeutics (P&T) Committee, has the responsibility of reviewing new and existing drugs. This committee decides which drugs provide quality treatment at the best value. Updates occur quarterly; however, in certain situations, drugs may be added or removed to the Formulary more frequently. You may obtain a copy of the Formulary by contacting Customer Service or from PacifiCare's Web site at **www.pacificare.com**.

Please remember that the inclusion of a specific drug on the Formulary does not guarantee that your Participating Physician will prescribe that drug for treatment of a particular condition.

What if my outpatient prescription medication is not on the Formulary?

Formularies list alternative medications, which are designed to be safe and effective. These medications generally have the same effect on your body. If your medication is not listed on PacifiCare's Formulary, ask

your Participating Physician or Participating Pharmacist for an alternative prescription medication that is on the Formulary and medically appropriate for you. For information on Preauthorization, please refer to your Pharmacy Schedule of Benefit.

How is a medication added or deleted from the Formulary?

A medication must first demonstrate safety and effectiveness to be added to the Formulary. Only after this is determined is the cost of the medication considered. Some medications have similar safety and effectiveness, but one or two are available at a lower cost. In these cases, the least costly medications are added to the Formulary.

When does the Formulary change? If a change occurs, will I have to pay more to use a drug I had been using?

The National Pharmacy and Therapeutics Committee meets regularly, at least four times a year, to review the Formulary and add or remove medications. Our Formulary books are printed and distributed to your Participating Physicians on a regular basis and any changes to the Formulary are also communicated to your Participating Physician on a regular basis. We also make available on our Web site a listing of the most recent Formulary changes. See the section "Recent Formulary Changes" on the pharmacy page of our Web site. Refer to your Pharmacy Schedule of Benefits to find out if your Copayments are dependent on Formulary status.

If you are currently taking a prescription drug that is covered by PacifiCare for a specific medical condition and PacifiCare removes that drug from the Formulary, PacifiCare will continue to cover that drug. It will be covered provided your Participating Physician continues to prescribe the drug for your specific medical condition and provided that the drug is appropriately prescribed and continues to be considered safe and effective for treatment of your medical condition. Continued coverage is subject to all terms and conditions of your PacifiCare Health Plan, including the exclusions and limitations of your Pharmacy Schedule of Benefits.

Generic Prescription Drugs

What is the difference between generic and brand-name drugs?

When a new drug is put on the market, for many years it is typically available only under a manufacturer's brand name. At first, this new drug is protected by a patent. Only after the patent expires are competing manufacturers allowed to offer the same drug. This type of drug is called a generic drug.

While the name of the drug may not be familiar to you, a generic drug has the same medicinal benefits as its brand-name competitor. In fact, a manufacturer must provide proof to the Food and Drug Administration (FDA) that a generic drug has the identical active chemical

compound as the brand-name product. A generic product must meet rigid FDA standards for strength, quality, purity and potency.

Only when a generic drug meets these standards is it considered the brand-name drug's equivalent. When the FDA approves a new generic drug, PacifiCare may choose to replace the brand-name drug on the Formulary with the generic drug.

NOTE: If you have a question about our Formulary or a particular drug, please contact PacifiCare's Customer Service department at 1-800-624-8822 or TDHI 1-800442-8833 or visit PacifiCare's Web site at **www.pacificare.com**.

Therapeutic Substitution of Medication

If there is no generic equivalent available for a specific brand-name drug, your Physician may prescribe a therapeutic substitute instead. Unlike a generic, which has the identical active ingredient as the brand-name version, a therapeutic substitute has a chemical composition that is different but acts similarly in clinical and therapeutic ways when compared to competing brand-name counterparts. If your Physician specifies therapeutic substitution, you will receive the therapeutic substitution medication and pay the applicable Copayment. (Refer to your Schedule of Benefits for the amount of your Copayment.)

Filling Your Prescription

Who can write my prescription?

Generally, to be eligible for coverage, your prescription must be written by a Participating Physician. There are two exceptions to this rule. The first is when the prescription is written by a Non-Participating Physician who has been preapproved by PacifiCare to treat you. The second exception is when a drug is prescribed for Emergency Services or Urgently Needed Services when you are out of the area. Emergency Service or Urgently Needed Service is defined in your medical Combined Evidence of Coverage and Disclosure Form.

How do I use my prescription drug benefit?

Your outpatient prescription drug benefit helps to cover the cost for some of the outpatient medications prescribed by a PacifiCare Participating Physician. Using your benefit is simple.

- Obtain your prescription from your PacifiCare Participating Physician.
- Present your prescription for a covered outpatient medication and PacifiCare Member ID card at any PacifiCare Participating Pharmacy. If ordering by phone, be sure to mention that you are a PacifiCare Member. Note that some prescription medications must be Preauthorized by PacifiCare.
- Pay the applicable Copayment (refer to your Schedule of Benefits for the amount of your Copayment) for a Prescription Unit or its retail cost, whichever is less.

- Receive your medication.

How much do I have to pay to get a prescription filled?

Refer to your Pharmacy Schedule of Benefits for specific details and Copayment amounts.

Where do I go to fill a prescription?

PacifiCare has a well-established network of pharmacies including most major pharmacy and supermarket chains as well as many independent pharmacies. A listing of Participating Pharmacies is available in the back of this brochure. Contact our Customer Service department at 1-800-624-8822 or TDHI 1-800-442-8833 to help locate a Participating Pharmacy near you or visit our Web site at www.pacificare.com for an up-to-date list.

When do I request a refill?

You may refill a prescription when a minimum of seventy-five percent (75%) of the quantity is consumed based on the days' supply.

I take maintenance medication on a continuing basis. How can I have my prescriptions filled when I am on vacation?

The most convenient and affordable way to obtain maintenance medications is to obtain a 90-day supply through our mail service program (for additional details refer to the Mail Service section in this document). It is important to plan ahead because it takes approximately seven days to receive your 90-day supply from the mail service program. Early refills for vacation are also available from Participating Pharmacies in certain circumstances – talk with your pharmacist about obtaining a vacation override. Our Customer Service Associates can also help you with planning for your medication needs while traveling – call 1-800-624-8822 or TDHI 1-800-442-8833.

What if I am sick and need a prescription when I'm away from home?

If you are sick and need an outpatient prescription medication filled when away from home, you may visit one of our Participating Pharmacies within our national pharmacy network and receive the medication for the applicable Copayment. For the nearest network pharmacy, contact Customer Service at 1-800-624-8822 or TDHI 1-800-442-8833 or visit our Web site at www.pacificare.com.

What happens in an emergency situation?

While in most circumstances you must fill your prescription at a Participating Pharmacy, you may fill your prescription for outpatient medication at a Non-Participating Pharmacy in an emergency or urgent situation. In such situations, you must pay the total cost of the prescription at the time you receive the medication, and you will be reimbursed by PacifiCare for the cost of the medication, less the applicable Copayment. However, if PacifiCare determines that you obtained the prescription medication from a Non-

Participating Pharmacy without an emergency or urgent situation, you will be responsible for the total cost of the medication, and PacifiCare will not reimburse you.

To obtain reimbursement for emergency or urgently needed prescription medications, you must follow the instructions below under "How do I obtain reimbursement?" You are only eligible for reimbursement for prescriptions related to urgent or emergency situations as defined by PacifiCare (refer to your medical Combined Evidence of Coverage and Disclosure Form) less the applicable Copayment.

Remember: You should only fill a prescription at a Non-Participating Pharmacy in an urgent or emergency situation.

How do I obtain reimbursement?

Call the Customer Service department at 1-800-624-8822 or TDHI 1-800-442-8833 or visit PacifiCare's Web site at www.pacificare.com to obtain the Direct Reimbursement Form. Provide the following: Direct Member Reimbursement Form; copies of the prescription receipts showing the prescription number, name of the medication, date filled, pharmacy name, name of the Member for whom the prescription was written, proof of payment, and a description of why a PacifiCare Participating Pharmacy was not available. Send these documents to: PacifiCare Pharmacy Department, P.O. Box 6037, Cypress, CA 90630.

You should submit the Direct Reimbursement Form within 90 days, or as soon as reasonably possible from the date of service. Payment will be forwarded to you once your request for reimbursement is determined by PacifiCare to be appropriate.

Emergency After-hours

PacifiCare will cover an emergency after-hours prescription without Preauthorization in the following situations:

- The prescription is for medication in conjunction with a Hospital discharge, emergency room or urgent care facility visit limited to a 7 days' supply except for antibiotics which may be dispensed in up to a fifteen (15)-day supply.
- Medications used for acute treatment and immediate use is required.
- Any time the prescribing Physician states that failure to supply the medication will result in a severe medical event or Hospital admission.

Note: After-hours Preauthorization will not be approved for any of the following situations:

- Continuation of a restricted medication based solely on a previous authorization or previous use.
- A change to an existing Preauthorization to extend the days' supply.
- A change to an existing Preauthorization to correct erroneous information.

- Early refills of maintenance medications.
- Early refills for signature changes or dosage changes.

When I fill a prescription, how much medication do I receive?

For a single Copayment, Members receive one Prescription Unit, which represents a maximum of one month's (30 days' supply) fill of outpatient prescription medication that can be obtained at one time. For most oral medications, a Prescription Unit is up to a 30-day supply of medication.

Medications dispensed in quantities other than the 30-day supply maximum are listed below:

- **Medications with quantity limitations:** The Prescription Unit for some medications may be set at a smaller quantity to promote appropriate medication use and patient safety. These quantity limits are based on generally accepted pharmaceutical practices and the manufacturer's labeling. For example, antibiotics typically require less than a 30-day supply; and certain drugs, such as controlled substances and migraine medications, may be limited due to the expectation of patient need and in accordance with manufacturer's recommended dosages. Drugs with quantity limitations may be dispensed in greater quantities if Medically Necessary and Preauthorized by PacifiCare.
- **Defined or prepackaged units of medications:** Prescriptions such as inhalers, eye drops, creams or other types of medications that are normally dispensed in prepackaged or defined units of 30 days or less will be considered a single Prescription Unit.
- **Medication obtained through PacifiCare's Mail Service program:** If you use the PacifiCare Mail Service Pharmacy program, you will receive three Prescription Units or up to a 90-day supply of maintenance medications (except for prepackaged medications as described above).

PacifiCare's Mail Service Program

What is the Mail Service Pharmacy program?

PacifiCare offers a Mail Service Pharmacy program through **Prescription Solutions**®. The Mail Service Pharmacy program provides convenient service and savings on maintenance medications that you may take on a regular basis by allowing you to purchase certain drugs for receipt by mail. You get quality medications mailed directly to your home or address of your choice within the United States in a discreetly labeled envelope to ensure privacy and safety. Shipping and handling is at no additional charge.

If you use our Mail Service Pharmacy program, you will generally get your maintenance medication within seven (7) working days after receipt of your order. All orders are shipped in discreetly labeled envelopes for privacy and safety.

Here's how to fill prescriptions through the Mail Service Pharmacy program.

1. Call your Participating Physician to obtain a new prescription for each medication. When you call, ask the Physician to write the prescription for a 90-day supply, which represents three (3) Prescription Units with up to three (3) additional refills. The doctor will tell you when to pick up the written prescription. (Note: Prescription Solutions must have a new prescription to process any new mail service request.)
2. After picking up the prescription, complete the Mail Service Form included in your enrollment materials. (To obtain additional forms or for assistance in completing the form, call PacifiCare's Customer Service department at 1-800-624-8822 or TDHI 1-800-442-8833. You can also find the form at the Web site address www.rxsolutions.com.)
3. Enclose the prescription and appropriate Copayment via check, money order or credit card. Your Pharmacy Schedule of Benefits will have the applicable Copayment for the Mail Service Pharmacy program. Make the check or money order payable to **Prescription Solutions**®. No cash please.

When you receive your prescription, you'll get detailed instructions that tell you how to take the medication, possible side effects and any other important information about the medication. If you have questions, registered pharmacists are available to help you by calling **Prescription Solutions**® at 1-800-562-6223 or TDHI 1-800-498-5428.

Note: Medications such as Schedule II substances (e.g., Morphine, Ritalin and Dexedrine), antibiotics, drugs used for short-term or acute illnesses, and drugs that require special packaging (including refrigeration) are not available through our Mail Service Pharmacy program. Prescription medications prescribed for the treatment of sexual dysfunction are not available through the Mail Service Pharmacy program.

Important Tip: If you are starting a new medication, please request two prescriptions from your Participating Physician. Have one filled immediately at a Participating Pharmacy while mailing the second prescription to PacifiCare's Mail Service Pharmacy. Once you receive your medication through the mail service, you should stop filling the prescription at the Participating Pharmacy.

Preauthorization

What is Preauthorization?

PacifiCare covers Medically Necessary prescription medications when prescribed by a Participating Physician, and Preauthorization may be required. For example, medications when prescribed for cosmetic purposes such as wrinkle creams, are not generally covered. Medication quantities may also be limited to ensure that they are being used safely and effectively, and Copayments, exclusions and limitations vary. Please be sure to read your Pharmacy Schedule of Benefits, which describes the details of your prescription drug coverage, including the types of medications that require Preauthorization and that are limited or excluded. Prescriptions that require Preauthorization will be charged at the applicable Copayment if approved.

We want to make sure our Members receive optimal care, and appropriate medication use is a big part of maintaining your overall health. That is why we have systems in place to make sure your medication is Medically Necessary and prescribed according to treatment guidelines consistent with standard professional practice. We also want to make sure you are not taking more medication than you need or are taking medication for a longer period of time than is necessary, and that you are receiving follow-up care. PacifiCare reserves the right to require Preauthorization and/or limit the quantity of any prescription. The following is a list of factors that PacifiCare takes into consideration when completing a Preauthorization review:

- The prescription is for the treatment of a covered medical condition and the expected beneficial effects of the prescription outweigh the harmful effects.
- There is sufficient evidence to draw conclusions about the effect of the prescription on the medical condition being treated and on your health outcome.
- The prescription represents the most cost-effective method to treat the medical condition.
- The prescription drug is prescribed according to established, documented and approved indications that are supported by the weight of scientific evidence.

What do I do if I need Preauthorization?

We understand that situations may arise in which it may be Medically Necessary to take a medication above the preset limits or for a particular condition/circumstance. In these instances, since your Participating Physician understands your medical history and health conditions, he/she can request Preauthorization. We have made the process simple and easy. Your Participating Physician can call or fax the Preauthorization request to **Prescription Solutions**[®], which is PacifiCare's pharmacy benefit manager. The Preauthorization staff of qualified pharmacists and technicians is available Monday through Friday from 6:00 a.m. to 6:00 p.m. to

assist Participating Physicians. Most authorizations are completed within 24 hours. The most common reason for delay in the authorization process is insufficient information. Your Participating Physician may need to provide information on diagnosis and medication history and/or evidence in the form of documents, records or lab tests which establish that the use of the requested medication meets plan criteria.

Does this plan limit or exclude certain drugs my health care provider may prescribe or encourage substitutions for some drugs?

Your PacifiCare pharmacy benefit provides you access to a wide range of FDA-approved brand-name and generic medications. The Formulary is developed with the input from Participating Physicians and pharmacists and is based on assessment of the drug's quality, safety, effectiveness and cost. If a medication is not included on the Formulary, it may be because the Plan's Formulary includes other drugs that are frequently prescribed for the same condition as those that are not included on the Formulary. For example, PacifiCare may have an equivalent generic medication on the Formulary for the brand-name medication prescribed by your Participating Physician. It is also important to remember there may be other options available for treating a particular medical condition. Non-Formulary medications may require Preauthorization and will be approved when Medically Necessary unless otherwise excluded by PacifiCare as described in the "Exclusions and Limitations" section of the Pharmacy Schedule of Benefits. Refer to the Section titled "What do I do if I need Preauthorization" in this document for additional information.

What should I do if I want to appeal a Preauthorization decision?

As a PacifiCare Member, you have the right to appeal any Preauthorization decision. Contact Customer Service at 1-800-624-8822 or TDHI 1-800-442-8833 for details on the Preauthorization or appeals process. Please refer to Section Eight of your medical Combined Evidence of Coverage and Disclosure Form for more details on the appeals process and the expedited review process.

Helpful tips:

- Take your medications list with you to the doctor's office.
- Ask your doctor if the drug prescribed is on the PacifiCare Formulary.
- Talk with your doctor about Formulary alternative medications to treat your medical condition.
- You and your doctor can access the most current Formulary information on our Web site at **www.pacificare.com** including information on Formulary alternatives.

Definitions

Contract Year - The twelve-month period that begins on the first day of the month the Agreement became effective.

Calendar Year - The time period beginning on January 1st and ending on December 31st.

Formulary - The Formulary is a list that contains a broad range of FDA-approved generic and some brand-name medications that under state or federal law are to be dispensed by a prescription only. The Formulary does not include all prescription medications.

Non-Participating Pharmacy - A pharmacy that has NOT contracted with PacifiCare to provide outpatient prescription drugs to our Members.

Non-Participating Physician - A Physician that has NOT contracted with PacifiCare to provide health care services to our Members.

Participating Pharmacy - A pharmacy that has contracted with PacifiCare to provide outpatient prescription drugs to our Members.

Participating Physician - A Physician that has contracted with PacifiCare to provide health care services to our Members.

Plan Year - The twelve-month period that begins on the first day of the month the Agreement became effective.

Preauthorization - PacifiCare's review process that determines whether a prescription drug is Medically Necessary and not otherwise excluded prior to the Member receiving the prescription drug.

Prescription Unit - The maximum amount (quantity) of prescription medication that may be dispensed per single Copayment. For most oral medications, a Prescription Unit represents up to a 30-day supply of medication. The Prescription Unit for some medications may be set at a smaller quantity to promote appropriate medication use and patient safety. Quantity limits are based on generally accepted pharmaceutical practices and the manufacturer's labeling. Prescriptions that are normally dispensed in prepackaged or commercially available units of 30 days or less will be considered a single Prescription Unit, including, but not limited to, one inhaler, one vial of ophthalmic medication, one tube of topical ointment or cream.

Selected Brands List - The brand-name drugs included on the PacifiCare Formulary in place of their generic equivalents. These drugs are available at the generic drug Copayment amount.

Non-Formulary Preferred Drug - Non-Formulary drug that is more cost-effective than a similar non-Formulary drug.

Pharmacy Listing

For the most up-to-date list visit the Web site at www.pacificare.com

- Albertson's Food & Drug
- Bel Air Market Pharmacies
- Costco Pharmacies
- Drug Emporium
- Friendly Meds
- Gemmel Pharmacy Group
- Horton & Converse Pharmacies
- Kmart Pharmacies
- Long's Drug Stores (except Hawaii)
- Medicap Pharmacies
- Medicine Shoppe Pharmacies
- Network Pharmacies
- Raley's Drug Center
- Rite Aid Pharmacies
- Safeway Pharmacies
- Save Mart Pharmacies
- Sav-On Drugs/Sav-On Express
- Sharp Rees-Stealy Pharmacies
- Talbert Health Services
- Target Pharmacy
- United Supermarkets, Inc.
- Value Merchandise
- Vons Food and Drug
- Walgreen's
- Wal-Mart Pharmacies

P.O. Box 6006
Cypress, CA 90630

Customer Service:
800-624-8822
800-422-8833 (TDHI)
www.pacificare.com

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MANAGED TIERED
HMO PHARMACY SCHEDULE OF BENEFITS

Summary of Benefits	Generic Formulary	Brand-Name Formulary
Retail Pharmacy Copayment per Prescription Unit or up to 30 days	\$20	\$35
Mail Service Pharmacy Copayment up to 3 Prescription Units or up to 90 days	\$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 have a prescription deductible of \$100 per person covered medications consisting of brand name Formulary drugs. This deductible applies to retail and mail prescriptions. Until you satisfy the deductible, you will pay 100% of PacifiCare's contracted rate with the Pharmacy for the medication and that amount will be applied towards your deductible. The deductible is calculated on a Calendar Year basis and is not applied towards the deductible for the following year. Amounts previously applied to your deductible under a similar prescription drug plan from a different carrier or self-funded benefit plan are not applied to this prescription drug plan.

After satisfying your deductible, 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 Copayment of just \$20. Contact PacifiCare's Customer Service Department for Formulary information.

Preauthorization for all Non-Formulary Drugs

All non-Formulary drugs must be Preauthorized by PacifiCare as Medically Necessary in order to be covered under this pharmacy benefit. If approved, you will pay the applicable generic or brand-name Copayment. Non-Formulary drugs that are not otherwise excluded from coverage may be Preauthorized as

Medically Necessary in the following instances. (See "Exclusions and Limitations" section of this *Pharmacy Schedule of Benefits* for those medications that are excluded from coverage):

- No Formulary alternative is appropriate and the drug is Medically Necessary for patient care, as determined by PacifiCare and consistent with professional practice.
- The Formulary alternative has failed after a therapeutic trial. Your Participating Physician will be asked to provide a copy of the medical chart notes specifically stating treatment failure with the Formulary alternative.
- The Formulary alternative is not appropriate as determined by a review of Physician chart notes.
- You have been under treatment and remain stable on a non-Formulary prescription drug previously approved by PacifiCare as Medically Necessary that is not excluded from coverage and changing to a Formulary drug is medically inappropriate.
- Your Participating Physician provides evidence in the form of documents, records or clinical trials which establishes that use of the requested non-Formulary drug over the Formulary drug is Medically Necessary, as determined by PacifiCare.

Preauthorization for Selected Formulary Drugs

Selected Formulary drugs must also be Preauthorized by PacifiCare to determine that they are Medically Necessary and being prescribed according to treatment guidelines consistent with standard professional practice to be eligible for coverage. If approved, you will pay the applicable generic or brand-name Copayment. For a list of the Formulary medications that require PacifiCare's Preauthorization, please contact PacifiCare's Customer Service department.

Please note: If you are prescribed a non-Formulary or Selected Formulary medication for acute treatment that requires immediate use upon Hospital discharge, an urgent care or emergency room visit after normal business hours, you may receive a one-time authorization for coverage. You will need to obtain Preauthorization before refilling this prescription.

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. For brand-name drugs that have Food and Drug Administration (FDA)-approved equivalents, a prescription may be filled with a generic drug unless a specific brand-name drug is Medically Necessary and Preauthorized by PacifiCare, or is on PacifiCare's Selected Brands List. Preauthorization is necessary even if your Physician writes "Dispense as Written" or "Do Not Substitute" on your prescription. 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. If you choose to use a medication not included on the Formulary and not Preauthorized by PacifiCare, you will be responsible for the full retail price of the medication. However, you have the option of selecting a non-Formulary brand-name drug that has a generic equivalent on the Formulary at a cost that is generally lower than retail. The cost is the generic Copayment plus the difference between PacifiCare's contracted rate for the generic and brand-name drugs. You will not pay a rate higher than PacifiCare's contracted rate for the brand-name drug. If the brand-name drug with the generic equivalent is Medically Necessary, it may be Preauthorized by PacifiCare. If it is approved, you will only pay your brand-name Copayment.
- **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.
- **State Restricted Drugs:** Any medicinal substance that may be dispensed by prescription only, according to state law.

Exclusions and Limitations

While the prescription drug benefit covers most medications, there are some Drugs 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 under your medical benefit.

- **Administered Drugs:** Drugs or medicines delivered or administered to the Member by the prescriber or the prescriber's staff is 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* entitled "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 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, sexual performance, 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 Investigation 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 upon the purpose for which they are prescribed, as part of the home health or durable medical equipment benefit. Refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* for additional information.
- **Sexual Dysfunction Medication:** All forms of medications when prescribed for the treatment of sexual dysfunction, which includes, but is not limited to, erectile dysfunction, impotence, anorgasmia or hypogasmia, are not covered. An example of such medications includes Viagra.
- **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, entitled "Your Medical Benefits" under "Outpatient Benefits" located, for example, in subsections titled "Diabetic Self Management," "Durable Medical Equipment," "Home Health Care" or "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.

Questions? Call the HMO Customer Service department at 1-800-624-8822 or TDHI 1-800-442-8833.

OUTPATIENT PRESCRIPTION DRUG BENEFIT

Supplement to the Combined Evidence of Coverage and Disclosure Form

Understanding Your Outpatient Prescription Drug Benefit

This brochure contains important information for our Members about the PacifiCare outpatient prescription drug benefit. As part of PacifiCare's commitment to you, we want to provide you with the tools that will help you better understand and utilize your Pharmacy and Prescription Drug Plan. In an effort to eliminate confusion, PacifiCare has provided you with answers for your pharmacy questions such as:

- What is a Formulary?
- What is the difference between a brand-name and generic drug?
- Who can write my prescription?
- What happens in emergency situations?
- What is the Mail Service Pharmacy program?
- What is Preauthorization?

What else should I read to understand my pharmacy benefits?

We want our Members to get the most from their prescription drug benefit plan, so please read this Supplement to the Combined Evidence of Coverage and Disclosure Form ("Supplement") carefully. You need to become familiar with the terms used for explaining your coverage because understanding these terms is essential to understanding your benefit. Along with reading this publication, be sure to review your Pharmacy Schedule of Benefits. Your Pharmacy Schedule of Benefits provides the details of your particular pharmacy benefit plan, including the exclusions and limitations, applicable Copayments and PacifiCare's Preauthorization process. Together, these documents explain your outpatient pharmacy coverage. These documents should be read completely and carefully for a comprehensive understanding of your outpatient pharmacy benefits.

Your medical Combined Evidence of Coverage and Disclosure Form and Schedule of Benefits together with this Supplement to the Combined Evidence of Coverage and Disclosure Form and the Pharmacy Schedule of Benefits provide the terms and conditions of your benefit coverage. All applicants have a right to view these documents prior to enrollment.

What is covered, what is not?

PacifiCare covers Medically Necessary drugs that are not otherwise excluded from coverage by PacifiCare, and Preauthorization may be required. Refer to your Pharmacy Schedule of Benefits for a description of covered medications as well as the limitations and exclusions for certain medications.

Formulary Drugs

What is a Formulary?

A Formulary is a list that contains a broad range of Food-and-Drug-Administration (FDA)-approved generic and some brand-name medications that are covered under your prescription drug benefit. Please refer to your Pharmacy Schedule of Benefits to determine how the Formulary applies to your prescription drug benefit.

Why are Formularies necessary?

Medication costs continue to rise. Formularies list those medications that offer value while maintaining quality of care to help reduce health care and premium costs.

Who decides which medications are on the Formulary?

Medications are added or deleted from the Formulary only after careful review by a committee of practicing Physicians and pharmacists. This committee, called a Pharmacy and Therapeutics (P&T) Committee, has the responsibility of reviewing new and existing drugs. This committee decides which drugs provide quality treatment at the best value. Updates occur quarterly; however, in certain situations, drugs may be added or removed to the Formulary more frequently. You may obtain a copy of the Formulary by contacting Customer Service or from PacifiCare's Web site at www.pacificare.com.

Please remember that the inclusion of a specific drug on the Formulary does not guarantee that your Participating Physician will prescribe that drug for treatment of a particular condition.

What if my outpatient prescription medication is not on the Formulary?

Formularies list alternative medications, which are designed to be safe and effective. These medications generally have the same effect on your body. If your medication is not listed on PacifiCare's Formulary, ask

your Participating Physician or Participating Pharmacist for an alternative prescription medication that is on the Formulary and medically appropriate for you. For information on Preauthorization, please refer to your Pharmacy Schedule of Benefit.

How is a medication added or deleted from the Formulary?

A medication must first demonstrate safety and effectiveness to be added to the Formulary. Only after this is determined is the cost of the medication considered. Some medications have similar safety and effectiveness, but one or two are available at a lower cost. In these cases, the least costly medications are added to the Formulary.

When does the Formulary change? If a change occurs, will I have to pay more to use a drug I had been using?

The National Pharmacy and Therapeutics Committee meets regularly, at least four times a year, to review the Formulary and add or remove medications. Our Formulary books are printed and distributed to your Participating Physicians on a regular basis and any changes to the Formulary are also communicated to your Participating Physician on a regular basis. We also make available on our Web site a listing of the most recent Formulary changes. See the section "Recent Formulary Changes" on the pharmacy page of our Web site. Refer to your Pharmacy Schedule of Benefits to find out if your Copayments are dependent on Formulary status.

If you are currently taking a prescription drug that is covered by PacifiCare for a specific medical condition and PacifiCare removes that drug from the Formulary, PacifiCare will continue to cover that drug. It will be covered provided your Participating Physician continues to prescribe the drug for your specific medical condition and provided that the drug is appropriately prescribed and continues to be considered safe and effective for treatment of your medical condition. Continued coverage is subject to all terms and conditions of your PacifiCare Health Plan, including the exclusions and limitations of your Pharmacy Schedule of Benefits.

Generic Prescription Drugs

What is the difference between generic and brand-name drugs?

When a new drug is put on the market, for many years it is typically available only under a manufacturer's brand name. At first, this new drug is protected by a patent. Only after the patent expires are competing manufacturers allowed to offer the same drug. This type of drug is called a generic drug.

While the name of the drug may not be familiar to you, a generic drug has the same medicinal benefits as its brand-name competitor. In fact, a manufacturer must provide proof to the Food and Drug Administration (FDA) that a generic drug has the identical active chemical

compound as the brand-name product. A generic product must meet rigid FDA standards for strength, quality, purity and potency.

Only when a generic drug meets these standards is it considered the brand-name drug's equivalent. When the FDA approves a new generic drug, PacifiCare may choose to replace the brand-name drug on the Formulary with the generic drug.

NOTE: If you have a question about our Formulary or a particular drug, please contact PacifiCare's Customer Service department at 1-800-624-8822 or TDHI 1-800442-8833 or visit PacifiCare's Web site at **www.pacificare.com**.

Therapeutic Substitution of Medication

If there is no generic equivalent available for a specific brand-name drug, your Physician may prescribe a therapeutic substitute instead. Unlike a generic, which has the identical active ingredient as the brand-name version, a therapeutic substitute has a chemical composition that is different but acts similarly in clinical and therapeutic ways when compared to competing brand-name counterparts. If your Physician specifies therapeutic substitution, you will receive the therapeutic substitution medication and pay the applicable Copayment. (Refer to your Schedule of Benefits for the amount of your Copayment.)

Filling Your Prescription

Who can write my prescription?

Generally, to be eligible for coverage, your prescription must be written by a Participating Physician. There are two exceptions to this rule. The first is when the prescription is written by a Non-Participating Physician who has been preapproved by PacifiCare to treat you. The second exception is when a drug is prescribed for Emergency Services or Urgently Needed Services when you are out of the area. Emergency Service or Urgently Needed Service is defined in your medical Combined Evidence of Coverage and Disclosure Form.

How do I use my prescription drug benefit?

Your outpatient prescription drug benefit helps to cover the cost for some of the outpatient medications prescribed by a PacifiCare Participating Physician. Using your benefit is simple.

- Obtain your prescription from your PacifiCare Participating Physician.
- Present your prescription for a covered outpatient medication and PacifiCare Member ID card at any PacifiCare Participating Pharmacy. If ordering by phone, be sure to mention that you are a PacifiCare Member. Note that some prescription medications must be Preauthorized by PacifiCare.

- Pay the applicable Copayment (refer to your Schedule of Benefits for the amount of your Copayment) for a Prescription Unit or its retail cost, whichever is less.
- Receive your medication.

How much do I have to pay to get a prescription filled?

Refer to your Pharmacy Schedule of Benefits for specific details and Copayment amounts.

Where do I go to fill a prescription?

PacifiCare has a well-established network of pharmacies including most major pharmacy and supermarket chains as well as many independent pharmacies. A listing of Participating Pharmacies is available in the back of this brochure. Contact our Customer Service department at 1-800-624-8822 or TDHI 1-800-442-8833 to help locate a Participating Pharmacy near you or visit our Web site at www.pacificare.com for an up-to-date list.

When do I request a refill?

You may refill a prescription when a minimum of seventy-five percent (75%) of the quantity is consumed based on the days' supply.

I take maintenance medication on a continuing basis. How can I have my prescriptions filled when I am on vacation?

The most convenient and affordable way to obtain maintenance medications is to obtain a 90-day supply through our mail service program (for additional details refer to the Mail Service section in this document). It is important to plan ahead because it takes approximately seven days to receive your 90-day supply from the mail service program. Early refills for vacation are also available from Participating Pharmacies in certain circumstances – talk with your pharmacist about obtaining a vacation override. Our Customer Service Associates can also help you with planning for your medication needs while traveling – call 1-800-624-8822 or TDHI 1-800-442-8833.

What if I am sick and need a prescription when I'm away from home?

If you are sick and need an outpatient prescription medication filled when away from home, you may visit one of our Participating Pharmacies within our national pharmacy network and receive the medication for the applicable Copayment. For the nearest network pharmacy, contact Customer Service at 1-800-624-8822 or TDHI 1-800-442-8833 or visit our Web site at www.pacificare.com.

What happens in an emergency situation?

While in most circumstances you must fill your prescription at a Participating Pharmacy, you may fill your prescription for outpatient medication at a Non-Participating Pharmacy in an emergency or urgent situation. In such situations, you must pay the total cost of the prescription at the time you receive the

medication, and you will be reimbursed by PacifiCare for the cost of the medication, less the applicable Copayment. However, if PacifiCare determines that you obtained the prescription medication from a Non-Participating Pharmacy without an emergency or urgent situation, you will be responsible for the total cost of the medication, and PacifiCare will not reimburse you.

To obtain reimbursement for emergency or urgently needed prescription medications, you must follow the instructions below under "How do I obtain reimbursement?" You are only eligible for reimbursement for prescriptions related to urgent or emergency situations as defined by PacifiCare (refer to your medical Combined Evidence of Coverage and Disclosure Form) less the applicable Copayment.

Remember: You should only fill a prescription at a Non-Participating Pharmacy in an urgent or emergency situation.

How do I obtain reimbursement?

Call the Customer Service department at 1-800-624-8822 or TDHI 1-800-442-8833 or visit PacifiCare's Web site at www.pacificare.com to obtain the Direct Reimbursement Form. Provide the following: Direct Member Reimbursement Form; copies of the prescription receipts showing the prescription number, name of the medication, date filled, pharmacy name, name of the Member for whom the prescription was written, proof of payment, and a description of why a PacifiCare Participating Pharmacy was not available. Send these documents to: PacifiCare Pharmacy Department, P.O. Box 6037, Cypress, CA 90630.

You should submit the Direct Reimbursement Form within 90 days, or as soon as reasonably possible from the date of service. Payment will be forwarded to you once your request for reimbursement is determined by PacifiCare to be appropriate.

Emergency After-hours

PacifiCare will cover an emergency after-hours prescription without Preauthorization in the following situations:

- The prescription is for medication in conjunction with a Hospital discharge, emergency room or urgent care facility visit limited to a 7 days' supply except for antibiotics which may be dispensed in up to a fifteen (15)-day supply.
- Medications used for acute treatment and immediate use is required.
- Any time the prescribing Physician states that failure to supply the medication will result in a severe medical event or Hospital admission.

Note: After-hours Preauthorization will not be approved for any of the following situations:

- Continuation of a restricted medication based solely on a previous authorization or previous use.

- A change to an existing Preauthorization to extend the days' supply.
- A change to an existing Preauthorization to correct erroneous information.
- Early refills of maintenance medications.
- Early refills for signature changes or dosage changes.

When I fill a prescription, how much medication do I receive?

For a single Copayment, Members receive one Prescription Unit, which represents a maximum of one month's (30 days' supply) fill of outpatient prescription medication that can be obtained at one time. For most oral medications, a Prescription Unit is up to a 30-day supply of medication.

Medications dispensed in quantities other than the 30-day supply maximum are listed below:

- **Medications with quantity limitations:** The Prescription Unit for some medications may be set at a smaller quantity to promote appropriate medication use and patient safety. These quantity limits are based on generally accepted pharmaceutical practices and the manufacturer's labeling. For example, antibiotics typically require less than a 30-day supply; and certain drugs, such as controlled substances and migraine medications, may be limited due to the expectation of patient need and in accordance with manufacturer's recommended dosages. Drugs with quantity limitations may be dispensed in greater quantities if Medically Necessary and Preauthorized by PacifiCare.
- **Defined or prepackaged units of medications:** Prescriptions such as inhalers, eye drops, creams or other types of medications that are normally dispensed in prepackaged or defined units of 30 days or less will be considered a single Prescription Unit.
- **Medication obtained through PacifiCare's Mail Service program:** If you use the PacifiCare Mail Service Pharmacy program, you will receive three Prescription Units or up to a 90-day supply of maintenance medications (except for prepackaged medications as described above).

PacifiCare's Mail Service Program

What is the Mail Service Pharmacy program?

PacifiCare offers a Mail Service Pharmacy program through **Prescription Solutions**®. The Mail Service Pharmacy program provides convenient service and savings on maintenance medications that you may take on a regular basis by allowing you to purchase certain drugs for receipt by mail. You get quality medications mailed directly to your home or address of your choice within the United States in a discreetly labeled envelope to ensure privacy and safety. Shipping and handling is at no additional charge.

If you use our Mail Service Pharmacy program, you will generally get your maintenance medication within seven

(7) working days after receipt of your order. All orders are shipped in discreetly labeled envelopes for privacy and safety.

Here's how to fill prescriptions through the Mail Service Pharmacy program.

1. Call your Participating Physician to obtain a new prescription for each medication. When you call, ask the Physician to write the prescription for a 90-day supply, which represents three (3) Prescription Units with up to three (3) additional refills. The doctor will tell you when to pick up the written prescription. (Note: Prescription Solutions must have a new prescription to process any new mail service request.)
2. After picking up the prescription, complete the Mail Service Form included in your enrollment materials. (To obtain additional forms or for assistance in completing the form, call PacifiCare's Customer Service department at 1-800-624-8822 or TDHI 1-800-442-8833. You can also find the form at the Web site address www.rxsolutions.com.)
3. Enclose the prescription and appropriate Copayment via check, money order or credit card. Your Pharmacy Schedule of Benefits will have the applicable Copayment for the Mail Service Pharmacy program. Make the check or money order payable to **Prescription Solutions**®. No cash please.

When you receive your prescription, you'll get detailed instructions that tell you how to take the medication, possible side effects and any other important information about the medication. If you have questions, registered pharmacists are available to help you by calling **Prescription Solutions**® at 1-800-562-6223 or TDHI 1-800-498-5428.

Note: Medications such as Schedule II substances (e.g., Morphine, Ritalin and Dexedrine), antibiotics, drugs used for short-term or acute illnesses, and drugs that require special packaging (including refrigeration) are not available through our Mail Service Pharmacy program. Prescription medications prescribed for the treatment of sexual dysfunction are not available through the Mail Service Pharmacy program.

Important Tip: If you are starting a new medication, please request two prescriptions from your Participating Physician. Have one filled immediately at a Participating Pharmacy while mailing the second prescription to PacifiCare's Mail Service Pharmacy. Once you receive your medication through the mail service, you should stop filling the prescription at the Participating Pharmacy.

Preauthorization

What is Preauthorization?

PacifiCare covers Medically Necessary prescription medications when prescribed by a Participating Physician, and Preauthorization may be required. For example, medications when prescribed for cosmetic purposes such as wrinkle creams, are not generally covered. Medication quantities may also be limited to ensure that they are being used safely and effectively, and Copayments, exclusions and limitations vary. Please be sure to read your Pharmacy Schedule of Benefits, which describes the details of your prescription drug coverage, including the types of medications that require Preauthorization and that are limited or excluded. Prescriptions that require Preauthorization will be charged at the applicable Copayment if approved.

We want to make sure our Members receive optimal care, and appropriate medication use is a big part of maintaining your overall health. That is why we have systems in place to make sure your medication is Medically Necessary and prescribed according to treatment guidelines consistent with standard professional practice. We also want to make sure you are not taking more medication than you need or are taking medication for a longer period of time than is necessary, and that you are receiving follow-up care. PacifiCare reserves the right to require Preauthorization and/or limit the quantity of any prescription. The following is a list of factors that PacifiCare takes into consideration when completing a Preauthorization review:

- The prescription is for the treatment of a covered medical condition and the expected beneficial effects of the prescription outweigh the harmful effects.
- There is sufficient evidence to draw conclusions about the effect of the prescription on the medical condition being treated and on your health outcome.
- The prescription represents the most cost-effective method to treat the medical condition.
- The prescription drug is prescribed according to established, documented and approved indications that are supported by the weight of scientific evidence.

What do I do if I need Preauthorization?

We understand that situations may arise in which it may be Medically Necessary to take a medication above the preset limits or for a particular condition/circumstance. In these instances, since your Participating Physician understands your medical history and health conditions, he/she can request Preauthorization. We have made the process simple and easy. Your Participating Physician can call or fax the Preauthorization request to **Prescription Solutions**[®], which is PacifiCare's pharmacy benefit manager. The Preauthorization staff of qualified pharmacists and technicians is available Monday through Friday from 6:00 a.m. to 6:00 p.m. to

assist Participating Physicians. Most authorizations are completed within 24 hours. The most common reason for delay in the authorization process is insufficient information. Your Participating Physician may need to provide information on diagnosis and medication history and/or evidence in the form of documents, records or lab tests which establish that the use of the requested medication meets plan criteria.

Does this plan limit or exclude certain drugs my health care provider may prescribe or encourage substitutions for some drugs?

Your PacifiCare pharmacy benefit provides you access to a wide range of FDA-approved brand-name and generic medications. The Formulary is developed with the input from Participating Physicians and pharmacists and is based on assessment of the drug's quality, safety, effectiveness and cost. If a medication is not included on the Formulary, it may be because the Plan's Formulary includes other drugs that are frequently prescribed for the same condition as those that are not included on the Formulary. For example, PacifiCare may have an equivalent generic medication on the Formulary for the brand-name medication prescribed by your Participating Physician. It is also important to remember there may be other options available for treating a particular medical condition. Non-Formulary medications may require Preauthorization and will be approved when Medically Necessary unless otherwise excluded by PacifiCare as described in the "Exclusions and Limitations" section of the Pharmacy Schedule of Benefits. Refer to the Section titled "What do I do if I need Preauthorization" in this document for additional information.

What should I do if I want to appeal a Preauthorization decision?

As a PacifiCare Member, you have the right to appeal any Preauthorization decision. Contact Customer Service at 1-800-624-8822 or TDHI 1-800-442-8833 for details on the Preauthorization or appeals process. Please refer to Section Eight of your medical Combined Evidence of Coverage and Disclosure Form for more details on the appeals process and the expedited review process.

Helpful tips:

- Take your medications list with you to the doctor's office.
- Ask your doctor if the drug prescribed is on the PacifiCare Formulary.
- Talk with your doctor about Formulary alternative medications to treat your medical condition.
- You and your doctor can access the most current Formulary information on our Web site at **www.pacificare.com** including information on Formulary alternatives.

Definitions

Contract Year - The twelve-month period that begins on the first day of the month the Agreement became effective.

Calendar Year - The time period beginning on January 1st and ending on December 31st.

Formulary - The Formulary is a list that contains a broad range of FDA-approved generic and some brand-name medications that under state or federal law are to be dispensed by a prescription only. The Formulary does not include all prescription medications.

Non-Participating Pharmacy - A pharmacy that has NOT contracted with PacifiCare to provide outpatient prescription drugs to our Members.

Non-Participating Physician - A Physician that has NOT contracted with PacifiCare to provide health care services to our Members.

Participating Pharmacy - A pharmacy that has contracted with PacifiCare to provide outpatient prescription drugs to our Members.

Participating Physician - A Physician that has contracted with PacifiCare to provide health care services to our Members.

Plan Year - The twelve-month period that begins on the first day of the month the Agreement became effective.

Preauthorization - PacifiCare's review process that determines whether a prescription drug is Medically Necessary and not otherwise excluded prior to the Member receiving the prescription drug.

Prescription Unit - The maximum amount (quantity) of prescription medication that may be dispensed per single Copayment. For most oral medications, a Prescription Unit represents up to a 30-day supply of medication. The Prescription Unit for some medications may be set at a smaller quantity to promote appropriate medication use and patient safety. Quantity limits are based on generally accepted pharmaceutical practices and the manufacturer's labeling. Prescriptions that are normally dispensed in prepackaged or commercially available units of 30 days or less will be considered a single Prescription Unit, including, but not limited to, one inhaler, one vial of ophthalmic medication, one tube of topical ointment or cream.

Selected Brands List - The brand-name drugs included on the PacifiCare Formulary in place of their generic equivalents. These drugs are available at the generic drug Copayment amount.

Non-Formulary Preferred Drug - Non-Formulary drug that is more cost-effective than a similar non-Formulary drug.

Pharmacy Listing

For the most up-to-date list visit the Web site at www.pacificare.com

- Albertson's Food & Drug
- Bel Air Market Pharmacies
- Costco Pharmacies
- Drug Emporium
- Friendly Meds
- Gemmel Pharmacy Group
- Horton & Converse Pharmacies
- Kmart Pharmacies
- Long's Drug Stores (except Hawaii)
- Medicap Pharmacies
- Medicine Shoppe Pharmacies
- Network Pharmacies
- Raley's Drug Center
- Rite Aid Pharmacies
- Safeway Pharmacies
- Save Mart Pharmacies
- Sav-On Drugs/Sav-On Express
- Sharp Rees-Stealy Pharmacies
- Talbert Health Services
- Target Pharmacy
- United Supermarkets, Inc.
- Value Merchandise
- Vons Food and Drug
- Walgreen's
- Wal-Mart Pharmacies

P.O. Box 6006
Cypress, CA 90630

Customer Service:
800-624-8822
800-422-8833 (TDHI)
www.pacificare.com

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HMO PHARMACY SCHEDULE OF BENEFITS

Summary of Benefits	Generic Formulary	Brand-Name Formulary
Retail Pharmacy Copayment per Prescription Unit or up to 30 days	\$20	\$35
Mail Service Pharmacy Copayment up to 3 Prescription Units or up to 90 days	\$40	\$70

What is my Schedule of Benefits?

This *Schedule of Benefits* is a companion to your prescription drug Supplement to the *Combined Evidence of Coverage and Disclosure Form*. It provides specific details about your Prescription Drug Benefit, as well as its exclusions and limitations.

Along with your Supplement, please consult your medical *Combined Evidence of Coverage and Disclosure Form* for a description of your covered medical benefits, exclusions and limitations, as well as the terms and conditions of your coverage. You should also become familiar with the terms used for explaining your coverage. You'll find important definitions in the Supplement as well as your medical *Combined Evidence of Coverage and Disclosure Form*.

How do I use my Prescription Drug Benefit?

Your Prescription Drug Benefit helps cover the cost for some of the medications prescribed by a Participating Physician. Using your benefit is simple.

- Present your prescription and PacifiCare ID card at any PacifiCare Participating Pharmacy.
- Pay the Copayment for a Prescription Unit or its retail cost, whichever is less.
- Receive your medication.

What do I pay when I fill a prescription?

You will pay only a Copayment when filling a prescription at a PacifiCare Participating Pharmacy. You will pay a Copayment every time a prescription is filled. Your benefits are as follows:

- When you fill or refill a prescription for a Formulary generic medication, your Copayment is \$20.
- When you fill or refill a prescription for a Formulary brand-name medication, your Copayment is \$35.

The Copayment for specified smoking cessation products is \$20 per 30-day supply. There are selected brand-name medications where you will have a Copayment of just \$20. A copy of the Selected Brand List is available upon request from PacifiCare's Customer Service department.

When I fill a prescription, how much medication do I receive?

For a single Copayment, Members receive either one Prescription Unit or up to a 30-day supply of a drug. For maintenance medications, you make a Copayment for each Prescription Unit or every 30-day supply; however, you can fill your prescription for two Prescription Units or up to 60 days.

If you use the PacifiCare Mail Service Pharmacy program, for the price of only two Copayments, you will receive three Prescription Units or up to a 90-day supply of maintenance medications. To learn more about maintenance medications and the mail-service program, please refer to your Supplement to the *Combined Evidence of Coverage and Disclosure Form*.

What else do I need to know?

- You should become familiar with PacifiCare's prescription drug Formulary. **Any medication not on our Formulary must be Preauthorized by PacifiCare; otherwise, you will pay the full cost.** For more on our Formulary, please refer to your Supplement to the *Combined Evidence of Coverage and Disclosure Form* or visit www.pacificare.com.
- It is possible to buy a brand-name drug in place of a generic equivalent, even though the generic drug is the only one listed on our Formulary. Your cost, however, will likely be substantially higher. For more information, please continue to "Medications Covered by Your Benefit" and read the description for Generic Drugs.
- Occasionally a brand-name drug is Medically Necessary, even though a generic equivalent is available. If Preauthorized by PacifiCare, you will only pay the brand-name Copayment.

ADDITIONAL INFORMATION

Medications Covered by Your Benefit

The following medications are included in the PacifiCare managed Formulary and are available to your Participating Physician. Your benefit also includes non-Formulary drugs ordered by a Participating Physician when Preauthorized by PacifiCare and filled at a PacifiCare Participating Pharmacy.

- **Federal Legend Drugs:** Any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription."
- **State Restricted Drugs:** Any medicinal substance that may be dispensed by prescription only according to state law.
- **Generic Drugs:** Comparable generic drugs may be substituted for brand-name drugs. For brand-name drugs that have U.S. Food and Drug Administration (FDA)-approved equivalents, a prescription may be filled with a generic drug unless a brand-name drug is Medically Necessary and Preauthorized by PacifiCare or is on PacifiCare's Selected Brands List. A copy of the Selected Brands List is available upon request from PacifiCare's Customer Service department. If you choose to use a medication not included on the Formulary and not Preauthorized by PacifiCare, you will be responsible for the full retail price of the medication. However, you have the option of selecting a non-Formulary brand-name drug that has a generic equivalent on the Formulary at a cost that is generally lower than retail. The cost is the generic Copayment plus the difference between PacifiCare's contracted rate of the generic and brand-name drugs. You will not pay a rate higher than PacifiCare's contracted rate for the brand-name drug. If the brand-name drug with the generic equivalent is Medically Necessary, it may be Preauthorized by PacifiCare. If it is approved, you will pay the brand-name Copayment.
- Federal Legend oral contraceptives and prescription diaphragms.
- Specified smoking cessation products when you meet nicotine dependency criteria and have enrolled participation in PacifiCare's StopSmoking™ program.
- For the purposes of determining coverage, the following items are considered Prescription Drug Benefits: glucagon, 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 benefit portion of the *Combined Evidence of Coverage and Disclosure Form* for coverage of other injectable medications.
- You will not be denied a drug that has been previously approved for coverage by PacifiCare, provided a Participating Physician continues to prescribe the drug for your medical condition. The drug must also be

appropriately prescribed as well as considered safe and effective for treating your medical condition.

Preauthorization for All Non-Formulary Drugs and Selected Formulary Drugs

To take advantage of your benefit, all non-Formulary drugs must be Preauthorized by PacifiCare.

Preauthorization requests may be initiated by your PacifiCare Participating Physician. Selected Formulary drugs must also be Preauthorized by PacifiCare to determine that they are Medically Necessary and being prescribed according to treatment guidelines consistent with good professional practice.

For a list of the selected Formulary medications that require PacifiCare's Preauthorization, please contact PacifiCare's Customer Service department. Non-Formulary drugs that are not otherwise excluded from coverage may be Preauthorized in the following instances:

- No Formulary alternative is appropriate and the drug is Medically Necessary for patient care, as determined by PacifiCare and consistent with professional practice.
- The Formulary alternative has failed after a therapeutic trial. Your Participating Physician will be asked to provide a copy of the medical chart notes specifically stating treatment failure with the Formulary alternative.
- The Formulary alternative is not appropriate as determined by a review of physician chart notes.
- You have been under treatment and remain stable on a non-Formulary prescription drug previously approved by PacifiCare that is not excluded from coverage. Furthermore, switching to a Formulary drug is medically inappropriate.
- You experience typical allergic reaction or established adverse reaction relating to the pharmacological properties of the Formulary drug. This reaction must be attributed to formulations or difference in the absorption, distribution or elimination of a Formulary drug.
- Your Participating Physician provides evidence in the form of documents, records or clinical trials which establishes that use of the requested non-Formulary drug over the Formulary drug is Medically Necessary, as determined by PacifiCare.

If you are prescribed a non-Formulary medication for acute treatment that requires immediate use upon hospital discharge, an urgent care or emergency room visit after normal business hours, you may receive a one-time authorization for coverage.

Exclusions and Limitations

While the Prescription Drug Benefit covers most medications, there are some that are not covered:

- Drugs or medicines not on the PacifiCare Formulary, unless Preauthorized by PacifiCare.

- Drugs or medicines purchased and received prior to the Member's effective date or subsequent to the Member's termination.
 - Therapeutic devices or appliances including hypodermic needles, syringes (except insulin syringes), support garments and other nonmedicinal substances.
 - All nonprescription (over-the-counter) contraceptive jellies, ointments, foams or devices.
 - Medications to be taken or administered to the eligible Member while a patient in a hospital, rest home, nursing home, sanitarium, etc.
 - Drugs or medicines delivered or administered to the Member by the prescriber or the prescriber's staff.
 - Dietary supplements, including vitamins and fluoride supplements (except prenatal), health or beauty aids, herbal supplements and/or alternative medicine.
 - Compounded Medication: Any medicinal substance that has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount. All compounded medications are subject to PacifiCare's prior authorization process.
 - Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the patient.
 - Medication prescribed for Experimental or Investigational therapies, unless required by an external independent review panel pursuant to California Health and Safety Code Section 1370.4. For non-FDA-approved indications see the following exclusion.
 - Off-Label Drug Use: Off-Label Drug Use means that the Provider has prescribed a drug approved by the 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 Subscriber Agreement 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 for the treatment of a life-threatening condition or for a chronic and seriously debilitating condition. (3) The drug is Medically Necessary to treat the condition. (4) The drug has been recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following: *The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopoeia Dispensing Information* or in two articles from major peer-reviewed medical journals that present data supporting the proposed Off-Label Drug Use or Uses as generally safe and effective. (5) The drug is administered as part of a core medical benefit as determined by PacifiCare. Nothing in this section shall prohibit PacifiCare from use of a Formulary, Copayment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA. Denial of a drug as Investigational or Experimental will allow the Member to use the Independent Medical Review System as defined in the medical *Combined Evidence of Coverage and Disclosure Form*.
 - Medications available without a prescription (over-the-counter) or for which there is a nonprescription equivalent available, even if ordered by a physician.
 - Elective or voluntary enhancement procedures, services, supplies and medications, including, but not limited to, weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance. Examples of these drugs include, but are not limited to, Penlac[®], Retin-A[®], Renova[®], Vaniqa[®], Propecia[®], Lustra[®], Xenical[®] or Meridia[®].
 - Medications prescribed by Non-Participating Physicians (except for prescriptions required as a result of an Emergency or Urgently Needed Service for an acute condition).
 - Medications dispensed by a Non-Participating Pharmacy (except for prescriptions required as a result of an Emergency or Urgently Needed Service for an acute condition).
 - Smoking cessation products (other than those available by participating in PacifiCare's StopSmoking[™] program) including, but not limited to, nicotine gum, nicotine patches and nicotine nasal spray.
 - Injectable drugs (except as listed under "Medications Covered by Your Benefit").
 - Drugs prescribed by a dentist or drugs used for dental treatment.
 - Drugs used for diagnostic purposes.
 - Disposable all-in-one prefilled insulin pens, insulin cartridges, and needles for nondisposable pen devices are covered when Medically Necessary in accordance with PacifiCare's Preauthorization process.
 - Saline and irrigation solutions.
 - MUSE[®] suppositories.
 - Replacement of lost, stolen or destroyed medications.
 - All forms of medications prescribed for the treatment of sexual dysfunction, which includes, but is not limited to, erectile dysfunction, impotence and anorgasmia or hyporgasmia. An example of such medication would include Viagra.
- PacifiCare reserves the right to expand the prior authorization requirement for any drug product to assure adherence to FDA-approved indications and national practice standards.

OUTPATIENT PRESCRIPTION DRUG BENEFIT

Supplement to the Combined Evidence of Coverage and Disclosure Form

Understanding Your Outpatient Prescription Drug Benefit

This brochure contains important information for our Members about the PacifiCare outpatient prescription drug benefit. As part of PacifiCare's commitment to you, we want to provide you with the tools that will help you better understand and utilize your Pharmacy and Prescription Drug Plan. In an effort to eliminate confusion, PacifiCare has provided you with answers for your pharmacy questions such as:

- What is a Formulary?
- What is the difference between a brand-name and generic drug?
- Who can write my prescription?
- What happens in emergency situations?
- What is the Mail Service Pharmacy program?
- What is Preauthorization?

What else should I read to understand my pharmacy benefits?

We want our Members to get the most from their prescription drug benefit plan, so please read this Supplement to *the Combined Evidence of Coverage and Disclosure Form* ("Supplement") carefully. You need to become familiar with the terms used for explaining your coverage because *understanding these terms is essential to understanding your benefit*. Along with reading this publication, be sure to review your *Pharmacy Schedule of Benefits*. Your *Pharmacy Schedule of Benefits* provides the details of your particular pharmacy benefit plan, including the exclusions and limitations, applicable Copayments and PacifiCare's Preauthorization process. Together, these documents explain your outpatient pharmacy coverage. These documents should be read completely and carefully for a comprehensive understanding of your outpatient pharmacy benefits.

Your medical *Combined Evidence of Coverage and Disclosure Form* and *Schedule of Benefits* together with this *Supplement to the Combined Evidence of Coverage and Disclosure Form* and the *Pharmacy Schedule of Benefits* provide the terms and conditions of your benefit coverage. All applicants have a right to view these documents prior to enrollment.

What is covered, what is not?

PacifiCare covers Medically Necessary drugs that are not otherwise excluded from coverage by PacifiCare, and Preauthorization may be required. Refer to your *Pharmacy Schedule of Benefits* for a description of covered medications as well as the limitations and exclusions for certain medications.

Formulary Drugs

What is a Formulary?

A Formulary is a list that contains a broad range of FDA-approved generic and some brand-name medications that are covered under your prescription drug benefit. Please refer to your *Pharmacy Schedule of Benefits* to determine how the Formulary applies to your prescription drug benefit.

Why are Formularies necessary?

Medication costs continue to rise. Formularies list those medications that offer value while maintaining quality of care to help reduce health care and premium costs.

Who decides which medications are on the Formulary?

Medications are added or deleted from the Formulary only after careful review by a committee of practicing Physicians and pharmacists. This committee, called a Pharmacy and Therapeutics (P&T) Committee, has the responsibility of reviewing new and existing drugs. This committee decides which drugs provide quality treatment at the best value. Updates occur quarterly; however, in certain situations, drugs may be added or removed to the Formulary more frequently. You may obtain a copy of the Formulary by contacting Customer Service or from PacifiCare's Web site at www.pacificare.com.

Please remember that the inclusion of a specific drug on the Formulary does not guarantee that your Participating Physician will prescribe that drug for treatment of a particular condition.

What if my outpatient prescription medication is not on the Formulary?

Formularies list alternative medications, which are designed to be safe and effective. These medications generally have the same effect on your body. If your medication is not listed on PacifiCare's Formulary, ask your Participating Physician or Participating Pharmacist for an alternative prescription medication that is on the Formulary and medically appropriate for you. For

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

information on Preauthorization, please refer to your *Pharmacy Schedule of Benefit*.

How is a medication added or deleted from the Formulary?

A medication must first demonstrate safety and effectiveness to be added to the Formulary. Only after this is determined is the cost of the medication considered. Some medications have similar safety and effectiveness, but one or two are available at a lower cost. In these cases, the least costly medications are added to the Formulary.

When does the Formulary change? If a change occurs, will I have to pay more to use a drug I had been using?

The National Pharmacy and Therapeutics Committee meets regularly, at least four times a year, to review the Formulary and add or remove medications. Our Formulary books are printed and distributed to your Participating Physicians on a regular basis and any changes to the Formulary are also communicated to your Participating Physician on a regular basis. We also make available on our Web site a listing of the most recent Formulary changes. See the section "Recent Formulary Changes" on the pharmacy page of our Web site. Refer to your *Pharmacy Schedule of Benefits* to find out if your Copayments are dependent on Formulary status.

If you are currently taking a prescription drug that is covered by PacifiCare for a specific medical condition and PacifiCare removes that drug from the Formulary, PacifiCare will continue to cover that drug. It will be covered provided your Participating Physician continues to prescribe the drug for your specific medical condition and provided that the drug is appropriately prescribed and continues to be considered safe and effective for treatment of your medical condition. Continued coverage is subject to all terms and conditions of your PacifiCare Health Plan, including the exclusions and limitations of your *Pharmacy Schedule of Benefits*.

Generic Prescription Drugs

What is the difference between generic and brand-name drugs?

When a new drug is put on the market, for many years it is typically available only under a manufacturer's brand name. At first, this new drug is protected by a patent. Only after the patent expires are competing manufacturers allowed to offer the same drug. This type of drug is called a generic drug.

While the name of the drug may not be familiar to you, a generic drug has the same medicinal benefits as its brand-name competitor. In fact, a manufacturer must provide proof to the FDA that a generic drug has the identical active chemical compound as the brand-name

product. A generic product must meet rigid FDA standards for strength, quality, purity and potency.

Only when a generic drug meets these standards is it considered the brand-name drug's equivalent. When the FDA approves a new generic drug, PacifiCare may choose to replace the brand-name drug on the Formulary with the generic drug.

NOTE: If you have a question about our Formulary or a particular drug, please contact PacifiCare's Customer Service department at 1-800-624-8822 or TDHI 1-800-442-8833 or visit PacifiCare's Web site at www.pacificare.com.

Therapeutic Substitution of Medication

If there is no generic equivalent available for a specific brand-name drug, your Physician may prescribe a therapeutic substitute instead. Unlike a generic, which has the identical active ingredient as the brand-name version, a therapeutic substitute has a chemical composition that is different but acts similarly in clinical and therapeutic ways when compared to competing brand-name counterparts. If your Physician specifies therapeutic substitution, you will receive the therapeutic substitution medication and pay the applicable Copayment. (Refer to your *Schedule of Benefits* for the amount of your Copayment.)

Filling Your Prescription

Who can write my prescription?

Generally, to be eligible for coverage, your prescription must be written by a Participating Physician. There are two exceptions to this rule. The first is when the prescription is written by a Non-Participating Physician who has been preapproved by PacifiCare to treat you. The second exception is when a drug is prescribed for Emergency Services or Urgently Needed Services when you are out of the area. Emergency Service or Urgently Needed Service is defined in your medical *Combined Evidence of Coverage and Disclosure Form*.

How do I use my prescription drug benefit?

Your outpatient prescription drug benefit helps to cover the cost for some of the outpatient medications prescribed by a PacifiCare Participating Physician. Using your benefit is simple.

- Obtain your prescription from your PacifiCare Participating Physician.
- Present your prescription for a covered outpatient medication and PacifiCare Member ID card at any PacifiCare Participating Pharmacy. If ordering by phone, be sure to mention that you are a PacifiCare Member. Note that some prescription medications must be Preauthorized by PacifiCare.
- Pay the applicable Copayment (refer to your *Schedule of Benefits* for the amount of your Copayment) for a Prescription Unit or its retail cost, whichever is less.
- Receive your medication.

How much do I have to pay to get a prescription filled?

Refer to your *Pharmacy Schedule of Benefits* for specific details and Copayment amounts.

Where do I go to fill a prescription?

PacifiCare has a well-established network of pharmacies, including most major pharmacy and supermarket chains as well as many independent pharmacies. A listing of Participating Pharmacies is available in the back of this brochure. Contact our Customer Service department at 1-800-624-8822 or TDHI 1-800-442-8833 to help locate a Participating Pharmacy near you or visit our Web site at www.pacificare.com for an up-to-date list.

When do I request a refill?

You may refill a prescription when a minimum of seventy-five percent (75%) of the quantity is consumed based on the days' supply.

I take maintenance medication on a continuing basis. How can I have my prescriptions filled when I am on vacation?

The most convenient and affordable way to obtain maintenance medications is to obtain a 90-day supply through our mail-service program (for additional details refer to the Mail Service section in this document). It is important to plan ahead because it takes approximately seven days to receive your 90-day supply from the mail-service program. Early refills for vacation are also available from Participating Pharmacies in certain circumstances – talk with your pharmacist about obtaining a vacation override. Our Customer Service Associates can also help you with planning for your medication needs while traveling – call 1-800-624-8822 or TDHI 1-800-442-8833.

What if I am sick and need a prescription when I'm away from home?

If you are sick and need an outpatient prescription medication filled when away from home, you may visit one of our Participating Pharmacies within our national pharmacy network and receive the medication for the applicable Copayment. For the nearest network pharmacy, contact Customer Service at 1-800-624-8822 or TDHI 1-800-442-8833 or visit our Web site at www.pacificare.com.

What happens in an emergency situation?

While in most circumstances you must fill your prescription at a Participating Pharmacy, you may fill your prescription for outpatient medication at a Non-Participating Pharmacy in an emergency or urgent situation. In such situations, you must pay the total cost of the prescription at the time you receive the medication, and you will be reimbursed by PacifiCare for the cost of the medication, less the applicable Copayment. However, if PacifiCare determines that you obtained the prescription medication from a Non-

Participating Pharmacy without an emergency or urgent situation, you will be responsible for the total cost of the medication, and PacifiCare will not reimburse you.

To obtain reimbursement for emergency or urgently needed prescription medications, you must follow the instructions below under “How do I obtain reimbursement?” You are only eligible for reimbursement for prescriptions related to urgent or emergency situations as defined by PacifiCare (refer to your medical *Combined Evidence of Coverage and Disclosure Form*) less the applicable Copayment.

Remember: You should only fill a prescription at a Non-Participating Pharmacy in an urgent or emergency situation.

How do I obtain reimbursement?

Call the Customer Service department at 1-800-624-8822 or TDHI 1-800-442-8833 or visit PacifiCare's Web site at www.pacificare.com to obtain the Direct Member Reimbursement Form. Provide the following: Direct Member Reimbursement Form; copies of the prescription receipts showing the prescription number, name of the medication, date filled, pharmacy name, name of the Member for whom the prescription was written, proof of payment, and a description of why a PacifiCare Participating Pharmacy was not available. Send these documents to: PacifiCare Pharmacy Department, P.O. Box 6037, Cypress, CA 90630.

You should submit the Direct Member Reimbursement Form within 90 days, or as soon as reasonably possible from the date of service. Payment will be forwarded to you once your request for reimbursement is determined by PacifiCare to be appropriate.

Emergency After-Hours

PacifiCare will cover an emergency after-hours prescription without Preauthorization in the following situations:

- The prescription is for medication in conjunction with a Hospital discharge, emergency room or urgent care facility visit limited to a seven days' supply except for antibiotics which may be dispensed in up to a fifteen (15)-day supply.
- Medications used for acute treatment and immediate use is required.
- Any time the prescribing Physician states that failure to supply the medication will result in a severe medical event or Hospital admission.

Note: After-hours Preauthorization will not be approved for any of the following situations:

- Continuation of a restricted medication based solely on a previous authorization or previous use.
- A change to an existing Preauthorization to extend the days' supply.

- A change to an existing Preauthorization to correct erroneous information.
- Early refills of maintenance medications.
- Early refills for signature changes or dosage changes.

When I fill a prescription, how much medication do I receive?

For a single Copayment, Members receive one Prescription Unit, which represents a maximum of one month's (30 days' supply) fill of outpatient prescription medication that can be obtained at one time. For most oral medications, a Prescription Unit is up to a 30-day supply of medication.

Medications dispensed in quantities other than the 30-day supply maximum are listed below:

- **Medications with quantity limitations:** The Prescription Unit for some medications may be set at a smaller quantity to promote appropriate medication use and patient safety. These quantity limits are based on generally accepted pharmaceutical practices and the manufacturer's labeling. For example, antibiotics typically require less than a 30-day supply; and certain drugs, such as controlled substances and migraine medications, may be limited due to the expectation of patient need and in accordance with manufacturer's recommended dosages. Drugs with quantity limitations may be dispensed in greater quantities if Medically Necessary and Preauthorized by PacifiCare.
- **Defined or prepackaged units of medications:** Prescriptions such as inhalers, eye drops, creams or other types of medications that are normally dispensed in prepackaged or defined units of 30 days or less will be considered a single Prescription Unit.
- **Medication obtained through PacifiCare's mail service program:** If you use the PacifiCare Mail Service Pharmacy program, you will receive three Prescription Units or up to a 90-day supply of maintenance medications (except for prepackaged medications as described above).

PacifiCare's Mail Service Program

What is the Mail Service Pharmacy program?

PacifiCare offers a Mail Service Pharmacy program through **Prescription Solutions**[®]. The Mail Service Pharmacy program provides convenient service and savings on maintenance medications that you may take on a regular basis by allowing you to purchase certain drugs for receipt by mail. You get quality medications mailed directly to your home or address of your choice within the United States in a discreetly labeled envelope to ensure privacy and safety. Shipping and handling is at no additional charge.

If you use our Mail Service Pharmacy program, you will generally get your maintenance medication within seven (7) working days after receipt of your order. All orders

are shipped in discreetly labeled envelopes for privacy and safety.

Here's how to fill prescriptions through the Mail Service Pharmacy program.

1. Call your Participating Physician to obtain a new prescription for each medication. When you call, ask the Physician to write the prescription for a 90-day supply, which represents three (3) Prescription Units with up to three (3) additional refills. The doctor will tell you when to pick up the written prescription. (Note: Prescription Solutions must have a new prescription to process any new mail-service request.)
2. After picking up the prescription, complete the Mail Service Form included in your enrollment materials. (To obtain additional forms or for assistance in completing the form, call PacifiCare's Customer Service department at 1-800-624-8822 or TDHI 1-800-442-8833. You can also find the form at the Web site address www.rxsolutions.com.)
3. Enclose the prescription and appropriate Copayment via check, money order or credit card. Your *Pharmacy Schedule of Benefits* will have the applicable Copayment for the Mail Service Pharmacy program. Make the check or money order payable to **Prescription Solutions**. No cash please.

When you receive your prescription, you'll get detailed instructions that tell you how to take the medication, possible side effects and any other important information about the medication. If you have questions, registered pharmacists are available to help you by calling **Prescription Solutions** at 1-800-562-6223 or TDHI 1-800-498-5428.

Note: Medications such as Schedule II substances (e.g., morphine, Ritalin and Dexedrine), antibiotics, drugs used for short-term or acute illnesses, and drugs that require special packaging (including refrigeration) are not available through our Mail Service Pharmacy program. Prescription medications prescribed for the treatment of sexual dysfunction are not available through the Mail Service Pharmacy program.

Important Tip: If you are starting a new medication, please request two prescriptions from your Participating Physician. Have one filled immediately at a Participating Pharmacy while mailing the second prescription to PacifiCare's Mail Service Pharmacy. Once you receive your medication through the mail service, you should stop filling the prescription at the Participating Pharmacy.

Preauthorization

What is Preauthorization?

PacifiCare covers Medically Necessary prescription medications when prescribed by a Participating Physician, and Preauthorization may be required. For example, medications when prescribed for cosmetic purposes, such as wrinkle creams, are not generally covered. Medication quantities may also be limited to ensure that they are being used safely and effectively, and Copayments, exclusions and limitations vary. Please be sure to read your *Pharmacy Schedule of Benefits*, which describes the details of your prescription drug coverage, including the types of medications that require Preauthorization and that are limited or excluded. Prescriptions that require Preauthorization will be charged at the applicable Copayment if approved.

We want to make sure our Members receive optimal care, and appropriate medication use is a big part of maintaining your overall health. That is why we have systems in place to make sure your medication is Medically Necessary and prescribed according to treatment guidelines consistent with standard professional practice. We also want to make sure you are not taking more medication than you need or are taking medication for a longer period of time than is necessary, and that you are receiving follow-up care. PacifiCare reserves the right to require Preauthorization and/or limit the quantity of any prescription. The following is a list of factors that PacifiCare takes into consideration when completing a Preauthorization review:

- The prescription is for the treatment of a covered medical condition and the expected beneficial effects of the prescription outweigh the harmful effects.
- There is sufficient evidence to draw conclusions about the effect of the prescription on the medical condition being treated and on your health outcome.
- The prescription represents the most cost-effective method to treat the medical condition.
- The prescription drug is prescribed according to established, documented and approved indications that are supported by the weight of scientific evidence.

What do I do if I need Preauthorization?

We understand that situations may arise in which it may be Medically Necessary to take a medication above the preset limits or for a particular condition/circumstance. In these instances, since your Participating Physician understands your medical history and health conditions, he or she can request Preauthorization. We have made the process simple and easy. Your Participating Physician can call or fax the Preauthorization request to **Prescription Solutions**, which is PacifiCare's pharmacy benefit manager. The Preauthorization staff of qualified pharmacists and technicians is available Monday through Friday from

6:00 a.m. to 6:00 p.m. to assist Participating Physicians. Most authorizations are completed within 24 hours. The most common reason for delay in the authorization process is insufficient information. Your Participating Physician may need to provide information on diagnosis and medication history and/or evidence in the form of documents, records or lab tests which establish that the use of the requested medication meets plan criteria.

Does this plan limit or exclude certain drugs my health care provider may prescribe or encourage substitutions for some drugs?

Your PacifiCare pharmacy benefit provides you access to a wide range of FDA-approved brand-name and generic medications. The Formulary is developed with the input from Participating Physicians and pharmacists and is based on assessment of the drug's quality, safety, effectiveness and cost. If a medication is not included on the Formulary, it may be because the Plan's Formulary includes other drugs that are frequently prescribed for the same condition as those that are not included on the Formulary. For example, PacifiCare may have an equivalent generic medication on the Formulary for the brand-name medication prescribed by your Participating Physician. It is also important to remember there may be other options available for treating a particular medical condition. Non-Formulary medications may require Preauthorization and will be approved when Medically Necessary unless otherwise excluded by PacifiCare as described in the "Exclusions and Limitations" section of the *Pharmacy Schedule of Benefits*. Refer to the section titled "What do I do if I need Preauthorization" in this document for additional information.

What should I do if I want to appeal a Preauthorization decision?

As a PacifiCare Member, you have the right to appeal any Preauthorization decision. Contact Customer Service at 1-800-624-8822 or TDHI 1-800-442-8833 for details on the Preauthorization or appeals process. Please refer to Section Eight of your medical *Combined Evidence of Coverage and Disclosure Form* for more details on the appeals process and the expedited review process.

Helpful tips:

- Take your medications list with you to the doctor's office.
- Ask your doctor if the drug prescribed is on the PacifiCare Formulary.
- Talk with your doctor about Formulary alternative medications to treat your medical condition.
- You and your doctor can access the most current Formulary information on our Web site at **www.pacificare.com** including information on Formulary alternatives.

Definitions

Contract Year – The 12-month period that begins on the first day of the month the Agreement became effective.

Calendar Year – The time period beginning on January 1 and ending on December 31.

Formulary – The Formulary is a list that contains a broad range of FDA-approved generic and some brand-name medications that under state or federal law are to be dispensed by a prescription only. The Formulary does not include all prescription medications.

Non-Participating Pharmacy – A pharmacy that has NOT contracted with PacifiCare to provide outpatient prescription drugs to our Members.

Non-Participating Physician – A Physician who has NOT contracted with PacifiCare to provide health care services to our Members.

Participating Pharmacy – A pharmacy that has contracted with PacifiCare to provide outpatient prescription drugs to our Members.

Participating Physician – A Physician who has contracted with PacifiCare to provide health care services to our Members.

Plan Year – The 12-month period that begins on the first day of the month the Agreement became effective.

Preauthorization – PacifiCare's review process that determines whether a prescription drug is Medically Necessary and not otherwise excluded prior to the Member receiving the prescription drug.

Prescription Unit – The maximum amount (quantity) of prescription medication that may be dispensed per single Copayment. For most oral medications, a Prescription Unit represents up to a 30-day supply of medication. The Prescription Unit for some medications may be set at a smaller quantity to promote appropriate medication use and patient safety. Quantity limits are based on generally accepted pharmaceutical practices and the manufacturer's labeling. Prescriptions that are normally dispensed in prepackaged or commercially available units of 30 days or less will be considered a single Prescription Unit, including, but not limited to, one inhaler, one vial of ophthalmic medication, one tube of topical ointment or cream.

Selected Brands List – The brand-name drugs included on the PacifiCare Formulary in place of their generic equivalents. These drugs are available at the generic drug Copayment amount.

Non-Formulary Preferred Drug – Non-Formulary drug that is more cost-effective than a similar non-Formulary drug.

Pharmacy Listing

For the most up-to-date list visit the Web site at www.pacificare.com.

- Albertson's Food & Drug
- Bel Air Market Pharmacies
- Costco Pharmacies
- Drug Emporium
- Friendly Meds
- Gemmel Pharmacy Group
- Horton & Converse Pharmacies
- Kmart Pharmacies
- Long's Drug Stores (except Hawaii)
- Medicap Pharmacies
- Medicine Shoppe Pharmacies
- Network Pharmacies
- Raley's Drug Center
- Rite Aid Pharmacies
- Safeway Pharmacies
- Save Mart Pharmacies
- Sav-On Drugs/Sav-On Express
- Sharp Rees-Stealy Pharmacies
- Talbert Health Services
- Target Pharmacy
- United Supermarkets, Inc.
- Value Merchandise
- Vons Food and Drug
- Walgreen's
- Wal-Mart Pharmacies

**P.O. Box 6006
Cypress, CA 90630**

**Customer Service:
800-624-8822
800-442-8833 (TDHI)
www.pacificare.com**

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CALIFORNIA

Supplement to the Combined Evidence of Coverage and Disclosure Form
SMI/Individual Plan

SMI/INDIVIDUAL
PBH SCHEDULE OF BENEFITS

Preauthorization is required for all Mental Health Services, including 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. PBHC is available to you toll-free, 24 hours a day, 7 days a week, at 1-800-999-9585.

Severe Mental Illness Benefits³

Inpatient Residential and Day Treatment <i>Unlimited days</i>	Same as medical plan hospitalization Copayment ¹
Outpatient Treatment <i>Unlimited Visits</i>	Same as medical plan office visit Copayment
Emergency and Urgently Needed Services ²	Same as medical plan Emergency and Urgently Needed Services ² Copayment waived if admitted as an inpatient

The Lifetime Dollar Maximum for Severe Mental Illness will be applied to Medical Plan Lifetime Dollar Maximum Benefit, if applicable.

¹Each Hospital Admission may require an additional Copayment. Please refer to your PacifiCare of California Medical Plan *Schedule of Benefits*.

²Emergency and Urgently Needed Services are Medically Necessary services 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.

³Severe Mental Illness diagnoses include: 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. In addition, the Severe Mental Illness Benefit includes coverage of Serious Emotional Disturbance of Children (SED).

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WELCOME TO PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA

THIS IS A SUPPLEMENT TO THE PACIFICARE OF CALIFORNIA MEDICAL COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM

Your PacifiCare of California Medical Plan includes Mental Disorder coverage through PacifiCare Behavioral Health of California (PBHC). This coverage includes the treatment of Severe Mental Illness (SMI) for adults and children and treatment for children with Serious Emotional Disturbance (SED). As a PBHC Member, you and your eligible Dependent always have direct, around-the-clock access to behavioral health benefits. You do not need to go through a Primary Care Physician (PCP) to access your behavioral health benefits, and all services are completely confidential.

This *Combined Evidence of Coverage and Disclosure Form* will help you become more familiar with your Behavioral Health Care benefits. This *Combined Evidence of Coverage and Disclosure Form* should be used in conjunction with your *PacifiCare of California Combined Evidence of Coverage and Disclosure Form*. It is a legal document that explains your Behavioral Health 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 Seven – Definitions**.

Whether you are the Subscriber of this coverage or enrolled as a Family Member, your *Combined Evidence of Coverage and Disclosure Form* is a key to making the most of your membership, and it should be read completely and carefully. All applicants have a right to view this document prior to enrollment. Individuals with special behavioral health needs should carefully read those sections that apply to them.

Introduction



What else should I read to understand my benefits?

Along with this *Combined Evidence of Coverage and Disclosure Form*, be sure to review your PBHC *Schedule of Benefits* in this *Combined Evidence of Coverage and Disclosure Form* and your *PacifiCare of California Medical Schedule of Benefits* for details of your particular Behavioral Health Plan, including any Co-payments or coinsurance that you may have to pay when accessing Behavioral Health Services. Together, these documents explain your coverage.

What if I still need help?

After you become familiar with your behavioral health benefits, you may still need assistance. Please do not hesitate to call our Customer Service Department at 1-800-999-9585 or for the hearing and speech impaired use 1-888-877-5378 (TDHI).

You may write to PBHC at the following address:

PacifiCare Behavioral Health of California, Inc.
3120 West Lake Center Drive
Santa Ana, CA 92704-6917

Or visit the PBHC's Web site: www.pbhi.com



Section One – Understanding Behavioral Health: Your Benefits

- *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.

What is a Severe Mental Illness?

A Severe Mental Illness (SMI) 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

What is the Serious Emotional Disturbance of a Child?

Serious Emotional Disturbance (SED) 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; 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*.

Section One – Understanding Behavioral Health: Your 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 on both an inpatient and outpatient basis. Details concerning your behavioral health benefits can be found in your *Schedule of Benefits* and in Section Four of this *Combined Evidence of Coverage and Disclosure Form*.



Section Two – 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 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 your Participating Provider, please call our Customer Service Department. You 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.

Section Two – Getting Started: Your Participating Provider



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 **Section Seven – 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/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



Section Two – Getting Started: Your Participating Provider

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.

Section Three – 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 experiencing a situation which requires the immediate provision of Behavioral Health Services such that a delay caused by seeking treatment from a PBHC Participating Provider 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 Psychiatric 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



Section Three – Emergency Services and 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 Five – Overseeing Your Behavioral Health Services** in this *Combined Evidence of Coverage and Disclosure Form*.

Section Four – Covered Behavioral Health Services



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

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 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 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 Physician 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. 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 a Mental Disorder 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 while the Member is confined to an Inpatient 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

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.



Section Four – Covered Behavioral Health Services

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 laws are not covered.
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 nonlicensed 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 non-medical 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. Counseling, treatment or services associated with or in preparation for a sex (gender) reassignment operation are not covered.
19. Sexual therapy programs, including therapy for sexual addiction, the use of sexual surrogates, and sexual treatment for sexual offenders/perpetrators of sexual violence.
20. Personal or comfort items, and non-Medically Necessary private room and/or private-duty nursing during inpatient hospitalization are not covered.
21. With the exception of injectable psychotropic medication as set forth in Section Four, 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.)
22. Surgery or acupuncture.
23. Services that are required by a court order as a part of parole or probation, or instead of incarceration, which are not Medically Necessary.
24. Neurological services and tests, including, but not limited to, EEGs, PET scans, beam scans, MRIs, skull X-rays and lumbar punctures.
25. Treatment sessions by telephone or computer Internet services.
26. Evaluation or treatment for education, professional training, employment investigations, fitness for duty evaluations or career counseling.
27. 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

Section Four – Covered Behavioral Health Services



defined by the *American Academy of Pediatrics Policy Statement – Learning Disabilities, Dyslexia and Vision: A Subject Review*.

28. Treatment of problems that are not Mental Disorders are not covered, except for diagnostic evaluation.

29. 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”.



Section Four – Covered Behavioral Health Services

30. All exclusions and limitations listed in the PacifiCare of California Group *Subscriber Agreement* and EOC under the “Exclusions and Limitations” section.
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.)

Section Five – 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, 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*. 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/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



Section Five – Overseeing Your Behavioral Health Services

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 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 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,

Section Five – Overseeing Your Behavioral Health Services



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.
P.O. 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 endpoint 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.



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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.
P.O. 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 but 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

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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 endpoint 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:



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1. Your Provider 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 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 a 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 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 Medical 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 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

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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 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 days of the request for expedited review. The review period can be extended up to three 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 exist, including, but not limited to, serious pain, the potential loss of life, limb or major bodily function or the immediate and serious deterioration of the Member's health. In this instance, any analyses and recommendation of the experts must be expedited and rendered within three 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 experts' 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,



Section Five – Overseeing Your Behavioral Health Services

citing the Member's specific medical condition, the relevant documents provided and the relevant medical and scientific evidence supporting the expert's 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 reviewer's 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 working days. In the case of services not yet rendered to the Member, PBHC will authorize the services within five 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.

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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 treatment 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.



Section Six – 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
Claims Department
P.O. Box 31053
Laguna Hills, CA 92654-1053

Your Financial Responsibility

Please refer to the "Payment Responsibility" 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.

Section Six – General Information



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.

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 1-888-777-3465.

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.



Section Seven – 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, 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, 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 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 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.

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

Section Seven – Definitions



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 Mental Disorders.

Domestic Partner is a person who meets the eligibility requirements, as defined by your Employer Group, and the following:

- i. Is eighteen (18) years of age or older;
- ii. Is mentally competent to consent to contract;
- iii. Resides with the Subscriber and intends to do so indefinitely;
- iv. Is jointly responsible with the Subscriber for their common welfare and financial obligations;
- v. Is unmarried or not a member of another domestic partnership; and
- vi. Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

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.

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 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 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.



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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 Disorder;
- 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 to maintain or restore functional ability. A health intervention is defined not only by the intervention itself, but also by the Mental Disorder 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 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 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

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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.

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 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:



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- 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.

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

PacifiCare Behavioral Health of California, Inc.
3120 West Lake Center Drive
Santa Ana, CA 92704-6917

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



Notes



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Visit our Web site @ www.pacificare.com