27333

PACIFICARE OF CALIFORNIA
MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT
COVER SHEET
(This Cover Sheet is an integral part of this Agreement)

GROUP NAME: CITY OF LONG BEACH

GROUP CODE: 515102 Active; 515103 - Cobra

GROUP COVERAGE EFFECTIVE DATE: December 1, 2005 through November 30, 2006

PLAN CODE: FHC, FHZ, ACD, HA1, MPU, R04

PLAN DESCRIPTION: $10 SignatureValue (HMO) 2000 Series Plan with Acupuncture/ChiroCare $10/40 Visits, Hearing Aid Benefit – Unlimited Max, PacifiCare Behavioral Health/SMI + Supplement U and Managed Formulary $5 Generic/$15 Brand/$25 Non-Formulary Outpatient Prescription Drugs

HEALTH PLAN PREMIUMS:

Super Composite Rate: $713.45

BILLING CODE: 01*
* Charged entire month if eligible at least one day of the month.

PREMIUMS DUE ON OR BEFORE (refer to Section 3.06): The 1st of the month of coverage.
ANNUAL COPAY MAXIMUM PER INDIVIDUAL: $1000.00
ANNUAL COPAY MAXIMUM PER FAMILY: $3000.00
CONTINUATION OF BENEFITS ELECTIONS: Yes

ELIGIBILITY:
Group Eligibility

See Section 2 of the enclosed American Specialty Health Plans Group Subscriber Agreement for Group Eligibility as it applies to the Chiropractic/Acupuncture benefit.

Minimum hours required per week: 40

Dependent Member Eligibility: Dependent children are Eligible through age: 19
Students are Eligible through age: 25

Start and End date of coverage: New hires hired between the 1st of the month through the 4th of the month are effective 1st of the following month. New hires hired on or after the 5th of the month are effective 1st of the month following 1 full month of employment. Coverage ends at the end of the month of termination of employment.

A new spouse, Domestic Partner or children are eligible as set forth in the PacifiCare Evidence of Coverage and Disclosure Form.

ATTACHMENTS: **(The following Attachments are an integral part of this Agreement)**

* Surviving Dependent, Eligibility and Domestic Partner Amendment
A - Schedule of Benefits, PacifiCare Combined Evidence of Coverage and Disclosure Form
D - Acupuncture/Chiropractic Services
H - Hearing Aid
L - PacifiCare Behavioral Health
R - Outpatient Prescription Drug Benefit

PACIFICARE OF CALIFORNIA

MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT

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MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT

This Medical and Hospital Group Subscriber Agreement (the "Agreement") is entered into between PACIFICARE OF CALIFORNIA, a California corporation, hereinafter called "PacifiCare," and the employer, association or other entity specified as "GROUP" on the Cover Sheet, hereinafter called "Group."

RECITAL OF FACTS

PacifiCare is a health care service plan which arranges for the provision of medical, hospital and preventive medical services to persons enrolled as Members through contracts with associations of licensed physicians, hospitals and other health care providers. Group is an employer, union, trust, organization, or association which desires to provide such health care for its eligible Subscribers and family Dependents. PacifiCare desires to contract with Group to arrange for the provision of such health care services to Subscribers and family Dependents of Group, and Group desires to contract with PacifiCare to arrange for the provision of such services to its Subscribers and family Dependents.

AGREEMENT

NOW THEREFORE, in consideration of the application of Group for the benefits provided under this Agreement, and in consideration of the periodic payment of Health Plan Premiums on behalf of Members in advance as they become due, PacifiCare agrees to arrange for or provide medical, surgical, hospital, and related health care benefits subject to all terms and conditions of this Medical and Hospital Group Subscriber Agreement, including the Cover Sheet and Attachments.

1. DEFINITIONS

1.01 Agreement is this Medical and Hospital Group Subscriber Agreement, including, but not limited to, the Cover Sheet, Attachments and any amendments thereto.

1.02 Combined Evidence of Coverage and Disclosure Form is the document issued to prospective and enrolled Subscribers disclosing and setting forth the benefits and terms and conditions of coverage to which Members of the Health Plan are entitled.

1.03 Copayments are fees payable to a health care provider by the Member at the time of provision of services which are in addition to the Health Plan Premiums paid by the Group. Such fees may be a specific dollar amount or a percentage of total fees as specified herein, depending on the type of services provided.

1.04 Cover Sheet is the Medical and Hospital Group Subscriber Agreement Cover Sheet which is attached to and an integral part of this Agreement.

1.05 Dependent is any spouse, Domestic Partner or unmarried child (including a step-child, adopted child, child(ren) for whom the Subscriber, the Subscriber's spouse or Domestic Partner has assumed permanent guardianship or a child of a Domestic Partner) of a Subscriber who is enrolled hereunder, who meets all the eligibility requirements set forth in the PacifiCare Combined Evidence of Coverage and Disclosure Form attached to this Agreement and for whom applicable Health Plan Premiums are received by PacifiCare.

1.05(a) Domestic Partner is a person who meets the eligibility requirements, as defined by the 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; and
(vi) Is not related by blood to the Subscriber to a degree of closeness that would prohibit marriage in the state of residence.

1.06 Eligible Employee is a Group employee who works a fixed number of hours per week as established by the Group, meets any applicable waiting period required by the Group, and meets the following additional criteria:

(a) Is defined as an employee under state and federal law;

(b) Is actively working or is able to return to active work and has certain rights pertaining to leaves of absence if his or her condition improves. Consultants, temporary labor, suppliers or contractors are not Eligible Employees.

1.07 Enrollment is the execution of a PacifiCare Enrollment form, or a non-standard Enrollment form approved by PacifiCare, by the Subscriber on behalf of the Subscriber and his or her Dependents, and acceptance thereof by PacifiCare, conditioned upon the execution of this Agreement by PacifiCare, and either the execution of this Agreement by Group or the timely payment of applicable Health Plan Premiums by Group. In its discretion and subject to specific protocols, PacifiCare may accept Enrollment through an electronic submission from Group.

1.08 Group is the single employer, labor union, trust, organization, or association identified on the Cover Sheet.

1.09 Group Contribution is the amount of the Health Plan Premium applicable to each Subscriber which is paid solely by the Group or employer and which is not paid by the Subscriber either through payroll deduction or otherwise.

1.10 Group Participation is the number of individuals in the Group who are enrolled as Subscribers expressed as a percentage of the number of individuals in the Group who are eligible to enroll as Subscribers.

1.11 Health Plan is the health plan described in this PacifiCare Medical and Hospital Group Subscriber Agreement, Cover Sheet and Attachments, subject to modification pursuant to the terms of this Agreement.

1.12 Health Plan Premiums are amounts established by PacifiCare to be paid to PacifiCare by Group on behalf of Members in consideration of the benefits provided under this Health Plan; such amounts are set forth in the Cover Sheet of this Agreement.

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

1.14 Open Enrollment Period is the annual period of not less than thirty (30) days agreed upon by PacifiCare and Group, during which all eligible and prospective Group Subscribers and their Eligible Dependents may enroll in this Health Plan.

1.15 PacifiCare Enrollment Packet is 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 or a non-standard Enrollment form approved by PacifiCare, and the PacifiCare Combined Evidence of Coverage and Disclosure Form.

1.16 Subscriber is the individual enrolled in the Health Plan for whom the appropriate Health Plan Premium has been received by PacifiCare, and whose employment or other status, except for family dependency, is the basis for enrollment eligibility.

2. ELIGIBILITY AND ENROLLMENT

2.01 Enrollment Procedure

2.01.01 Application Form. A properly completed, signed application for Enrollment on a form provided by PacifiCare, or on a non-standard form approved by PacifiCare, must be submitted to PacifiCare by Group for each eligible and/or prospective 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 from Group.

2.01.02 Time of Enrollment. All applications for Enrollment shall be submitted by prospective Subscribers to the Group during Open Enrollment Periods, except that

prospective Subscribers and their Eligible Dependents who were not eligible during the previous Open Enrollment Period may apply for Enrollment within thirty-one (31) days after becoming eligible. All applications for Enrollment which are not received by PacifiCare within the thirty-one (31) days from the first day the prospective Subscriber or Dependent becomes eligible shall be subject to rejection by PacifiCare. Prospective Subscribers and their Eligible Dependents may reapply at the next Open Enrollment Period in the event an application was not received by PacifiCare within such thirty-one (31) day period. Group shall provide notice to Members of the applicable Open Enrollment Periods.

2.01.03 Notice and Certification. Group shall provide a written notice and certification, prepared by PacifiCare, as part of the PacifiCare Enrollment Packet to Eligible Employees at the commencement of the initial Open Enrollment Period. The written notice and certification section of the PacifiCare application for Enrollment shall provide notice of the availability of coverage under the Health Plan and indicate that an Eligible Employee's failure to elect coverage, on his or her behalf or on behalf of his or her Eligible Dependents during the initial Open Enrollment Period, permits PacifiCare to exclude coverage for a period of up to twelve (12) months until the Employer's next open enrollment period. Group shall require any Eligible Employee declining coverage under the Health Plan on behalf of himself or herself or any Eligible Dependent, to certify on the written notice and certification prepared by PacifiCare, the reason for declining Enrollment in the Health Plan and that he or she has reviewed the notice and certification and understands the consequences of declining coverage under the Health Plan. Group agrees to submit all completed notices and certifications to PacifiCare for:

a. Each Eligible Employee and/or his or her Eligible Dependents who declined coverage at renewal of this Agreement; and

b. Each Eligible Employee and/or his or her Eligible Dependents who became eligible during the term of this Agreement specified on the Cover Sheet of this Agreement and who have declined coverage.

2.01.04 Late Enrollment. Please refer to the section of this Agreement entitled Combined Evidence of Coverage and Disclosure Form for a complete description of Late Enrollment procedures.

2.02 Commencement of Coverage. The commencement date of coverage under this Health Plan shall be effective in accordance with the terms of the Cover Sheet and this Agreement. PacifiCare's acceptance of each Member's Enrollment is contingent upon receipt of the applicable Health Plan Premium payment.

2.03 PacifiCare's Liability in the Event of Conversion from a Prior Carrier. In the event PacifiCare replaces a prior carrier responsible for the payment of benefits or provision of services under a group contract within a period of sixty (60) days from the date of discontinuation of the prior contract or policy, PacifiCare will immediately cover all employees and dependents who were validly covered under the previous contract or

policy at the date of discontinuation, and who are eligible for enrollment under this Agreement, without regard to health status or hospital confinement. Notwithstanding the foregoing, with respect to employees or dependents who were totally disabled on the date of discontinuation of the prior contract or policy, and entitled to an extension of benefits pursuant to Section 1399.62 of the California Health & Safety Code or Section 10128.2 of the California Insurance Code under the prior contract or policy, PacifiCare shall not be financially responsible for any payment of benefits or provision of services directly related to any condition which caused the total disability. In such a situation, the prior carrier shall continue to be financially responsible for all benefits or services directly related to any condition which caused the total disability until such extension of benefits is no longer required under California or federal law.

3. GROUP OBLIGATIONS, HEALTH PLAN PREMIUMS AND COPAYMENTS

3.01 Non-Discrimination. Group shall offer PacifiCare an opportunity to market this Health Plan to its employees and shall offer its employees an opportunity to enroll in this Health Plan under no less favorable terms or conditions than Group offers enrollment in other health care service plans or employee health benefit plans.

3.02 Notices to PacifiCare. Group shall forward all completed or amended Enrollment forms for each Member for receipt by PacifiCare within thirty-one (31) days of the Member's initial eligibility. Group acknowledges that any Enrollment applications not received by PacifiCare within such thirty-one (31) day period may be rejected by PacifiCare. Group further agrees to transmit to PacifiCare any Enrollment application amendments pursuant to the Administrative Manual described in Section 8.07 below.

Group shall forward all notices of termination to PacifiCare within thirty-one (31) days after Member loses eligibility or elects to terminate membership under this Agreement. Group agrees to pay any applicable Member Health Plan Premiums through the last day of the month in which notice of termination is received by PacifiCare.

3.03 Notices to Member. If Group or PacifiCare terminates this Agreement pursuant to Section 7 below, Group shall promptly notify all Members enrolled through Group of the termination of their coverage in this Health Plan. Group shall provide such notice by delivering to each Subscriber a true, legible copy of the notice of termination sent from PacifiCare to Group at the Subscriber's then current address. Group shall promptly provide PacifiCare with a copy of the notice of termination delivered to each Subscriber, along with evidence of the date the notice was provided. In the event that PacifiCare terminates this Agreement for non-payment of Health Plan Premiums, Members will receive notice of termination from PacifiCare.

If, pursuant to Sections 3.07.01 and 3.07.02 below, PacifiCare increases Health Plan Premiums payable by the Subscriber, or if PacifiCare increases Copayments or reduces covered services provided under this Agreement, Group shall promptly notify all Members enrolled through Group of the increase or reduction. In addition, Group

shall promptly notify Members enrolled through Group of any other changes in the terms or conditions of this Agreement affecting the Members' benefits or obligations under the Health Plan. Group shall provide such notice by delivering to each Subscriber a true, legible copy of the notice of the Health Plan Premium or Copayment increase or reduction in covered services sent from PacifiCare to Group at the Subscriber's then current address. Group shall promptly provide PacifiCare with a copy of the notice of Health Plan Premium or Copayment increase or reduction in covered services delivered to each Subscriber, along with evidence of the date the notice was provided. PacifiCare shall have no responsibility to Members in the event Group fails to provide the notices required by this Section 3.03.

3.04 Indemnification. Group agrees to indemnify, defend and hold PacifiCare harmless and accept all legal and financial responsibility for any liability arising out of Group's failure to perform its obligations as set forth in this Section 3.

3.05 Rates (Prepayment Fees). The Health Plan Premium rates are set forth in the Health Plan Premiums section of the Cover Sheet and supplemental Health Plan Premium notices.

3.06 Due Date . Health Plan Premiums are due in full on a monthly basis by check or electronic transfer and must be paid directly by Group to PacifiCare on or before the last business day of the month prior to the month for which the premium applies. Failure to provide payment on or before the due date may result in termination of Group, as set forth in Section 7.02.01 below. PacifiCare reserves the right to assess an administrative fee of five percent (5%) of the monthly premium prorated on a thirty (30)-day month for each day it is delinquent thereafter. This fee will be assessed solely at PacifiCare's discretion. In the event that deposit of payments not made in a timely manner are received by PacifiCare after termination of Group, the depositing or applying of such funds does not constitute acceptance, and such funds shall be refunded by PacifiCare within twenty (20) business days of receipt if PacifiCare, in its sole discretion, does not reinstate Group.

3.07 Modification of Rates and Benefits.

3.07.01 Modification of Health Plan Premium Rates. The Health Plan Premium rates set forth on the Cover Sheet and the PacifiCare Enrollment Packet may be modified by PacifiCare in its sole discretion upon thirty (30) days prior written notice mailed postage prepaid to Group. Any such modification shall take effect commencing the first full month following the expiration of the thirty (30)-day notice period.

Notwithstanding the above, if the State of California or any other taxing authority imposes upon PacifiCare a tax or license fee which is levied upon or measured by the monthly amount of Health Plan Premiums or by PacifiCare's gross receipts or any portions of either, then upon thirty (30) days written notice to Group, Group shall remit to PacifiCare, with the appropriate payment, a pro rata amount sufficient to cover all such

taxes and license fees, rounded to the nearest cent.

3.07.02 Modification of Benefits or Terms. The covered services set forth in the Combined Evidence of Coverage and Disclosure Form, the Schedule of Benefits, and the Schedule of Supplemental Benefits in the PacifiCare Enrollment Packet, as well as other terms of this Agreement, may be modified by PacifiCare in its sole discretion upon thirty (30) days written notice mailed postage prepaid to Group. Any such modification shall take effect commencing the first full month following the expiration of the thirty (30)-day notice period.

3.08 Effect of Payment. Except as otherwise provided in this Agreement, only Members for whom Health Plan Premiums are received by PacifiCare are entitled to health care benefits as described in this Agreement, and then only for the period for which such payment is received. Group agrees to pay premium to PacifiCare for the first month of coverage for newborn or adopted children who become eligible as provided in the Combined Evidence of Coverage and Disclosure Form section of this Agreement.

3.09 Continuation of Benefits and Conversion Coverage.

3.09.01 Notice Regarding Continuation Coverage. With the exception of Domestic Partners and their Dependents, upon the occurrence of a qualifying event, as defined by the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended by the 1986 Tax Reform Act (P.L. 99-514) and the 1986 Omnibus Budget Reconciliation Act (P.L. 99-509) ("COBRA"), Group shall provide affected Members with written notice of available continuation coverage as required by and in accordance with COBRA and amendments thereto. Group shall be solely responsible for collecting Health Plan Premiums from Members who elect to continue benefits under COBRA and shall transmit such Health Plan Premiums to PacifiCare along with the Group's Health Plan Premiums otherwise due under this Agreement. Group shall maintain accurate records regarding Health Plan Premiums for Members who elect to continue benefits, including qualifying events, terminating events, and other information necessary to administer this continuation of benefits. The obligations to be performed by Group under this Subsection may be performed directly by Group, or wholly or in part through a subsidiary or affiliate of Group, or on behalf of Group by a third party, including but not limited to a COBRA coverage administrator; provided that Group will remain liable to PacifiCare for satisfaction of the obligations to be performed by Group under this Subsection. PacifiCare is not responsible for the acts or omissions of Group or designee and shall be held harmless for any failure by Group to fulfill its obligations, including but not limited to failure to provide proper notice or failure to forward premium payments to PacifiCare within applicable statutory time frames.

3.09.02 Notice of Individual Conversion Rights. Within fifteen (15) days after a Member's coverage terminates, Group shall notify the Subscriber on behalf of the Subscriber and his or her Dependents or, if no Subscriber is available, any terminated Dependent, including a Domestic Partner and his or her Dependents of the availability, terms, and individual conversion rights as set forth in the Combined Evidence of

Coverage and Disclosure Form.

4. BENEFITS AND CONDITIONS FOR COVERAGE

The attached PacifiCare Combined Evidence of Coverage and Disclosure Form, Schedule of Benefits, and additional related attachments included at the end of this Agreement, are an integral part of this Agreement, and include a complete description of the Benefits and Conditions of Coverage of this Health Plan.

5. PARTIES AFFECTED BY THIS AGREEMENT; RELATIONSHIPS BETWEEN PARTIES

5.01 Relationship of Parties. Group is not the agent or representative of PacifiCare and shall not be liable for any acts or omissions of PacifiCare, its agents, employees or providers, or any other person or organization with which PacifiCare has made, or hereafter shall make, arrangements for the performance of services under this Health Plan. Member is not the agent or representative of PacifiCare and shall not be liable for any acts or omissions of PacifiCare, its agents or employees.

5.02 Compliance with the Health Insurance Portability and Accountability Act of 1996. PacifiCare agrees to furnish written certification of prior creditable coverage ("Certificates") to all eligible Members, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). PacifiCare and Group acknowledge that PacifiCare's agreement to issue Certificates to all eligible Members relieves Group of its obligation under HIPAA to furnish Certificates. Group acknowledges that PacifiCare must rely completely on eligibility information and data (including, but not limited to, Member's name and current address) furnished by Group in issuing Certificates to Members. Group agrees to notify PacifiCare of all terminations within thirty (30) days of the termination, and to provide PacifiCare with eligibility information and data within thirty (30) days of its receipt or change. Group agrees to indemnify, defend and hold PacifiCare harmless and accept all legal, financial and regulatory responsibility for any liability arising out of PacifiCare's furnishing Certificates to eligible members under HIPAA.

6. TERM OF AGREEMENT; RENEWAL PROVISIONS

6.01 Term; Automatic Renewal. The term of this Agreement shall be one (1) year, commencing on the Group Coverage Effective Date set out in the Cover Sheet, unless otherwise indicated on the Cover Sheet or unless this Agreement is terminated as provided herein. This Agreement shall automatically renew for a one (1) year term on each anniversary of the date of commencement of this Agreement or as indicated on the Cover Sheet, unless terminated as provided herein. Renewal of this Agreement shall be subject to modification of rates and benefits pursuant to Section 3.07.

7. TERMINATION

7.01 Termination by Group. Group may terminate this Agreement by giving a minimum of thirty (30) days written notice of termination to PacifiCare. Group termination must always be effective on the first day of the month. Group shall continue to be liable for Health Plan Premiums for all Members enrolled in this Health Plan through Group until the date of termination.

7.02 Termination by PacifiCare.

7.02.01 For Nonpayment of Health Plan Premiums. PacifiCare may terminate this Agreement in the event Group or its designee fails to remit Health Plan Premiums in full by the required date to PacifiCare by giving written notice of termination of this Agreement via first class mail to Group. Nonpayment of Health Plan Premiums includes but is not limited to, payments returned due to non-sufficient funds (NSF) and post-dated checks. Such notice shall specify that payment of all unpaid Health Plan Premiums must be received by PacifiCare within fifteen (15) days of the date of issuance of the notice, and that if payment is not received within the fifteen (15) day period, no further notice shall be given, and coverage for all Members enrolled in this Health Plan shall automatically be terminated effective at the end of the month for which Health Plan Premiums have been actually received by PacifiCare, subject to compliance with notice requirements. After the initial issuance of the notice to Group, PacifiCare will send a HIPAA Certificate of Creditable Coverage to the Subscribers, notifying the Subscriber's that their health care coverage and their Dependent's health care coverage under this Plan has terminated effective the first of the month for which Health Plan Premiums were not received. Subscribers and eligible Dependents will be able to elect either PacifiCare's Individual Conversion Plan or HIPAA Guaranteed Issue product effective the first of the month in which the Member loses coverage.

7.02.01.01 Reinstatement Following Non-Payment of Premium. Notwithstanding Section 7.02.01, receipt by PacifiCare of all Health Plan Premium payments then due and owing on or before the succeeding Health Plan Premium payment due date will reinstate this Agreement as though it had never been terminated. However, PacifiCare may, in its discretion, elect not to reinstate this Agreement in any of the following circumstances: (1) the notice of termination states that, if Health Plan Premium payment is not received within fifteen (15) days of issuance of the notice of termination, a new application is required and identifies conditions under which a new agreement will be issued or this Agreement reinstated; (2) if payment of Health Plan Premiums is received by PacifiCare more than fifteen (15) days after the issuance of notice of termination, and the Plan refunds such payment within twenty (20) business days of receipt; or, (3) if payment of Health Plan Premiums is received more than fifteen (15) days after issuance of the notice of termination, and PacifiCare issues to Group, within twenty (20) business days of receipt of such Health Plan Premiums, a new Agreement accompanied by written notice stating clearly those respects in which the new

Agreement differs from this Agreement in benefits, coverage or otherwise. In the event PacifiCare receives untimely payments after Group has been terminated, the deposit or application of such funds by PacifiCare does not constitute acceptance of such funds or reinstate group, and such funds may be refunded by PacifiCare at its sole discretion.

7.02.02 Termination for Breach of Material Term. PacifiCare may terminate this Agreement if Group breaches any material term, covenant or condition of this Agreement and fails to cure such breach within thirty (30) days after PacifiCare sends written notice of such breach. For purposes of this Section 7.02.02, material terms of this Agreement specifically include, but are not limited to, Sections 3.01 and 8.03. PacifiCare's written notice of breach shall make specific reference to Group's action causing such breach. If Group fails to cure its breach subject to PacifiCare's satisfaction within thirty (30) days after PacifiCare sends notice of the breach, PacifiCare may terminate this Agreement at the end of the thirty (30)-day notice period.

7.02.03 For Providing Misleading or Fraudulent Information. PacifiCare may terminate this Agreement thirty (30) days after PacifiCare sends written notice to Group if Group provides materially misleading or fraudulent information to PacifiCare in any Group questionnaires or is aware that materially misleading or fraudulent information has been provided on membership Enrollment forms.

7.02.04 For Ceasing to Meet Group Eligibility Criteria. PacifiCare may terminate Group upon thirty (30) days written notice to Group if Group fails to meet any of the following Group eligibility requirements:

(a) Group fails to maintain active Group Participation percentage of seventy-five percent (75%);

(b) For Subscribers without Dependents, Group fails to maintain a Group Contribution equal to seventy-five percent (75%) of the Health Plan Premium;

(c) For Subscribers with Dependents, Group fails to maintain a Group Contribution equal to the dollar amount of the Group Contribution for Subscribers without Dependents;

(d) Group fails to abide by and enforce the conditions of Subscriber Enrollment set forth in this Agreement.

7.02.05 For Changing the Nature of Group's Business. PacifiCare may terminate Group thirty (30) days after PacifiCare sends written notice to Group if Group materially alters the nature of its business. "Materially Alters," for the purposes of this Section 7.02.05, means a significant change in the business conducted by Group after the commencement of this Agreement.

7.02.06 For Loss of Group's Office Location within Geographic Area of

Licensure. PacifiCare may terminate Group if Group no longer maintains an office location within the area in which PacifiCare is licensed as a health care service plan. PacifiCare shall provide Group with thirty (30) days written notice prior to such termination. Group must notify PacifiCare of changes of the Group's office location provided on the Group application within (30) thirty days of the change.

7.03 Return of Prepayment Premium Fees Following Termination. In the event of termination by either 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) or Group, PacifiCare will, within thirty (30) days, return to Group 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.

8. MISCELLANEOUS PROVISIONS

8.01 Governing Law. This Agreement 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 thereunder 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 thereunder 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 Employee Retirement Income Security Act of 1974, as amended, (codified at Chapter 18 of Title 29 of the United States Code, and the regulations promulgated thereunder by the United States Department of Labor (codified at Chapter XXV of Title 29 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 by any of the above laws and regulations shall bind PacifiCare, Group and Member whether or not expressly provided in this Agreement.

8.02 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. Group shall not use PacifiCare's name, product names, symbols, logos, trademarks, or service marks without obtaining the prior written approval of PacifiCare.

8.03 Assignment. This Agreement 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 will continue in full force and effect as if such corporation, firm or person were a party to this Agreement, provided such corporation, firm or person continues to provide prepaid health services.

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

8.05 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 to PacifiCare, its agents and employees, Member's participating medical group, and appropriate governmental agencies. PacifiCare shall not release any information to Group which would directly or indirectly indicate to the Group that a Member is receiving or has received covered services, unless authorized to do so by the Member.

8.06 Amendments. This Agreement may be modified by PacifiCare as set forth in Section 3.07, above, or it may be amended upon the mutual written consent of the parties.

8.07 Group Use of Administrative Manual. Group agrees to comply with and conform to policies and procedures in the Administrative Manual provided by PacifiCare. PacifiCare agrees to provide thirty (30) days notice to Group of any changes in the Administrative Manual. In the event of conflict between this Agreement and the Administrative Manual, the terms of this Agreement shall prevail.

8.08 Attachments. The Cover Sheet and Attachments to this Agreement, and all terms and conditions set forth therein, as they are from time-to-time amended by parties, are incorporated by reference herein and made an integral part of this Agreement.

8.09 Use of Gender. The use of masculine gender in this Agreement includes the feminine gender and the singular includes the plural.

8.10 Waiver of Default. The waiver by PacifiCare of any one or more defaults by Group or 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.

8.11 Notices. Any notice required or permitted under this Agreement 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, California 90630-0006

If to Group or Member, at Group's or 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 forty-eight (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 twenty-four (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.

8.12 Acceptance of Agreement. Group may accept this Agreement either by execution of the Agreement or by making its initial payment to PacifiCare of Health Plan Premiums on or before the due date specified on the Cover Sheet. Member accepts the terms, conditions and provisions of this Agreement upon completion and execution of the Enrollment form. Acceptance by any of these methods shall render all terms and provisions of this Agreement binding on PacifiCare, Group and Members.

8.13 Entire Agreement. This Agreement, including all exhibits, attachments and amendments, contains the entire understanding of Group 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 Group and PacifiCare with respect to the subject matter of this Agreement.

8.14 Contracting Provider Termination. PacifiCare will provide written notice to Group within a reasonable time if it receives notice that any contracting provider terminates or breaches its contract with PacifiCare, or is unable to perform such contract, if the termination, breach, or inability to perform may materially and adversely affect Group.

8.15 Headings. The headings of the various sections of this Agreement 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.

8.16 No Third Party Beneficiaries. Except as otherwise expressly indicated in this Agreement, this Agreement shall not create any rights in any third parties who have

not entered into this Agreement, nor shall this Agreement entitle any such third party to enforce any rights or obligations that may be possessed by such third party.

9. ARBITRATION

9.01 Disputes Between Group and PacifiCare. All disputes between Group and PacifiCare shall be resolved by binding arbitration before JAMS, a non-judicial arbitration and mediation service. If the amount at issue is less than $200,000, then the arbitrator will have no jurisdiction to award more than $200,000. The JAMS Comprehensive Arbitration Rules and Procedures ("Rules") in effect at the time a demand for arbitration is made will be applied to the arbitration. The parties will seek to mutually agree on the appointment of an arbitrator; however, if an agreement cannot be reached within thirty (30) days following the date demanding arbitration, the parties will use the arbitrator appointment procedures in the Rules. Arbitration hearings will be held at the neutral administrator's offices in Orange County, California or at another location agreed upon in writing by the parties. Civil discovery may be taken in such arbitration as provided by California law and civil procedure. The arbitrator(s) selected will have the power to control the timing, scope and manner of the taking of discovery and will have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California. This includes, but is not limited to, the imposition of sanctions. The arbitrator(s) will have the power to grant all remedies provided by California law. The arbitrator(s) will prepare in writing an award that includes the legal and factual reasons for the decision. The parties will divide equally the fees and expenses of the arbitrator(s) and the neutral administrator. The arbitrator(s) will not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected pursuant to California law. The Federal Arbitration Act, 9 U.S.C. §§ 1-16, will also apply to the arbitration.

9.02 Disputes Between Member and PacifiCare.

9.02.01 Member Appeals and Grievances. The attached PacifiCare Combined Evidence of Coverage and Disclosure Form includes a complete description of the PacifiCare appeals and grievance procedures and dispute resolution processes for Members.

9.02.02 Binding Arbitration. Any and all disputes of any kind whatsoever, including, but not limited to, 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) between Member (including any heirs, successors, or assigns of Member) and PacifiCare except for claims subject to ERISA shall be submitted to binding arbitration. 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. Member and PacifiCare 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 Rules 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 to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules will be utilized.

Arbitration hearings shall be held in Orange County, California or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration as provided by California law and the Code of Civil Procedure. 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 California law. The parties shall divide equally the expenses of JAMS and the arbitrator. 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. 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 Federal Arbitration Act, 9 U.S.C. §§ 1-16, shall also apply to the arbitration.

9.03 Mandatory Arbitration. Group, Member and PacifiCare agree and understand that any and all disputes, including claims of 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, shall be determined by submission to binding arbitration in accordance with the terms of this Agreement. 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. Group, Member, and PacifiCare are giving up the constitutional right to have any such dispute decided in a court of law before a jury, and instead is accepting the use of binding arbitration.

AMENDMENT TO THE MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT BETWEEN PACIFICARE ("PACIFICARE") AND CITY OF LONG BEACH ("GROUP")

This **AMENDMENT TO THE PACIFICARE OF CALIFORNIA, MEDICAL AND HOSPITAL GROUP SUBSCRIBER AGREEMENT** dated as December 1, 2005 (this "Amendment"), is made and entered into by and between PacifiCare of California, a California corporation ("PacifiCare") and City of Long Beach ("Group").

1. Amendment. Pursuant to Section 3.07.02 of the Agreement, the benefits set forth in the Agreement are hereby amended as follows:

SECTION 1. DEFINITIONS

1.05 Definition of Dependent is amended to read as follows:

1.05 Dependent is any spouse, Domestic Partner (as defined below), or unmarried child (including a stepchild or adopted child) of Subscriber who is enrolled hereunder, who meets all the eligibility requirements set forth in Paragraph 2.03 and for whom applicable Health Plan Premiums are received by PacifiCare.

(i) The natural born or legally adopted children of the Subscriber or of the Subscriber's spouse or Domestic Partner(i.e. stepchildren);
(ii) Children for whom the Subscriber, Subscriber's spouse or Domestic Partner has been appointed a legal guardian by a court; and
(iii) Children for whom the Subscriber, Subscriber's spouse or Domestic Partner is required to provide health coverage pursuant to a qualified medical support order.

1.05(b) Definition of Same Gender Domestic Partner is added to read as follows:

1.05(b) Domestic Partner is defined as an adult who shares an emotional, physical and financial relationship with the employee, similar to that of a spouse. To be eligible for domestic partner coverage under the Group's employee benefits plans, the employee and domestic partner must complete the Affidavit of Domestic Partnership, in which each person individually certifies to the following facts:

- Each person is age 18 or older.
- Neither party may be currently married to another party. Proof of final decree of divorce may be required.
- Neither may be related to the other and are not related by blood closer than would prohibit legal marriage such as a parent, brother or sister, half brother or sister, niece, nephew, aunt uncle, grandparent or grandchild. Domestic Partnership does not include roommates, friends or other similar relationships.
- Both partners reside together and intend to do so indefinitely.
- Both partners agree to be economically responsible to third parties for their common welfare and financial obligations incurred during the period covered by the Group employer Health Plan. Examples include joint contribution for food, shelter and living expenses.

- Each domestic partner must be a citizen of the United States or an immigrant who has been lawfully admitted for permanent residence in the United States in accordance with the United States immigration laws.

1.06 Definition of Eligible Employee is amended to read as follows:

1.06 Eligible Employee is a permanent full-time City of Long Beach employee that is working a minimum of 40 hours per week and meets the applicable waiting period required by the City of Long Beach as follows:

a. New employee's hired on the 1st through the 4th of the month are eligible on the first of the following month;
b. New employee's hired on or following the 5th of the month are eligible on the first of the month following 30 days employment;

Additionally, an Eligible Employee is:

c. Defined as an employee under state and federal law;
d. Actively working or is able to return to active work and has certain rights pertaining to leaves of absence if his or her condition improves. Consultants, temporary labor, suppliers or contractors are not Eligible Employees.

SECTION 3. GROUP OBLIGATIONS, HEALTH PLAN PREMIUMS AND COPAYMENTS

Section 3.07. 01 Modification of Health Plan Premium Rates is hereby amended to read as follows:

3.07.01 Modification of Health Plan Premium Rates. The City of Long Beach's premium rates are guaranteed for the twelve (12) month period that this agreement is in force.

Notwithstanding the above, if the State of California or any other taxing authority imposes upon PacifiCare a tax or license fee which is levied upon or measured by the monthly amount of Health Plan Premiums or by PacifiCare's gross receipts or any portions of either, then upon thirty (30) days written notice to Group, Group shall remit to PacifiCare with the appropriate payment, a pro rata amount sufficient to cover all such taxes and license fees rounded to the nearest cent.

SECTION 7. TERMINATION OF GROUP COVERAGE

Section 7.02.04 For Ceasing to Meet Group Eligibility Criteria is hereby deleted.

SECTION 8. MISCELLANEIOUS PROVISIONS

Section 8.12 Acceptance of Agreement is hereby amended to read as follows:

Section 8.12 Acceptance of Agreement Group may accept this Agreement only by execution of the agreement. Such acceptance shall render all terms and provisions of this Agreement binding on PacifiCare, Group and Members.

Section 8.17 Death of Retiree Subscriber, (Dependent Eligibility), shall be added to read as follows:

Section 8.17 Death of Retiree Subscriber, Survivor Benefits. In the event of the Subscriber who elects or elected, upon retirement, to convert sick leave credits to a cash equivalency to pay health and dental insurance plan premiums or both, following retirement, any accumulated cash equivalency unused at the time of the death of Subscriber may be utilized for the purpose of continuing payment by the City of Long Beach of the health and dental insurance plan premiums for the spouse and eligible dependents provided that:

(1) The Subscriber has an effective retirement date of July 1, 1983 or later; or
(2) The Subscriber did not predecease the surviving eligible dependent prior to July 1, 1983;

The payment of the premiums shall continue until any of the following:

(i) There is an insufficient cash equivalency to pay the required monthly premiums as determined by Group; or
(ii) In the case of a surviving spouse, the spouse remarries; or
(iii) In the case of a dependent child, the child reaches the age of 19 or is no longer a full-time student in an accredited educational institution as recognized by PacifiCare.
(iv) In the case of a surviving spouse, the spouse becomes eligible for Medicare during a period of premium eligibility under this Section. In that case, premium payment may be adjusted to pay for the Medicare Supplement plan in accordance with the provisions of Subsection 2.11 of Article Two of City of Long Beach Ordinance No. C-3548.

enforced in accordance with its terms and conditions. **This amendment shall expire on November 30, 2006. IN WITNESS WHEREOF, the parties hereto have executed this Agreement in Cypress, California, on** 10/6/05.

PACIFICARE OF CALIFORNIA

BY Michael S Mallory

Michael S. Mallory
Vice President, Mid-Market Sales

PACIFICARE OF CALIFORNIA

BY Susan L Berkel

Susan L. Berkel
Senior Vice President, Financial Planning and Analysis, Western Region

APPROVED AS TO FORM
3/16 20 06
ROBERT E. SHANNON, City Attorney
BY
SENIOR DEPUTY CITY ATTORNEY

CITY OF LONG BEACH

BY

Name: Gerald R. Miller

Title: City Manager

State of California
County of Orange

On 10/6/05 before me, Timothy John Mock, personally appeared Michael S. Mallory, Vice President, Mid-Market Sales and Susan L. Berkel, Senior Vice President, Financial Planning and Analysis, Western Region,

[X] proved to me on the basis of satisfactory evidence

to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledge to me that he/she/they executed the same in his/her their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

Timothy John Mock, Notary Public

TIMOTHY JOHN MOCK
Commission # 1351331
Notary Public - California
Orange County
My Comm. Expires Apr 14, 2006

SECTION 15. STATEMENT OF ERISA RIGHTS

Contact your Company Benefit Administrator to learn whether your plan is an employee welfare benefit plan as defined by the Employee Retirement Income Security Act of 1974 (ERISA). If you participate in an ERISA employee welfare benefit plan, ERISA provides you with certain rights and protections.

1. All benefit determination, or Claim, procedures are described for you in your summary plan description.

2. If you receive an adverse benefit determination, a determination notice will be forwarded to you, electronically or in writing, within a reasonable time not to exceed ninety (90) days of the date the Claim is submitted.

3. You may appeal any adverse benefit determination. ERISA provides you with at least one hundred and eighty (180) days from the day you receive notice of an adverse benefit determination to appeal it. You will be provided an opportunity to submit relevant information in support of your appeal.

4. ERISA provides for up to two (2) mandatory appeal levels for any adverse determination. You have a right to bring a civil action on any adverse determination that you believe, after participating in the mandatory appeal process, was incorrectly made under your plan.

5. ERISA provides that, in connection with any appeal of an adverse benefit determination, you have the right to request access to and receive a free copy of any and all documents, records, and other information, as follows:
   a. Relied on in making your benefit determination;
   b. Submitted, considered, or generated in the course of making your benefit determination;
   c. Which demonstrates compliance with administrative safeguards concerning consistent application of the plan document among similar Claims, and
   d. Any plan policy statement or guidance regarding your diagnosis.

6. ERISA provides that most benefit appeal determination notices will be forwarded to you, in writing, within a reasonable period not to exceed sixty (60) days from the date of the plan's receipt of the benefit appeal request.

7. Your plan or your state insurance code provides you with the right to a voluntary Independent External Review. This review is conducted by an Independent Review Organization with no financial, personal or professional connection to your plan and no prior knowledge of your Claim's facts. Your plan will provide the Independent Review Organization any and all information it relied on in making the adverse benefit determination. You may provide any additional information you believe is relevant to the Claim determination.

8. Your participation in a voluntary appeal level does not effect your legal review rights, or any rights you have under your plan. Any statute of limitations will be tolled during the time you participate in a voluntary review level.

9. You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state insurance regulatory agency.

PACIFICARE LIFE AND HEALTH INSURANCE COMPANY, INC.
3100 Lake Center Drive
Santa Ana Ca. 92704

CERTIFICATE OF GROUP INSURANCE

Group Policy Number: PL10586-V

When a validation sticker (showing Your name, Your benefits and the effective date of those benefits) is attached to the inside front cover of this booklet, it becomes Your Certificate of Group Insurance. The Policy is issued by PacifiCare Life and Health Insurance Company, Inc., (the Company) to:

CITY OF LONG BEACH

The benefits that apply to You and Your Dependents are described in this booklet and are subject to the terms of the Policy. If that Policy is changed in any way which affects Your insurance, riders describing those changes will be issued to You for You to attach to this booklet, or a new booklet will be issued to You to replace this one.

PacifiCare Life and Health Insurance Company, Inc.

Ron Davis, President

PLEASE KEEP THIS BOOKLET IN A SAFE PLACE.

TABLE OF CONTENTS

SCHEDULE OF BENEFITS
(PacifiCare Vision Plus Option)

VISION CARE COVERAGE – For you and your Covered Dependents

The Validation Sticker shows the Vision Care Maximums and any deductible amount that apply to You and to any Dependents You may have covered under the Policy. The Validation Sticker will either confirm the amount shown below or show the different amount that applies to Your coverage.

VISION CARE MAXIMUMS	Participating Provider	Non-Participating Provider
Examinations	100% of Covered Vision Care Charges	$ 55.00
Frames	$ 90.00	$ 50.00
Lenses (Basic – See Vision Definitions):		
Single Vision	100% of Covered Vision Care Charges	$ 35.00
Bifocal	100% of Covered Vision Care Charges	$ 50.00
Trifocal	100% of Covered Vision Care Charges	$ 75.00
Lenticular	100% of Covered Vision Care Charges	$130.00
Contact Lenses:		
When Medically Necessary	100% of Covered Vision Care Charges	$200.00
For Cosmetic Purposes	$100.00	$90.00
Lens Options	20% Retail Discount	Not Covered

If a covered Person incurs a Covered Vision Care Charge for one lens only, the Vision Care Coverage will not pay more than 50% of the maximum shown above for a pair of the lenses.

VISION CARE MATERIAL DEDUCTIBLE .....NONE
The Vision Care Material Deductible applies to all Vision Care Covered Charges, except charges for examinations and refractive surgery.

VISION CARE COVERAGE

We will pay Vision Care Benefits for Covered Vision Charges as provided by the provision, limits and exclusions of this Vision Care Coverage. Terms with special meanings are capitalized in the text and defined in this Vision Care Coverage section and in the Definitions section of the Certificate.

VISION CARE BENEFIT

A vision Care Benefit is the amount of Covered Vision Care Charges incurred in excess of the Vision Care Material Deductible shown in the Schedule of Benefits.

Benefits payable under the Vision care Coverage may be reduced by the amount of benefits paid to, or on behalf of, a Covered Person because of coverage under another group benefit plan. See the section of the Certificate titled "If you Have Another Group Benefit Plan."

VISION CARE MATERIAL DEDUCTIBLE

The Vision Care Maximums and the services and supplies to that they apply are shown in the Vision Care Coverage section of the Schedule of Benefits.

VISION CARE MAXIMUMS

The Vision Care Maximums and the services and supplies to that they apply are shown in the Vision Care Coverage section of the Schedule of Benefits.

COVERED VISION CARE CHARGES

A Covered Vision Care Charged is a charge which meets all of the following tests:

1. The charge is incurred by a Covered Person while insured under the Vision Care Coverage;
2. The treatment, service or supply for which the charge is made is prescribed by a Provider acting within the lawful scope of his or her license;
3. The charge is made for an item shown in the Covered Vision Care Services and supplies List;
4. The charges is for a treatment, service or supply that is not excluded by the exclusions of the Vision Care Coverage or otherwise by the Policy;
5. The charge is determined to be (a) the negotiated fee if it is made by a Participating Provider, or (b) is the usual and customer amount if it is made by a Non-Participating Provider; and
6. The charge is not more than any limit that applies to the charge;

COVERED VISION CARE SERVICES AND SUPPLIES LIST

Covered Vision Care Services and Supplies are:

1. One comprehensive eye examination during any 12-month period;
2. One pair of lenses during any 12-month period, except that if a Change in Prescription is indicated by the examination that gives rise to the prescription order, one pair of lenses is covered during any 12-month period;
3. One frame during any 12-month period;
4. One pair of contact lenses during any 12-month period that are Medically Necessary;
   a. Following cataract surgery;
   b. For anisometropia;
   c. For keratoconus;
   d. When visual acuity cannot be corrected to 20/70 in the better eye with conventional lenses;
5. One Pair of contact lenses during any 12-month period that are for cosmetic purposes or for convenience when provided in place of other eye wear during the periods such other eye wear would be covered.

VISION CARE COVERAGE (cont'd.)

VISION CARE EXCLUSIONS

No benefits under the Policy are payable for, and Covered Vision Care Charges do not include:

1. A lens when no Change in Prescription is indicated by the examination giving rise to the prescription order;
2. Services and materials in connection with special procedures such as orthotics, vision training or subnormal vision aids;
3. Non-prescription (plano) lens;
4. Replacement or repair or lost, stolen or broken lenses or frames, except at the intervals specified above for any other lenses or frames;
5. Services or supplies obtained through, or required by, any government agency or program, whether Federal or State, or a subdivision thereof;
6. Services or supplies for which the enrolled person may be entitled to benefits under any workers' compensation law;
7. Charges for which the Insured is not required to pay;
8. Any lens or lens style or feature not specifically listed in the Vision Care Coverage description or the Schedule of Benefits;
9. Drugs or any other medication;
10. Duplicate eyeglasses, lenses or frames;
11. Contact lenses provided in addition to eyeglasses; or
12. Services begun, or supplies provided, prior to the Insured's effective date of coverage or after the Vision Care Coverage has terminated;.
13. Medical or surgical treatment of the eyes; or
14. Any service or material provided by another group benefit plan.

VISION CARE DEFINITIONS

The following words and phrases when capitalized in the text of this Certificate have the meanings shown below. Other words and phrases that have special meanings are defined in the General Definitions section of the Certificate and as they are used in the description of the Vision Care Coverage.

"Change in Prescription" means any of the following: (a) a change in prescription of 0.50 diopter or more in one or both eyes; (b) a shift in axis of astigmatism of 15°; or (c) a difference in vertical prism greater than 1 prism diopter.

"Medically Necessary" means those services and supplies that are: (a) required to treat an injury or sickness in a manner consistent with the diagnosis and treatment of the Covered Person's condition; (b) in accordance with the standards of good medical proactive; (c) not for the convenience of the Covered Person or the Provider; (d) performed or provided as the most appropriate level of care as determined by the Covered Person's medical condition.

" Non-Participating Provider" means a Provider who has contracted with the Company or the Company's designated provider organization to provide services, treatment and supplies to a Covered Person at a negotiated fee.

"Participating Provider" means a Provider who has contracted with the Company or the Company's designated provider organization to provide services, treatment and supplies to a Covered Person at a negotiated fee.

"Provider" means a licensed physician, ophthalmologist, optometrist or optician practicing within the lawful scope of his or her license.

"Usual and Customary Charge" means the lesser of:

a. Provider's usual charge for furnishing treatment, service or a supply; or
b. The charge the Company determines to be the general rate charged by others who render or furnish such treatment, services or supplies to persons who reside in the same area for a condition of comparable nature and severity.

IF YOU HAVE ANOTHER GROUP BENEFIT PLAN

1. COORDINATION OF BENEFITS (COB). All the Benefits provided under this Plan are subject to these COB provisions.

   If the Company has paid benefits under this Plan and if benefits with respect to the same expenses are also payable under another Plan, the Company may recover from the Covered Person or from such other Plan an amount equal to the benefits it has so paid.

2. DEFINITIONS. In addition to the Definitions of this Plan, the following definitions apply to this section:

   a. A "Plan" means any group insurance coverage, prepayment plan, coverage under union welfare plan, other plan growing out of Employer/employee relationship, and other statutory plan.

   b. "Allowable Expense" means any usual and customary item of expense at least a portion of which is covered by one or more Plans (s) covering the Covered Person. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and benefit paid.

3. NON-DUPLICATION.

   a. Workers' Compensation. The benefits under this Plan are not designed to duplicate any Benefit to which the Covered Person is entitled under Worker's Compensation insurance laws. Charges for services arising out of job related injuries are not covered under this Plan. In the event services are provided, all sums payable to, and retained by the Company. Each Covered Person shall complete and submit to the Company such consents, releases, assignments and other documents reasonably requested by the Company in order to obtain or assure such reimbursement.

   b. Other Plans. If any benefits to which a Covered Person is entitled under this Plan are also covered by any other Plan, the benefits payable shall be coordinated with the benefits that are available to the Covered Person under such other Plan, whether or not a claim is made for the same.

4. ORDERS OF BENEFIT DETERMINATION. The order of Benefit determination between this Plan and any other Plan covering the Covered Person on whose behalf a claim is made is established as follows.

   a. Whenever a Plan does not contain a Coordination of Benefits clauses, the Plan which pays first is the primary Plan must pay its benefits before the secondary Plan pays.

   b. When two or more Plans contain Coordination of Benefits clauses, the Plan which pays first is the primary Plan. The Plan that pays additional benefits for Allowable Expenses not covered by the primary Plan, but not to exceed 100% of total Allowable Expenses, is the secondary Plan. The sequence of Payments is as follows:

      1) The Plan covering the Covered Person as an employee pays before the Plan covering the Covered Person as a Dependent.

      2) The benefits of a Plan which covers a Covered Person as a Dependent of a person whose date of birth, excluding year of birth occurs earlier in a Calendar year, shall be determined before the benefits of any other Plan which covers such Covered Person as a Dependent of a person whose date of birth, excluding year of birth, occurs later in a Calendar Year.

         If either Plan does not coordinate benefits in the same manner as in this Subparagraph 2 regarding Dependents, and as a result each Plan determines its benefits before the other or each Plan determines it's benefits after the other, the rule set forth in the Plan which does not have this provision of this Subparagraph 2 shall determine the order of benefits.

IF YOU HAVE ANOTHER GROUP BENEFIT PLAN (cont'd.)

3) If the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a Plan which covers the child as a Dependent of the parent with custody of the child shall be determined before the benefits of a Plan which covers the child as a Dependent of a parent without custody.

4) If the parents are divorced and the parent with custody of the child has remarried, the benefits of a Plan which covers the child as a Dependent of the parent with custody shall be determined before the benefits of a Plan which covers that child as a Dependent of the step-parent, and the benefits of a Plan which covers that child as the Dependent of the step-parent shall be determined before the benefits of a Plan which covers that child as the Dependent of the parent without custody.

5) Notwithstanding Subparagraphs (3) and (4) above, if there is a court decree which would otherwise establish financial responsibility for the expenses with respect to the child, the benefits of a Plan which covers the child as a Dependent of the parent with financial responsibility shall be determined before the benefits of any other Plan which covers the child as a Dependent child. It is Your obligation to notify the Company and, upon the Company's request, to provide a copy of such court decree.

6) When the foregoing rules do not establish an order of Benefit determination, the benefits of a Plan which has covered the Covered Person for the longer period of time shall be determined before the benefits of a Plan which has covered the Covered Person the shorter period of time except that:

a) The benefits of a Plan covering the Covered Person as a laid-off or retired employee, or Dependent of such Covered Person, shall be determined after the benefits of any other Plan covering such person as an active employee, other than a laid-off or retired employee, or Dependent of such person; and

b) If either Plan does not have a provision regarding laid-off or retired employees, and, as a result, each Plan determines its benefits after the other, then the provisions of this Subparagraph (6) do not apply.

7) The primary Plan Calculates its benefits as though duplicate coverage did not exist. The other Plans will then reimburse for all Allowable Expenses not covered by the other Plan, provided this amount does not exceed the benefits payable under the Plan in the absence of duplicate coverage.

5. NO INCREASE IN BENEFITS. Benefits under this Plan will not be increased by virtue of these provisions.

6. INFORMATION TO BE FURNISHED. Any covered Person claiming benefits under this provision must furnish to the Company all information necessary by the Company to implement this provision.

7. RIGHT TO RECEIVE AND RELEASE INFORMATION. For the purposes of determining the applicability and implementing the terms of the provision of this Plan or any provision of similar purpose of any other Plan, the Company may, without the consent of or notice to any other person, release to or obtain from any other insurance company or other organization or person any information if permitted by law, with respect to any person, which the Company deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish the Company such information as may be necessary to determine the benefits payable or coverage to be provided under this Plan.

8. PAYMENT TO CERTAIN ORGANIZATIONS. Whenever payment which would otherwise have been made under this Plan in accordance with this provision have been made under any other Plans, the company shall have the right, exercisable alone and in its sole discretion, to determine whether or not to pay to any organization making such request, and to determine the amount of such payment, to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan, and, to the extent such payment, the Company shall be fully discharged from liability under this Plan.

IF YOU HAVE ANOTHER GROUP BENEFIT PLAN (cont'd.)

9. RIGHT OF RECOVERY. Whenever payments have been made by the Company in excess of the maximum amount of payment necessary to satisfy the intent of this provision, the Company shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Company shall determine: any persons to, or for,, or with respect to whom such payments were made by any insurance company, person, firm, Health Maintenance Organization or other involved organization.

10. GOVERNMENT PROGRAMS. The benefits under this Plan are not designed to duplicate any benefits to which Covered Persons are, or would be, entitled under government programs for which they are eligible, including Medicare. All sums payable under such programs for services covered by this Plan shall be payable to, and retained by the Company. Each Covered Person shall submit to the Company such consents, releases, assignments, and other documents as may be requested by the Company in order to obtain or assure reimbursement under government programs for which Covered Persons are eligible.

11. THIRD PARTY REFUND. When a Covered Person is injured or becomes ill through the act or omission of another person (the "Third Party") and benefits are paid under the Policy as a result of injury or illness, the Company is entitled to a refund by the Insured Employee of all Policy benefits paid as a result of the injury or illness. The refund must be made to the extent that the Insured Employee received payment for the injured from the Third Party, or that party's insurance carrier. The Company may file a lien against the Third Party payment. To enforce this lien, the Insured Employee must complete and send any required forms to the Company upon request.

HOW TO FILE A CLAIM

A Covered Person may choose to go any ophthalmologist, optometrist or optician. Participating Provider benefits, however, are available **only** from a Provider listed in the Vision PPO Provider Directory.

WHEN YOU VISIT A PARTICIPATING PROVIDER LISTED IN THE VISION PPO PROVIDER DIRECTORY

1. Complete the personal information in the first section of the claim form before Your visit to the Participating Provider. A claim form was included with your I.D. card. If You do not have a claim form, contact PacifiCare Vision Member Services department at 1-800622-6388 and one will be sent to You.

2. Give the Participating Provider the claim form.

3. The Participating Provider will complete the remainder of the claim form and forward it to the Administrator for processing.

4. The amount of Covered Vision Care Charges will be determined in accordance with the Schedule of Benefits and the other terms of the certificate.

5. The Insured will be responsible for satisfying and Vision Care Material Deductible, any copayments and any amounts that are not determined to be Covered Vision Care Charges.

WHEN YOU VISIT A NON-PARTICIPATING PROVIDER

1. Complete the personal information in the first section of the claim form before Your visit to the Non-Participating Provider of Your choice. A claim form was included with Your ID card. If you do not have a claim form, contact PacifiCare Vision Member Services department at 1-800-622-6388 and one will be sent to you.

2. Give the Provider the claim form.

HOW TO FILE A CLAIM (cont'd.)

3. Once the services have been completed and materials delivered, the Covered Person or his or her Provider should return the claim form, with the appropriate signatures, indicating the date(s) services and materials were rendered. The claim form should be mailed to:

MEDICAL EYE SERVICES
POST OFFICE BOX 93033
LONG BEACH, CALIFORNIA 92781

4. A check will be sent to the Insured Employee or, if the benefits have been assigned, to the Provider for the appropriate amount. Covered Vision Care Benefits will be determined as follows:

   a. The amount of the Covered Vision Care Charges will be determined in accordance with the Schedule of Benefits section and the other terms of the certificate.

   b. Any applicable deductible and copayment amounts that have not been satisfied will be subtracted from the Covered Vision Care Charges.

   c. The scheduled maximums will be applied to the submitted claim.

   d. The resulting amount, to the extent that it does not exceed the scheduled maximums, will be the Covered Vision Care Benefits for the services performed. Any amounts that are determined not to be Covered Vision Care Charges are payable by the Covered Person to the Provider.

5. For claims information, please call 1-800-877-6372.

Claim Forms: You must give Us written notice of Your claim within 20 days after the services were performed or as soon as it is reasonably possible. We will furnish You with forms for submitting proof of services performed ("proof of loss") within 15 days after we receive notice of Your claim. If such forms are not furnished, You will still meet the "proof of loss" requirement by submitting written proof covering the extent of the loss, its character and when it happened.

Proof of Loss: You must give Us written proof of vision services performed ("proof of loss") within 90 days after the services were performed, or after the end of each benefit period for which insurance benefits are, i reasonable possible, but not later than one year after the end of the 90-day period, except in the absence of legal capacity.

Right to receive and Release Necessary Information: For the purposes of making claims payments, the Company may, with the consent of the affected person, as may be necessary, release to or obtain from any insurance company, organization or person any information, with respect to any person, which this Company considers necessary for such purposes. Any person claiming benefits under the Policy shall furnish to this Company the information as may be necessary to implement this provision.

Payment of Claims: When we receive Your completed claim form, Your claim will be paid within 30 days, unless periodic payments are specified. They will be paid as they accrue and at least once a month.

Assignment: No assignment of the Policy, nor any rights or benefits under the Policy, shall be valid unless We have consented to tit in writing, except for assignment of benefits payable under this insurance coverage for covered charges.

Benefits Exempt from Attachment: To the full extent permitted by law, all rights and benefits under the Policy are exempt from execution, attachment, garnishment or other legal or equitable process, for the debts or liabilities of any Insured Employee.

HOW TO FILE A CLAIM (cont'd.)

Examination: The Company, at its own expense, will have the right and opportunity to have a covered person examined as often as reasonable necessary while a claim is pending. This right may be used as often as it is reasonably required.

WHEN YOUR BENEFITS BEGIN

Your Benefits will begin on the 1st day of the month after both of the following conditions are met:

1. You have enrolled for coverage; and

2. We have received the required monthly payment for your coverage.

WHO IS ELIGIBLE TO RECEIVE BENEFITS UNDER THIS BENEFIT PLAN?

1. You are eligible for coverage if You are Actively Employed by a Covered Employer and satisfy the eligibility requirements established by that employer, including the completion of any probationary or waiting period.

2. Your Dependents eligible for coverage are: (a) Your spouse and (b) each of Your children under the age of 19 years who is unmarried and chiefly Dependent upon You for support. If a student verification form is submitted, eligibility can be extended for a full-time, unmarried student to the day preceding his or her 25th birthday.

3. Your eligible Dependents will also include newborn infants. Coverage for such an infant will begin at the moment of birth. Adopted and foster children will be covered from the date any such child is placed in Your physical custody.

   Coverage of a Dependent child will not end at age 19 if:

   a. The child cannot hold a job because of a mental or physical handicap, as defined by the applicable state law; and

   b. The child is chiefly Dependent upon You for support and maintenance.

   You must give us proof of this within 31 days of the time the child reaches the age of 19 and every two years after that. We must, of course, receive the correct monthly payment to continue providing Benefits.

4. No person may be covered as a Dependent if he or she is eligible for coverage as an Employee. No person may be covered as the Dependent of more than one Employee.

5. Eligible Dependents may be added at the time of enrollment or during the Employer's annual open enrollment period. Dependents may not be deleted until the annual open enrollment period unless they become ineligible under the terms of the Policy. Eligible Dependents may be added when a qualifying event (such as marriage or birth) takes place. You must give us proof of this qualifying event within 31 days.

6. It Is YOUR responsibility to keep us advised of changes that affect each Dependent's status.

WHEN YOUR BENEFITS END

1. If You leave the Covered Employer or a class of persons eligible for coverage or You quit or lose Your job, Your benefits will continue through the last day of the month in which that happens.

2. Benefits will end of the last day of the month for which the last monthly payment was received by us except as otherwise provided in this Certificate.

3. We can terminate the coverage under the Policy of a Covered Employer's Insured Employees and their covered Dependents upon 31 days' written notice, if the required monthly payment for such coverage has not been paid.

4. A Covered Employer is responsible for making the monthly payments for coverage up to the date benefits end for employees and Dependents who are Covered Persons under the Policy. If We receive all of the money the owed us, We will reinstate coverage for those Covered Persons, as long as the Monthly Payment is no more than 60 days past due. However, We will not reinstate coverage for such Covered Persons:

   a. If We do not receive payment within those 60 days. In that case, a Covered Employer must apply anew for coverage under the Policy. Or

   b. If We receive payment more than 31 days after the termination notice and refund that money to the Covered Employer within 20 business days after giving that notice; OR

   c. If We receive payment more than 31 days after the termination notice and, in return for that payment, We issue new coverage to the Employer, clearly showing any differences between the new and the canceled coverage.

5. We reserve the right to cancel Our Policy with the Policyholder if it has been in effect as least 12 months from its effective date and We give at least 20 days' advance written notice.

IF YOU LOSE YOUR ELIGIBILITY FOR THIS BENEFIT PLAN

1. If a Covered Employer is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, and if You cease to be eligible for the group coverage provided under the Policy, You may elect to continue such coverage as provided by COBRA. If Your employer provides a plan of group medical care coverage in addition to the group coverage provided under the Policy and You are covered under that plan, You must elect to continue that group medical care coverage in order to continue this group coverage. You should ask Your employer for more information on this subject.

2. If Your group coverage under this Policy is subject to COBRA, as described above, anyone of Your Dependents who ceases to be eligible for such coverage because of Your death, divorce, legal separation, or reaching the limiting age provided in the Policy may also be entitled to continue this group coverage in accordance with COBRA. You or that Dependent should ask Your employer for more information on this subject.

EXTENDED BENEFITS

If a person's insurance under the Policy ends, other than for payment of the maximum benefit, before completing a course of treatment that was begun while that person was insured, the insurance for the incomplete treatment only will be extended until the first to occur of the dates that follow:

1. The date insurance begins under another group plan that pays benefits for the treatment in progress.

2. The expiration date of the three-months period that begins on the date the insurance would otherwise end.

This Extended Benefits provision will not apply if the insurance ends because of non-payment of the required premiums.

PROVISIONS REQUIRED BY LAW

Worker's Compensation: The Policy is not in lieu of, and does not affect any requirement for coverage by workers' compensation insurance.

Misstatement of Facts: If relevant information about any Insured Employee is not accurate, the facts will decide whether and in what amount, insurance is valid under the Policy, and if any adjustment of premium will be made.

Changes in the Entire Contract: The Policy (with the group application and any individual applications) make up the entire contract. In the absence of fraud, all statements made by the Covered Employer or by any Insured Employee shall be deemed representations and not warranties. No statement made for the purpose of effective insurance shall avoid insurance or reduce benefits unless contained in a written instrument signed by the Covered Employer or Insured Employee and a copy of the document has been furnished to the Company and/or the Insured Employee.

No agent nor other individual, except the President or Secretary of the Company, can approve a change to the Policy or extend the time for payment of premium. No change will be valid unless it is made by an endorsement to the Policy, or by an amendment signed by the Policyholder and the President or Secretary of the Company. Any change made will be binding on each person insured and on any other individual(s) referred to in the Policy.

Conformity with State Statute: Any provision of the Policy which, on its effective date, is in conflict with the state laws in which the Policy was issued or delivered, is hereby amended to meet the minimum requirements of the law.

Grace Period: After payment of the first premium, We will allow the Policyholder a Grace Period of thirty-one (31) days, following a premium due date, to pay subsequent premiums. During this Grace Period, the Policy will remain in force. The Policyholder will be liable for payment of premium for the period the Policy continues in force.

Age: When an insured's age has been misstated, the Company will provide the amount of insurance for the correct age. A premium adjustment may be made so that the Company will receive the correct premium for the true age.

New Entrants: A Covered Employer may add from time to time, eligible new employees and Dependents as the case may be, in accordance with the enrollment and eligibility sections of the Policy.

Time Limit on Certain Defenses: A claim shall not be denied nor shall the validity of insurance be contested because of any statement with respect to insurability made by the Insured Employee while eligible for coverage under the Policy, if:

1. the insurance has been in force for at least two years before any such contest; and

2. the Insured Employee, with respect to whom any such statement was made, was alive during such two years.

PROVISIONS REQUIRED BY LAW (cont'd.)

Discharge of Liability: Any payment made in accordance with the provisions of the Policy shall fully discharge the liability of the Company to the extent of such payment.

Legal Action: No legal action will be brought to recover benefits under the Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished. No such action will be brought after the expiration of three (3) years following the time written proof of loss is required to be furnished.

Recovery of Payments: The Company reserves the right to deduct from any benefits properly payable under this Policy the amount of any payment which has been made:

1. in error;

2. pursuant to a misstatement contained in a proof of loss;

3. pursuant to a misstatement made to obtain coverage under this Policy within two (2) years after the date such coverage commences;

4. with respect to an ineligible person;

5. Pursuant to a claim for which benefits are recoverable under any policy or act of law provided for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision shall not be deemed to require the Company to pay benefits under this policy in any such instance.

Such deduction may be made against any claim for benefits under this Policy by an Insured Employee or by any of this or her covered Dependents is such payment is made with respect to such insured person or any person covered or asserting coverage as a Dependent of such Insured Employee.

DEFINITIONS

The following words and phrases have the meanings shown below when those words and phrases appear capitalized in the text of the Certificate. Other words and phrases that have special meanings are defined in the description of the benefit coverage.

"Actively Employed" means that, in accordance with Your Employer's eligibility rules, You are working on a scheduled workday in performance of the regular duties of the Employer's business. On a day this is not a scheduled workday, You will be considered Actively Employed on the last preceding scheduled workday.

"Administrator" means the organization named at the beginning of booklet that, among other duties, is responsible for paying the claims for benefits.

DEFINITIONS (cont'd.)

"Calendar Year" means a period beginning January 1st and ending on December 31st each year.

"Company" means PacifiCare Life and Health Insurance Company, Inc.

"Covered Employer" means the Policyholder. When the Policy issued to trustees of a trust fund established to provide benefits to employees of employers that have agreed to subscribe to the trust and have been reported in writing to the Administrator as participating employers, ":Covered Employer" shall include such participating employers. "Covered Employer" also includes a Covered Employer's affiliates and subsidiaries that have been reported in writing to the Administrator as having employees covered under the Policy.

"Covered Person" means the Policyholder. When the Policy is issued to trustees of a trust fund established to provide benefits to employee's Dependents who are covered under the Policy.

"Dependent" means the legal spouse and Dependent children of an Employee who satisfy the eligibility requirements as described in the section entitled "who is Eligible to Receive Benefits".

"Employee" means a person who meets the eligibility rules set by the Employer.

"Exclusion" means any service or supply for which no benefits are provided under the Policy, including, but not limited to, those items listed in any exclusions or limitations sections of the Policy.

"Insured or Insured Employee" means an eligible Employee who is actually enrolled as an insured person.

"Policy" means the agreement between the Company, and the Policyholder, including any addenda and Riders, as well as the Application by the Policyholder and Applications by any individual Insured Employee.

"Policyholder" means the organization or entity that has executed an application for the Policy and to whom the Policy has been issued.}

"Our", "We" or "Us" means PacifiCare Life and Health Insurance Company, Inc., or the Administrator acting on behalf of the Company.

"You" or "Your" means an Insured Employee.

A SOLUTION FOR CAREGIVERS

PROGRAM AGREEMENT
(PacifiCare Client Groups)

This Program Agreement ("Agreement") is made and entered into as of the 1st day of **December, 2005** ("Effective Date") by and between SeniorCo Inc., a Delaware corporation, ("SeniorCo"), and **City of Long Beach**, a **California** corporation ("Group") as follows:

RECITAL OF FACTS

WHEREAS, SeniorCo, a subsidiary of PacifiCare Health Systems, Inc., offers *A Solution for Caregivers Program* ("Caregiver Program") which provides resources and information to Participants and/or Participant's Eligible Family Members who have assumed or are concerned about the role of caregiver and are making decisions about maintenance and support for an elderly family member.

WHEREAS, Group is an employer, organization, association or other entity which desires to make the Caregiver Program available to Participants; and

NOW THEREFORE, in consideration of the payment of the monthly fees specified in this Agreement, SeniorCo agrees to offer the Caregiver Program to Group subject to the terms and conditions of this Agreement.

1. DEFINITIONS.

Adult Care Recipient. An individual over twenty one (21) years of age who has adult care needs commonly associated with the elderly and who may receive services under the Caregiver Program through his or her own status as a Participant or through his or her relationship with Participant or one of Participant's Eligible Family Members.

Caregiver Program or Program. *" A Solution for Caregivers"* program offered by SeniorCo to Group pursuant to which Participants may obtain Caregiver Services. The Caregiver Program is offered by SeniorCo, an affiliate of the PacifiCare Health Plan, and is completely separate and independent from the PacifiCare Health Plan and the health plan coverage provided to the Group by the PacifiCare Health Plan. The Program is not a health plan or insurance product.

Caregiver Services. Those services set forth in Exhibit A of this Agreement, which may be accessed by Participant or Participant's Eligible Family Members for Adult Care Recipient pursuant to this Agreement.

Care Resource Center or CRC. The centralized resource service that may be accessed by Participants and Participant's Eligible Family Members for Adult Care Recipients by utilizing the toll-free telephone number identified in the Program Materials. The CRC coordinates Caregiver Services and provides follow-up in conjunction with the Geriatric Care Manager as described in Exhibit A of this Agreement.

Care Resource Center Services. Those Caregiver Services provided by CRC to Participants or Participant's Eligible Family Members for Adult Care Recipients under the Caregiver Program.

Contract Year. The twelve (12) month period beginning on the Effective Date set forth above and ending on the last day of the twelfth month following the Effective Date.

Elder Law Referral Services. Those Caregiver Services provided to Participants for Adult Care Recipients under the Caregiver Program, as described more fully in Exhibit A.

Geriatric Care Manager or GCM. An individual who satisfies SeniorCo's credentialing standards, with experience in eldercare services, and who has agreed to provide Caregiver Services to Participants and Participant's Eligible Family Members for Adult Care Recipients under the Caregiver Program.

Geriatric Care Manager Services. Those Caregiver Services provided by the GCM to Participants or Adult Care Recipients under the Caregiver Program.

Outside Provider. Any health care professionals, health care facilities, community services, Elder Law Referral Services or other programs or facilities that a Participant may be referred to under the Caregiver Program.

Participant. An individual who is an employee or retiree of Group who satisfies the requirements to participate in the Caregiver Program, as determined by SeniorCo, and who has not, for any reason, become ineligible to participate in the Caregiver Program, and who is listed on the Group's eligibility list.

Participant's Eligible Family Member. Unless as otherwise stated herein (i) in the case of a Participant who is an active employee or retiree employee, a Participant's Eligible Family Member shall mean the spouse, sibling, domestic partner or adult child of the Participant, if such previously listed individual shares his or her primary residence with the Participant, or (ii) in the case of a Participant who is a retiree employee, a Participant's Eligible Family Member shall include an adult child or other relative who do not share his or her primary residence and who initiate service on behalf of the Participant.

Program Fees. The fees paid by Group to SeniorCo for the Caregiver Services under this Agreement. The Program Fees are determined as set forth in Exhibit B to this Agreement.

Program Materials. The written and printed materials describing the Caregiver Program and how to access Caregiver Services. Program Materials are prepared by SeniorCo and provided to Group for distribution to Participants.

2. ELIGIBILITY

2.01 Eligibility. Eligibility shall be effective as of the first day of the month for which the Program Fees have been paid by Group and received by SeniorCo or its designee.

2.02 Eligibility Reports. The applicable PacifiCare Health Plan, as Group's designee shall provide SeniorCo with an eligibility report listing all eligible Participants for the following month.

3. DUTIES AND RESPONBILITIES OF GROUP

3.01 Program Materials. Group shall distribute the Program Materials to Participants. Group shall not distribute any written or printed materials regarding the Caregiver Program without first obtaining the written approval of SeniorCo, unless materials have been provided by SeniorCo for the purpose of such distribution. Nothing in this provision shall prohibit SeniorCo from distributing Program Materials directly.

3.02 Promotion of Caregiver Program by Group: Group shall provide periodic Program Materials to Participants throughout the Contract Year, and shall promote and encourage Participant's use of the Caregiver Program.

3.03 Group Notice to Participants. In the event of the termination of this Agreement pursuant to Section 9 of this Agreement, Group shall promptly notify all Participants enrolled through Group of the termination of the Caregiver Program. SeniorCo shall have no responsibility to Participants in the event Group fails to provide the notices required by this Section 3.03.

4. PROGRAM FEES; MODIFICATION TO CAREGIVER SERVICES

Program Fees. The Program Fees may be paid to the PacifiCare Health Plan covering the Group at the same time the Group pays its monthly health plan premium.

5. DUTIES AND RESPONBILITIES OF SENIORCO

5.01 Caregiver Services. SeniorCo shall provide Caregiver Services to Participants for whom Program Fees have been paid.

5.02 Promotion and Implementation of Program. SeniorCo shall assist Group in the promotion and implementation of the Caregiver Program as follows:

a. Letter to Participants. SeniorCo shall assist the Group in drafting a standard introductory notice to Participants regarding the Caregiver Program. Group shall be responsible for distribution of such notice to Participants.

b. Written and Printed Materials. SeniorCo shall provide Group with Program Materials for distribution to Participants.

6. ACCESSING CAREGIVER SERVICES; FINANCIAL LIABILITY OF PARTICIPANT

6.01 Accessing Caregiver Services. Participants or Participant's Eligible Family Members may access Caregiver Services by calling the CRC at the toll-free telephone set forth in the Program Materials.

6.02 Participant Non-Liability for Authorized Services. Neither Participant, Participant's Eligible Family Members nor Adult Care Recipient shall be financially liable for GCM

Services authorized by the Caregiver Program up to the maximum number of GCM hours per Contract Year as specified in this Agreement.

6.03 Participant Liability for Elder Law Referral Services. Neither Participant, Participant's Eligible Family Members nor Adult Care Recipient shall be financially liable for Elder Law Referral Services, authorized by the Caregiver Program except as described in Exhibit A of this Agreement.

6.04 Participant Liability for Non-authorized Caregiver Services. Except for CRC Services, authorized GCM Services, and authorized Elder Law Referral Services, Participant shall be liable for all services.

7. DISPUTES BETWEEN THE PARTIES

7.01 In the event of a claim, controversy, dispute or disagreement arising out of or is related to the performance of this Agreement, either SeniorCo or Group may submit the dispute to binding arbitration before JAMS, an independent arbitration organization as described below.

7.01.01 **Binding Arbitration.** Any claim, controversy dispute or disagreement between SeniorCo and Group which arises out of or is related to this Agreement shall be resolved by Binding Arbitration by a single arbitrator. JAMS or such other neutral administrator as SeniorCo shall designate shall administer the arbitration. The Comprehensive Arbitration Rules and Procedures ("Rules") in effect at the time demand for arbitration is made will be applied to the arbitration. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Rules will be utilized. Arbitration hearings shall be held at the neutral administrator's offices in Los Angeles, California or at such other location as the parties may agree in writing.

The arbitrator(s) selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California including, but not limited to, the imposition of sanctions. The arbitrator(s) shall have the power to grant all remedies provided by California law. The arbitrator(s) shall prepare in writing an award that includes the legal and factual reasons for the decision.

The parties shall divide equally the fees and expenses of the arbitrator(s) and the neutral administrator.

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

8. TERM OF AGREEMENT

8.01 Term and Automatic Renewal. The term of this Agreement shall coincide with the term of the applicable PacifiCare Health Plan agreement covering Group. This Agreement shall automatically renew on the date that the applicable PacifiCare Health Plan agreement covering Group renews, unless terminated or amended to reflect additional services and/or applicable rate increases prior to the end of the then current contract year as provided herein.

9. TERMINATION OF AGREEMENT

9.01 Termination by Group. Group may terminate this Agreement by giving written notice of termination to SeniorCo in accordance with the applicable provisions in the PacifiCare Health Plan Agreement covering Group. The Agreement shall remain in effect and Group shall continue to be liable for Program Fees for all Participants through the effective date of termination.

9.02 Termination by SeniorCo. SeniorCo may terminate this Agreement by giving written notice of termination to Group sixty (60) days prior to the end of the then current contract year.

9.02.01 For Nonpayment of Program Fees. SeniorCo may terminate this Agreement if Group fails to remit Program Fees by the due date to SeniorCo or the PacifiCare Health Plan covering Group, by giving written notice of termination of this Agreement to Group. The written notice shall provide the effective date of termination of the Group. In SeniorCo's discretion, the effective date of termination may be retroactive to the Program Fee due date. Notwithstanding the effective date of termination, Group shall be liable for any unpaid Program Fees due prior to the effective date of termination.

9.02.02 For Breach of Material Term Other than Non-Payment of Program Fees. SeniorCo may terminate this Agreement upon thirty (30) days written notice to Group if Group breaches any material term, covenant or condition of this Agreement, including but not limited to the provision of misleading or fraudulent information to SeniorCo.

9.02.03 For Providing Misleading or Fraudulent Information. SeniorCo may terminate this Agreement upon thirty (30) days prior written notice to Group if Group provides materially misleading or fraudulent information to SeniorCo in any Group questionnaires or other materials.

10. TERMINATION OF PARTICIPATION.

10.01 Termination. Access to Caregiver Services by Participant and Participant's Eligible Family Members under this Agreement shall terminate upon occurrence of any of the following:

10.01.01 Termination of Agreement by Group. In the event Group voluntarily terminates this Agreement pursuant to Section 9.01 of this Agreement, Participant's ability to access Caregiver Services shall terminate at the end

of the last month for which the Program Fees were paid by Group and received by SeniorCo or its designee. All Caregiver Services must be completed within thirty (30) days of the effective date of termination

10.01.02 Termination of Agreement by SeniorCo. In the event SeniorCo terminates this Agreement as set forth in Section 9, Participant's ability to access Caregiver Services shall also terminate upon the effective date of termination of the Group.

10.01.03 Participant's Loss of Eligibility. Participant's ability to access Caregiver Services shall terminate on the last day of the month in which Participant's eligibility ceases, including upon termination of his or her employment with Group.

10.01.04 Participant Fraud or Deception. A Participant's ability to access Caregiver Services shall immediately terminate if such Participant or Participant's Eligible Family Member knowingly provides SeniorCo with fraudulent information upon which SeniorCo relies, which materially affects Participant's eligibility, or Participant, Participant's Eligible Family Member or Adult Care Recipient commits fraud or deception in the use of Caregiver Services or knowingly permits such fraud or deception by another. In such instance, SeniorCo shall notify Group that Participant is no longer eligible.

10.01.05 Termination of Participant for Cause A Participant may be deemed ineligible and terminated for cause if Participant or Adult Care Recipient is uncooperative, unruly or threatens the life or inflicts or threatens to inflict physical injury to a GCM. A termination for cause shall be effective on the first day of the calendar month following the month in which notice of termination is given to Participant.

10.02 Continuing Obligations Following Termination. In the event of termination of this Agreement for any reason other than non-payment of Program Fees, SeniorCo shall continue to arrange previously authorized GCM Services to those Participants and Adult Care Recipients who have already engaged in the Caregiver Program, up to a maximum of six (6) GCM hours per Participant per Contract Year, but in no event, for more than thirty (30) days following the effective date of termination of this Agreement. SeniorCo shall also continue to arrange Elder Law Referral Services, up to the maximum hourly benefit, but in no event for more than thirty (30) days following the effective date of termination of this Agreement. Group shall pay SeniorCo at the rates specified in Exhibit B of this Agreement for these continued Caregiver Services. CRC Services shall terminate as of the effective date of termination of this Agreement.

11. RELATIONSHIP OF THE PARTIES.

11.01 GCMs are Independent Contractors. The relationships between SeniorCo and GCMs and any other providers, subcontractors or resource providing Caregiver Services, are independent contractor relationships. None of the GCMs or their employees are employees or agents of SeniorCo, and neither SeniorCo nor any employee of SeniorCo is an employee or agent of any GCM or other provider or resource.

11.02 Relationship of Parties to this Agreement. Group is not the agent or representative of SeniorCo, and shall not be liable for any acts or omissions of SeniorCo, its agents or employees, or independent contractors, or any other person or organization with which SeniorCo has made, or hereafter shall make, arrangements for the performance of services under this Program. SeniorCo is not responsible for acts or omissions of Group or Participants.

11.03 Outside Providers. Outside Providers are not part of the Caregiver Program. Outside Providers are utilized as a referral resource for the Caregiver Program and are not employees, agents, or independent contractors of SeniorCo. SeniorCo shall not be responsible for any services provided by Outside Providers to Participants. It shall be the responsibility of Participant and/or Adult Care Recipient to determine whether or not services provided by Outside Providers are covered under the applicable health benefit plan.

12. MISCELLANEOUS PROVISIONS.

12.01 Governing Law. This Agreement is subject to and shall be governed by the laws of the State of California.

12.02 Assignment and Subcontracting. This Agreement and the rights, interests, and benefits hereunder shall not be assigned, transferred, pledged, or hypothecated in any way by Group and shall not be subject to execution, attachment or similar process, nor shall any duty or obligation hereunder be delegated or subcontracted by Group. Group acknowledges and agrees that the foregoing restriction on assignment and subcontracting does not apply to SeniorCo, and SeniorCo may contract with its affiliates and with third parties to provide Caregiver Services and operate the Program.

12.03 Amendments. This Agreement may be modified or amended upon the mutual written consent of the parties or as otherwise specified in this Agreement.

12.04 Attachments and Exhibits. All attachments and exhibits hereto are incorporated by reference and made an integral part of this Agreement.

12.05 Notice. Any notice required to be given to Group or SeniorCo hereunder shall be in writing and either delivered personally or sent by registered or certified mail, return receipt requested, to either Group or SeniorCo at the most current known address. All notices shall be deemed given on the date of delivery if delivered personally or on the day three (3) business days after such notice is deposited in the United States mail, addressed and sent as provided above.

As evidenced by the payment of the fees specified therein by Group, Group, Participants and SeniorCo accept the terms, conditions and provisions of this Agreement.

EXHIBIT A

CAREGIVER SERVICES

Caregiver Services consist of the following services made available to Participants and Participant's Eligible Family Members as part of the Caregiver Program. Caregiver Services may be accessed by contacting the CRC using the toll free telephone number set forth in the Program Materials.

I. Services through the Care Resource Center ("CRC")

The CRC provides Participants and Participant's Eligible Family Members with unlimited telephone access to geriatric specialists who may provide customized research, information, and resource matching concerning elder services such as meal delivery, in-home care, transportation to medical appointments and other assistance which provide the caregiver and the elder with assistance to meet daily needs. The CRC may also provide Participants with information concerning community services, support groups, long-term care planning, referrals to advisors in the community specializing in issues of particular concern to elders, as well as information concerning access to web based information and education in connection with elder care services. During the telephone call, the nature of the Participant's eldercare problem is determined and options for resolving the problem are discussed.

A Participant may be referred to a GCM for additional telephone or in-person assessment services or may be referred to an Outside Provider or other resource for assistance.

II. Referral to Geriatric Care Manager ("GCM")

In addition to the services provided by the CRC, the Participant may be referred to a GCM for assessment and information concerning local adult services. The GCM will provide a comprehensive telephonic or in-person assessment of the elder's needs and identify problem areas. The GCM shall provide a written report to Adult Care Recipients and Participants detailing the elder's current needs and living and care options and shall provide Adult Care Recipient and Participant with related recommendations. The GCM shall also provide assistance with coordinating local services and reviewing alternate living facilities. ***GCM Services must be pre-authorized by the CRC, and are limited to six (6) GCM hours per Participant per Contract Year. All services of the GCM must be coordinated and authorized by the CRC.***

III. Outside Providers

After the completion of in person or telephonic assessment services, the CRC or GCM will assist Participant in locating the most appropriate resources available. The CRC shall follow up with the Participant on the results of such referral to determine whether the referral has addressed the Participant's particular eldercare issue or problem. If the Participant is not satisfied with the initial referral, the Participant will be referred to an additional resource, if one is available. Participants may be entitled to a discounted rate for services rendered by Outside Providers where offered. ***Participants are responsible for fees and charges associated with all services received from an Outside Provider. It is the responsibility of the Participant to contact the applicable health care plan to determine whether such services are covered under the benefit plan of the Adult Care Recipient.***

IV. Elder Law Referral Services

Upon referral from the CRC, Participants and Participant's Eligible Family Members may receive the following Elder Law Referral Services under the Caregiver Program:

1. ***Attorney Consultation***: Participant or Participants' Eligible Family Member may consult with an attorney for up to two (2) hours per topic, up to a maximum of four (4) topics per Participant per Contract Year (ie: maximum of 8 hours). Such consultations may be in-person or telephonic, as requested by Participant, and shall be provided at no charge to Participant or Adult Care Recipient . In addition to the above, Participant shall be entitled to the additional legal services listed below at no charge.

(a) **Elder Law Legal Document Review by Attorney:** Review of one (1) legal document related to or in connection with the care of an elder, up to six (6) pages per document, per Participant per Contract Year.

(b) **Simple Preparation of Will by Attorney:** Preparation of one (1) simple will for Participant, the parents of Participant's spouse or Adult Care Recipient, up to a maximum of four (4) simple wills per Contract Year.

(c) **Preparation of Living Will by Attorney:** Preparation of one (1) living will for Participant, Participant's spouse, the parents of Participant or Participant's spouse, or Adult Care Recipient, up to a maximum of four (4) living wills per Contract Year.

(d) **Durable Power of Attorney Reviewed by Attorney:** Review of Durable Power of Attorney for Participant, Participant's spouse, the parents of Participant or Participant's spouse, or Adult Care Recipient, up to a maximum of two (2) per Contract Year.

2. ***Document preparation:*** In addition to the program services above, the program also includes the preparation of the following documents for a $35.00 copay per document paid directly to the attorney by the Participant.

a. **Durable Power of Attorney (DPA)**: A written document stating that one person gives to another the full power and authority to represent him or her, which authority will survive the maker's incapacity or disability. Prepared by a program attorney at a cost of $35.00 per document paid directly to the program attorney. One (1) each for Participant and Participant's spouse (can be used for parents) — up to four (4) per benefit year.

b. **HealthCare Durable Power of Attorney**: A written document stating that one person gives to another the full power and authority to make decisions involving only healthcare of the maker, which authority will survive the maker's incapacity or disability. Prepared by a program attorney at a cost of $35.00 per document paid directly to the program attorney by the Participant. One (1) each for Participant and Participant's spouse (can be used for parents) — up to four (4) per benefit year.

c. **HealthCare Directive:** A written document that allows a person to set out his or her wishes about what life-prolonging treatment should be withheld or provided if he or she becomes unable to communicate those wishes. Prepared by a program attorney at a cost of $35.00 per document paid directly to the program attorney. One (1) each for Participant and Participant's spouse (can be used for parents) — up to four (4) per benefit year.

d. **Financial Power of Attorney:** A written document stating that one person gives to another the full power and authority to represent him or her in financial matters. This document would not be effective upon incapacity of the maker. Prepared by a plan

attorney at a cost of $35.00 per document paid directly to the plan attorney. One (1) each for Participant and Participant's spouse (can be used for parents) — up to four (4) per benefit year.

3.***Discounted Attorney Fees:*** In the event Participant or Adult Care Recipient seeks Elder Law Services in excess of those listed above, Participant, Participant's Eligible Family Member and/or Adult Care Recipient shall be entitled to receive a twenty five percent (25%) discount from attorney's regular rates for such services

EXHIBIT B

PROGRAM FEES

I. Program Fees

The fees associated with this Program are $1.98 PPPM ("the Monthly Fee") multiplied by the number of Participants as indicated by the Group's Monthly Eligibility Report each month and are included in aggregate with the overall PacifiCare Health Plan premium.

PacifiCare
SignatureValue℠
A select group of physicians

CALIFORNIA

Combined Evidence of Coverage and Disclosure Form

TABLE OF CONTENTS

Welcome to PacifiCare®

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 a *Combined Evidence of Coverage and Disclosure Form*. It is a legal document that explains your health care plan and should answer many important questions about your benefits. Many of the words and terms are capitalized because they have special meanings. To better understand these terms, please see **Section 10. 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. You'll learn about important topics like how to select a Primary Care Physician and what to do if you need hospitalization.

What else should I read to understand my benefits?

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

What if I still need help?

After you become familiar with your benefits, you may still need assistance. Please don't hesitate to call our Customer Service department at 1-800-624-8822 or 1-800-442-8833 (TDHI).

Note: Your *Combined Evidence of Coverage and Disclosure Form* and *Schedule of Benefits* provides the terms and conditions of your coverage with PacifiCare and all applicants have a right to view these documents prior to enrollment. The *Combined Evidence of Coverage and Disclosure Form* should be read completely and carefully. Individuals with special health needs should pay special attention to those sections that apply to them.

You may correspond with PacifiCare at the following address:

PacifiCare of California

5701 Katella Avenue

P.O. Box 6006

Cypress, California 90630

1-866-316-9776

PacifiCare's Web site is:

www.pacificare.com

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**
- **Continuity of Care**

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

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

Introduction

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

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

What is a Primary Care Physician?

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

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

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

While both are Members of PacifiCare, there's a difference between a Subscriber and an enrolled Family Member. A Subscriber is the Member who enrolls through his or her employment after meeting the eligibility requirements of the Employer Group and PacifiCare. A Subscriber may also contribute toward a portion of the Premiums paid 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 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-mile radius of either your Primary Residence or Primary Workplace.

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

What is a Participating Medical Group?

When you select a Primary Care Physician, you are also selecting a Participating Medical Group. This is the group that's affiliated with both your doctor and PacifiCare. If you need a referral to a specialist or Non-Physician Health Care Practitioner, you will generally be referred to a doctor, Non-Physician Health Care Practitioner or service within this group. Only if a specialist, Non-Physician 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*. Along with addresses and phone numbers, you'll find other important information, including hospital affiliations, additional services and any restrictions about the availability of Providers.

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

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

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

Continuity of Care for New Members at the Time of Enrollment

Under certain circumstances, as a new Member of PacifiCare, you may be able to continue receiving services from a Non-Participating Provider to allow for the completion of Covered Services provided by a Non-Participating Provider, if you were receiving services from that Provider at the time your coverage became effective, for one of the Continuity of Care Conditions as limited and described in **Section 10. Definitions**.

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

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

1. Continuity of Care services from Non-Participating Provider must be Preauthorized by PacifiCare or the Member assigned Participating Provider;
2. The requested treatment must be a Covered Service under this Plan;

3. The Non-Participating Provider must agree in writing to meet the same contractual terms and conditions that are imposed upon PacifiCare's Participating Providers, including location within PacifiCare's Service Area, payment methodologies and rates of payment.

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

1. The Member's Continuity of Care Condition under treatment is medically stable; and
2. There are no clinical contraindications that would prevent a medically safe transfer to a Participating Provider as determined by a PacifiCare Medical Director in consultation with the Member, the Non-Participating Provider and as applicable, the newly enrolled Member's assigned Participating Provider.

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

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

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

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

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

If You Are Pregnant

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

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

You can learn more about changing Primary Care Physicians in **Section 4. Changing Your Doctor or Medical Group**. (For more about adding a newborn to your coverage, see **Section 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 1-800-624-8822 or 1-800-442-8833 (TDHI) to ensure that you can obtain the health care services that you need.

If you have chosen a Participating Medical Group that does not provide the family planning benefits you need, and these benefits have been purchased by your Employer Group, please call our Customer Service department.

SECTION 2. SEEING THE DOCTOR

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

Now that you've chosen a Primary Care Physician, you have a doctor for your routine health care. Your Primary Care Physician will determine when you need a specialist or Non-Physician Health Care Practitioner, arrange any necessary hospital care and oversee your health care needs.

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

Seeing the Doctor: Scheduling Appointments

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

When you see your Primary Care Physician or use one of your health care benefits, you may be required to pay a charge for the visit. This charge is called a Copayment. The amount of a Copayment depends upon the health care service. Your Copayments are outlined in your *Schedule of Benefits*. More detailed information can also be found in **Section 6. Payment Responsibility**.

Referrals to Specialists and Non-Physician Health Care Practitioners

The Primary Care Physician you have selected will coordinate your health care needs. If your Primary Care Physician determines you need to see a specialist or Non-Physician Health Care Practitioner, he or she will make an appropriate referral.(There is an exception for visits to obstetrical and gynecological (OB/GYN) Physicians. This is explained below in "Direct Access to OB/GYN Services.")

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

Your Primary Care Physician will determine the number of specialist or Non-Physician Health Care Practitioner visits that you require and will provide you with any other special instructions. This referral may also be reviewed by, 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 Review Committee, please refer to the definition of "Utilization Review Committee." A Utilization Review Committee meets on a regular basis as determined by membership needs, special requests or issues and the number of authorization or referral requests to be addressed. Decisions may be made outside of a formal committee meeting to assure a timely response to emergency or urgent requests.

PacifiCare Express Referrals®

PacifiCare's Express Referrals program is available through a select network of Participating Medical Groups. With Express Referrals, your Primary Care Physician decides when a specialist or Non-Physician Health Care Practitioner should be consulted – no further authorization is required. For a list of Participating Medical

Groups offering Express Referrals, please contact PacifiCare's Customer Service department or refer to your PacifiCare HMO *Provider Directory* or visit our Web site at **www.pacificare.com.**

Standing Referrals to Specialists

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

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

Extended Referral for Care by a Specialist

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

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

If you require an extended specialty referral, the referral will be made according to a treatment plan approved by your Participating Medical Group's Medical Director or a PacifiCare Medical Director. This is done in consultation with your Primary Care Physician, the specialist and you.

Once the extended specialty referral begins, the specialist begins serving as the main coordinator of your care. The specialist does this in accordance with your treatment plan.

OB/GYN: Getting Care Without a Referral

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

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

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

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

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

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

Second Medical Opinions

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

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

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

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

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

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

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

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

Please Note: The fact that an appropriately qualified Provider gives a second medical opinion and recommends a particular treatment, diagnostic test or service does not necessarily mean that the

recommended action is Medically Necessary or a Covered Service. You will also remain responsible for paying any outpatient office Copayments to the Provider who gives your second medical opinion.

If your request for a second medical opinion is denied, PacifiCare will notify you in writing and provide the reasons for the denial. You may appeal the denial by following the procedures outlined in **Section 8. Overseeing Your Health Care**. If you obtain a second medical opinion without Preauthorization from your Participating Medical Group or PacifiCare, you will be financially responsible for the cost of the opinion.

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

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

What is PacifiCare's Case Management Program?

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

Prearranging Hospital Stays

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

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

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

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.

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

Post-stabilization and Follow-up Care

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

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

Out-of-Area Services

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

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

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

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

What to Do When You Require Urgently Needed Services

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

You, or someone else on your behalf, must notify PacifiCare or your Participating Medical Group within 24 hours, or as soon as reasonably possible, after the initial receipt of Urgently Needed Services. When you call, please be prepared to give a description of the Urgently Needed Services that you received.

Out-of-Area Urgently Needed Services

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

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

When you are temporarily outside the geographic area served by your Participating Medical Group and you believe that you require Urgently Needed Services, you should, if possible, call (or have someone else call on your behalf) your Primary Care Physician or Participating Medical Group as described 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 nonbusiness hours, and a Physician is not immediately available, ask to have the Physician-on-call paged. A Physician should call you back shortly. Explain your situation and follow any provided instructions.

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

You, or someone else on your behalf, must notify PacifiCare or your Participating Medical Group within 24 hours, or as soon as reasonably possible, after the initial receipt of Urgently Needed Services. When you call, please be prepared to give a description of the Urgently Needed Services that you received.

International Emergency and Urgently Needed Services

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

Note: Under certain circumstances, you may need to initially pay for your Emergency or Urgently Needed Services. If this is necessary, please pay for such services and then contact PacifiCare at the earliest opportunity. Be sure to keep all receipts and copies of relevant medical documentation. You will need these to be properly reimbursed. For more information on submitting claims to PacifiCare, please refer to **Section 6** in this *Combined Evidence of Coverage and Disclosure Form*.

Always Remember

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

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

SECTION 4. CHANGING YOUR DOCTOR OR MEDICAL GROUP

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

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

Changing Your Primary Care Physician 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-mile radius 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 is high-risk or has reached the third trimester, to protect your health and the health of your unborn child, PacifiCare does not permit such change until after the pregnancy.

If you change your Participating Medical Group, authorizations issued by your previous Participating Medical Group will not be accepted by your new group. Consequently, you should request a new referral from your new Primary Care Physician within your new Participating Medical Group, which may require further evaluation by your new Participating Medical Group or PacifiCare. **Please note** that your new Participating Medical Group or PacifiCare may refer you to a different Provider than the Provider identified on your original authorization from your previous group.

If you are changing Participating Medical Groups, our Customer Service department may be able to help smooth the transition. When PacifiCare's Case Management is involved, the Case Manager is also consulted about the effective date of your Physician change request. At the time of your request, please let us know if you

are currently under the care of a specialist, receiving home health services or using durable medical equipment such as a wheelchair, walker, hospital bed or an oxygen delivery system.

When We Change Your Participating Medical Group

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

PacifiCare will also notify the Member in the event that the agreement terminates between PacifiCare and the Member's Participating Medical Group. If this occurs, PacifiCare will provide 30 days' 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 this Plan;
3. The Terminated Provider must agree in writing to be subject to the same contractual terms and conditions that were imposed upon the Provider prior to Termination, including, but not limited to, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements, notwithstanding the provisions outlined in the Provider contract related to Continuity of Care;
4. The Terminated Provider must agree in writing to be compensated at rates and methods of payment similar to those used by PacifiCare or Participating Medical Groups/Independent Practice Associations (PMG/IPA) for current Participating Providers providing similar services who are not capitated and who are practicing in the same or a similar geographic area as the Terminated Provider.

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

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

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

Continuity of Care also applies to Members who are receiving Mental Health care services from a Terminated Mental Health Provider, on the effective Termination date. Members eligible for continuity of Mental Health care services may continue to receive Mental Health services from the Terminated Mental Health Provider for a reasonable period of time to safely transition care to a Participating Mental Health Provider. Please refer to

"Medical Benefits" and "Exclusions and Limitations" in **Section 5. Your Medical Benefits** of the PacifiCare *Combined Evidence of Coverage and Disclosure Form*, and the *Schedule of Benefits* for supplemental Mental Health care coverage information, if any. For a description of coverage of Mental Health care services for the diagnosis and treatment of Severe Mental Illness (SMI) and Serious Emotional Disturbances of a Child (SED), please refer to the behavioral health supplement to this *Combined Evidence of Coverage and Disclosure Form.*

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

If you are receiving treatment for any of the specified Continuity of Care Conditions as limited and described in **Section 10. Definitions** and believe you qualify for continued care with the Terminating Provider, please call the Customer Service department and request the form "Request for Continuity of Care Benefits."

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

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

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

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.

I. Inpatient Benefits

THESE BENEFITS ARE PROVIDED WHEN ADMITTED OR AUTHORIZED BY EITHER THE MEMBER'S PARTICIPATING MEDICAL GROUP OR PACIFICARE. ALL SERVICES MUST BE MEDICALLY NECESSARY AS DEFINED IN THIS *COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM.*

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

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

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

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

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

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

A clinical trial with 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 PacifiCare with Participating Providers, in addition to any applicable Copayment, Coinsurance or deductibles.

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

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

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

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

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

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

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

   This benefit does not include drug, alcohol or other substance abuse rehabilitation.

10. **Mastectomy, Breast Reconstruction After Mastectomy and Complications From Mastectomy** – Medically Necessary mastectomy and lymph node dissection are covered, including prosthetic devices and/or reconstructive surgery to restore and achieve symmetry for the Member incident to the mastectomy. The length of a hospital stay is determined by the attending Physician and surgeon in consultation with the Member, consistent with sound clinical principles and processes. Coverage includes any initial and subsequent reconstructive surgeries or prosthetic devices for the diseased breast on which the mastectomy was performed. Coverage is provided for surgery and reconstruction of the other breast if, in the opinion of the attending surgeon, this surgery is necessary to achieve symmetrical appearance. Medical treatment for any complications from a mastectomy, including lymphedema, is covered.

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.
    - Nurse midwife services are covered only when available within the Member's Participating Medical Group.
    - 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 Roux-en-Y gastric bypass or vertical banded gastroplasty surgical procedures when Medically Necessary and Preauthorized; PacifiCare utilized the National Institutes of Health (NIH) Consensus Report criteria as a factor for determining the Medical Necessity of requests for surgical treatment for morbid obesity. Please refer to your *Schedule of Benefits* under the inpatient hospitalization benefit for your Copayment information, if any.

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 National Preferred Transplant Network Facility. Listing of the Member at a second National Preferred Transplant Network Center is excluded, unless the Regional Organ Procurement Agencies are different for the two Facilities and the Member is accepted for listing by both Facilities.

    In these cases, organ transplant listing is limited to two National Preferred Transplant Network Facilities. If the Member is dual listed, his or her coverage is limited to the actual transplant at the second Facility. The Member will be responsible for any duplicated diagnostic costs incurred at the second Facility. Covered Services for living donors are limited to Medically Necessary clinical services once a donor is identified. Transportation and other nonclinical expenses of the living donor are

excluded, and are the responsibility of the Member who is the recipient of the transplant. (See the definition for "National Preferred Transplant Network.")

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. Refer to your *Schedule of Benefits* for the number of days covered under your Health Plan.

    Skilled Nursing Facility services will be provided when authorized by the Member's Primary Care Physician or authorized by the Member's Participating Medical Group or PacifiCare in place of a Hospital stay, when Medically Necessary.

    Days spent out of a Skilled Nursing Facility when transferred to an acute hospital setting are not counted toward the limits as described in your *Schedule of Benefits* 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 limits as described in your *Schedule of Benefits*. In order to renew the room and board coverage in a Skilled Nursing Facility, the Member must either be out of all Skilled Nursing Facilities for 60 consecutive days, or if the Member remains in a Skilled Nursing Facility, then the Member must not have received Skilled Nursing Services or Skilled Rehabilitation Care for 60 consecutive days. Custodial care and services or supplies not included in the written treatment plan are not covered.

    Prescription drugs are covered when furnished by the Skilled Nursing Facility and used by the Member during a period of covered Skilled Nursing Facility care.

    Outpatient drugs and prescription medications may be available as a supplemental benefit. Please refer to "Drugs and Prescription Medication" (Outpatient) listed in "Exclusions and Limitations."

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 *Combined Evidence of Coverage and Disclosure Form*.

1. **Alcohol, Drug or Other Substance Abuse Detoxification** – Detoxification is the medical treatment of withdrawal from alcohol, drug or other substance addiction. Medically Necessary detoxification is covered. Methadone treatment for detoxification is not covered. In most cases of alcohol, drug or other substance abuse or toxicity, outpatient treatment is appropriate unless another medical condition requires close inpatient monitoring. Rehabilitation for substance abuse or addiction is not covered.

2. **Allergy Testing 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.

3. **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.

4. **Attention Deficit/Hyperactivity Disorder** – The medical management of Attention Deficit/ Hyperactivity Disorder (ADHD) is covered, including the diagnostic evaluation and laboratory monitoring of prescribed drugs. Coverage for outpatient prescribed drugs is only available if the Subscriber' s Employer Group has purchased the supplemental Outpatient Prescription Drug Benefit. This benefit does not include noncrisis Mental Health counseling, or behavior modification programs.

5. **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.

6. **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.

7. **Cancer Clinical Trials** – Please refer to the benefit described above 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.

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

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

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

9. **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."

10. **Cochlear Implant Medical and Surgical Services** – The implantation of a cochlear device for bilateral, profoundly hearing impaired or prelingual individuals who are not benefited from conventional amplification (hearing aids) is covered. This benefit includes services needed to support

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

11. **Dental Treatment Anesthesia** – See "Oral Surgery and Dental Services; Dental Treatment Anesthesia."

12. **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.

13. **Diabetic Self-Management Items** – Equipment and supplies for the management and treatment of Type 1, Type 2 and gestational diabetes are covered, based upon the medical needs of the Member, including, but not necessarily limited to: blood glucose monitors; blood glucose monitors designed to assist the visually impaired; strips; lancets and lancet puncture devices; pen delivery systems (for the administration of insulin); insulin pumps and all related necessary supplies; ketone urine testing strips; insulin syringes; podiatry services; and devices to prevent or treat diabetes related complications. Members must have coverage under the Outpatient Prescription Drug Benefit for insulin, glucagon and other diabetic medications to be covered.

    Visual aids are covered for Members who have a visual impairment that would prohibit the proper dosing of insulin. Visual aids do not include eyeglasses (frames and lenses) or contact lenses. The Member's Participating Provider will prescribe insulin syringes, lancets, glucose test strips and ketone urine test strips to be filled at a pharmacy that contracts with PacifiCare.

14. **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.

15. **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.

    Replacements, repairs and adjustments to durable medical equipment are limited to normal wear and tear or because of a significant change in the Member's physical condition. The Member's Participating Medical Group or PacifiCare has the option to repair or replace durable medical equipment items. Replacement of lost or stolen durable medical equipment is not covered. The following equipment and accessories are not covered: Non-Medically Necessary optional attachments and modifications to durable medical equipment for the comfort or convenience of the Member, accessories for portability or travel, a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment and home and/or car modifications to accommodate the Member's condition.

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

17. **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.

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

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

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

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

    a. Skilled nursing visits;

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

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

    d. Medical supplies, durable medical equipment; and

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

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

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

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

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

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

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

21. **Immunizations** – Immunizations for children (through age 18 years) are covered consistent with the most current version of the Recommended Childhood Immunization Schedule/United States[1]. An exception is made if, within 45 days of the published date of the schedule, the State Department of Health Services determines that the schedule is not consistent with state law. Immunizations for adults are covered consistent with the most current recommendations of the Center for Disease Control (CDC) for routine adult immunizations as advised by the Advisory Committee on Immunization Practices. For children under 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.

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

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

    - **Infusion Therapy** – Infusion therapy refers to the therapeutic administration of drugs or other prepared or compounded substances by the Intravenous route. Infusion therapy is covered when furnished as part of a treatment plan authorized by the Member's Primary Care Physician, Participating Medical Group or PacifiCare. The infusions must be administered in the Member's home, Participating Physician's office or in an institution, such as a board and care, Custodial Care, or assisted living facility, that is not a hospital or institution primarily engaged in providing Skilled Nursing Services orRehabilitation 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, [infertility drugs], [birth control], or off-label use of covered injectable medications). Outpatient injectable medications must be obtained through a Participating Provider or through the Member's Participating Medical Group and may require preauthorization by PacifiCare.

    - **Self-Injectable Medications** – Self-injectable medications (except insulin) are defined as those drugs which are either generally self-administered by Intramuscular injection at a frequency of one or more times per week, or which are generally self-administered by the Subcutaneous route. Self-injectable medications (except insulin) are covered when prescribed by a Participating Provider, as authorized by the Member's Participating Medical Group or by PacifiCare. Self-injectable medications must be obtained through a Participating Provider, through the Member's Participating Medical Group or PacifiCare-designated pharmacy/specialty injectable vendor, and may require preauthorization by PacifiCare. A separate Copayment applies to all self-injectable medications for a

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

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

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

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(s) and treatment of temporomandibular joint syndrome (TMJ);
        - Biopsy of gums or soft palate;
        - Oral or dental examinations performed on an inpatient or outpatient basis as part of a comprehensive workup prior to transplantation surgery;
        - Preventive fluoride treatment prior to an aggressive chemotherapeutic or radiation therapy protocol. Fluoride trays and/or bite guards used to protect the teeth from caries and possible infection during radiation therapy;
        - Reconstruction of a ridge that is performed as a result of and at the same time as the surgical removal of a tumor (for other than dental purposes);
        - Reconstruction of the jaw when Medically Necessary (e.g., radical neck or removal of mandibular bone for cancer or tumor);
        - Ridge augmentation or alveoplasty are covered when determined to be Medically Necessary based on state cosmetic reconstructive surgery law and jawbone surgery law;
        - Setting of the jaw or facial bones;
        - Tooth extraction prior to a major organ transplant or radiation therapy of neoplastic disease to the head or neck;
        - Treatment of maxillofacial cysts, including extraction and biopsy.

Dental Services beyond emergency treatment to stabilize an acute injury – including, but not limited to, crowns, fillings, dental implants, caps, dentures, braces, dental appliances and orthodontic procedures are not covered. Charges for the dental procedure(s) beyond emergency treatment to stabilize an acute injury including, but not limited to, professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth, dental services include those for crowns, root canals, replacement of teeth, complete dentures, gold inlays, fillings, and other dental services specific to the replacement of teeth or structures directly supporting the teeth and other dental services specific to the treatment of the teeth are not covered except for services covered by PacifiCare under this outpatient benefit, "Oral Surgery and Dental Services."

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: (a) 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 (b) 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 Surgery** – Short-stay, same-day or other similar outpatient surgery Facilities are covered when provided as a substitute for inpatient care.

33. **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. (Hearing screenings are limited to Dependents under age 19.)
    - **Prostate Screening** – Evaluations for the screening and diagnosis of prostate cancer is covered (including, but not limited to, prostate-specific antigen testing and digital rectal examination). These evaluations are provided when consistent with good professional practice.

- **Vision Screening** – Annual routine eye health assessment and screening by a Participating Provider are covered to determine the health of the Member's eyes and the possible need for vision correction. An annual retinal examination is covered for Members with diabetes.
- **Well-Baby Care** – Up to the age of two, preventive health services are covered (including immunizations) when provided by the child's Participating Medical Group. An office Copayment applies when infants are ill at the time services are provided.
- **Well-Woman Care** – Medically Necessary services, including a Pap smear (cytology), are covered. The Member may receive obstetrical and gynecological Physician services directly from an OB/GYN or Family Practice Physician or surgeon (designated by the Member's Participating Medical Group as providing OB/GYN services) affiliated with Member's Participating Medical Group.

34. **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.
35. **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.
36. **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.
37. **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, nondental prosthetic devices such as a limb that does not require surgical connection to nerves, muscles or other tissue.

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

    - Bionic, 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 limited to normal wear and tear or because of a significant change in the Member's physical condition. Repair or replacement must be authorized by the Member's Participating Medical Group or PacifiCare.

    Refer to "Footwear" in "Outpatient Benefits."

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

38. **Radiation Therapy (Standard and Complex):**
    - Standard photon beam radiation therapy is covered.
    - Complex radiation therapy is covered. This therapy requires specialized equipment, as well as specially trained or certified personnel to perform the therapy. Examples include, but are not limited to: brachytherapy (radioactive implants) and conformal photon beam radiation 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.)
39. **Radiology Services** – Including, but not limited to, Standard X-ray films (with or without oral, rectal, injected or infused contrast medium) for the diagnosis of an illness or injury are covered. Standard X-ray services are X-ray(s) of an extremity, abdomen, head, chest, back, mammograms, nuclear studies and barium studies. Also see "Maternity" and "Periodic Health Evaluations."
    - Specialized scanning and imaging procedures, such as CT, SPECT, PET, MRA and MRI (with or without contrast media), are covered.
40. **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.
41. **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 eyeglasses when prescribed following cataract surgery with an intra ocular lens implant. Eyeglasses must be obtained through Participating Medical Group.

III. Exclusions and Limitations of Benefits

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

General Exclusions

1. Services that are not Medically Necessary, as defined in the "Definitions" section of this *Combined Evidence of Coverage and Disclosure Form*, 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 *Combined Evidence of Coverage and Disclosure Form*, or any supplement purchased by the Subscriber's Employer Group, 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 *Combined Evidence of Coverage and Disclosure Form*, and for obstetrical and gynecological Physician services

obtained directly from an OB/GYN, Family Practice Physician or surgeon designated by the Member's Participating Medical Group as providing OB/GYN services) are not covered.

4. Services obtained from Non-Participating Providers or Participating Providers who are not affiliated with the Member's Participating Medical Group, when such services were offered or authorized by the Member's Participating Medical Group and the Member refused to obtain the services as offered by the Member's Participating Medical Group, are not covered.
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.

Other Exclusions and Limitations

1. **Acupuncture and Acupressure** – Acupuncture and acupressure are not covered. (Coverage for acupuncture and acupressure may be available if purchased by the Subscriber's employer as a supplemental benefit. If the Member's Health Plan includes an acupuncture and acupressure supplemental benefit, a brochure describing it will be enclosed with these materials.)
2. **Air Conditioners, Air Purifiers and Other Environmental Equipment** – Air conditioners, air purifiers and other environmental equipment are not covered.
3. **Alcoholism, Drug Addiction and Other Substance Abuse Rehabilitation** – Inpatient, outpatient and day treatment rehabilitation for chronic alcoholism, drug addiction or other substance abuse are not covered. Methadone treatment for detoxification is not covered. (Coverage for rehabilitation of alcohol, drug or other substance abuse or addiction may be available if purchased by the Subscriber's employer as a supplemental benefit. If the Member's health plan includes a Behavioral Health supplemental benefit, a brochure describing it will be enclosed with these materials.)

   Not Covered:

   - Rapid anesthesia opioid detoxification;
   - Alcoholism, drug addiction and other substance abuse rehabilitation services beyond detoxification are not covered;
   - Services that are required by a court order as a part of parole or probation, or instead of incarceration.
4. **Ambulance** – Ambulance service is covered only when medically necessary. Ambulance service is not covered when used only for the Member's convenience, or when another available form of transportation would be more appropriate except under circumstances when a Member believes that there is an emergency.

   Please refer to "Ambulance" in the "Outpatient Benefits" section and "Organ Transplants" in the "Other Exclusions and Limitations" section.
5. **Artificial Hearts and Ventricular Assist Devices (VADs)** – Artificial hearts and Ventricular Assist Devices as destination therapy devices are considered experimental and are therefore not covered. Destination therapy is defined as, "the VAD is placed with the expectation that the patient will likely require permanent mechanical cardiac support." Ventricular Assist Devices (VADs) are limited to use as

a bridge or temporary device for Members authorized for heart transplantation or to support circulation of blood following open-heart surgery (postcardiotomy).

A Member may be entitled to an expedited external, independent review of PacifiCare's coverage determination regarding Experimental or Investigational therapies as described in **Section 8**.

6. **Behavior Modification and Non-Crisis Mental Health Counseling and Treatment** – Behavior modification and noncrisis Mental Health counseling and treatment are not covered. Examples include, but are not limited to, art therapy, music therapy and play therapy.
7. **Biofeedback** – Biofeedback services are not covered except for bladder rehabilitation as part of an authorized treatment plan.
8. **Bloodless Surgery Services** – Bloodless surgery services are only covered to the extent available within the Member's Participating Medical Group.
9. **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 Eight** of this *Combined Evidence of Coverage and Disclosure Form*, under the caption "Independent Medical Review Procedures." Unrelated donor computer searches for Members who require a bone marrow or stem cell transplant are limited to $15,000. Unrelated donor searches must be performed at a PacifiCare-approved transplant center. (See "National Preferred Transplant Network" in "Definitions.")
10. **Chiropractic Care** – Care and treatment provided by a chiropractor are not covered. (Coverage for chiropractic care may be available if purchased by the Subscriber's employer as a supplemental benefit. If your Health Plan includes a chiropractic care supplemental benefit, a brochure describing it will be enclosed with these materials.)
11. **Communication Devices** – Computers, personal digital assistants and any speech-generating devices are not covered. For a detailed listing of covered durable medical equipment, including prosthetic and corrective appliances, please contact the PacifiCare Customer Service department at 1-800-624-8822.
12. **Complementary and Alternative Medicine** – Complementary and Alternative Medicine are not covered unless purchased by the Subscriber's Employer Group as a supplemental benefit. (See the definition for "Complementary and Alternative Medicine.")
13. **Cosmetic Services and Surgery** – Cosmetic surgery and cosmetic services are not covered. Cosmetic surgery and cosmetic services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered. Cosmetic surgeries or cosmetic services do not become reconstructive surgery because of a Member's psychological or psychiatric condition.
14. **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 *Combined Evidence of Coverage and Disclosure Form*. Custodial Care does not require the continuing attention of trained medical or paramedical personnel.
15. **Dental Care, Dental Appliances and Orthodontics** – Except as otherwise provided under the outpatient benefit captioned "Oral Surgery and Dental Services," dental care, dental appliances and orthodontics are not covered. Dental care means all services required for prevention and treatment of diseases and disorders of the teeth, including, but not limited to: oral exams, X-rays, routine fluoride treatment, plaque removal, tooth decay, routine tooth extraction, dental embryonal tissue disorders, periodontal disease, crowns, fillings, dental implants, caps, dentures, braces and orthodontic procedures. (Coverage for dental care may be available if purchased by the Subscriber's employer as a separate benefit. If your Health Plan includes a dental care separate benefit, a brochure describing it will be enclosed with these materials.)

16. **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."

17. **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.

18. **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.

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

20. **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 condition. For a detailed listing of covered durable medical equipment please contact the PacifiCare Customer Service department at 1-800-624-8822.

21. **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*.

22. **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.

23. **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.

24. **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 *Combined Evidence of Coverage and Disclosure Form* captioned "Eligibility for Independent Medical Review; Experimental or Investigational Treatment Decisions, or as described under "Cancer Clinical Trials" in the "Inpatient Benefits" and "Outpatient Benefits" sections of this *Combined Evidence of Coverage and Disclosure Form*. Unless otherwise required by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational and therefore not a covered benefit are determined by a PacifiCare Medical Director, or his or her designee. For the purposes of this *Combined Evidence of Coverage and Disclosure Form*, procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/guidelines is met:

- It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use.
- It is a subject of a current investigation of new drug or new device (IND) application on file with the FDA.
- It is the subject of an ongoing clinical trial (Phase I, II or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and Department of Health and Human Services (DHHS).
- It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose or effectiveness in comparison to conventional treatments.
- 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 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**, "Experimental or Investigational Treatment Decisions."

25. **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. (Coverage for frames and lenses may be available if the Subscriber's employer purchased a vision supplemental benefit. If your Health Plan includes a vision supplemental benefit, a brochure describing it will be enclosed with these materials.) Routine screenings for glaucoma are limited to Members who meet the medical criteria.
26. **Family Planning** – Family planning benefits, other than those specifically listed in the *Schedule of Benefits* that accompanies this document, are not covered.
27. **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.
28. **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.
29. **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.
30. **Genetic Testing and Counseling** – Genetic testing and counseling are excluded for all of the following:
    - Non-PacifiCare Members
    - Solely to determine the gender of a fetus
    - Nonmedical reasons (e.g. court-ordered tests, work-related tests, paternity tests)
    - 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 during childhood.
    - 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.
31. **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.
32. **Hearing Aids and Hearing Devices** – Hearing aids and nonimplantable hearing devices are not covered. Audiology services (other than screening for hearing acuity) are not covered. Hearing aid supplies are not covered. Implantable hearing devices are not covered except for cochlear devices for

bilaterally, profoundly hearing-impaired individuals or for prelingual Members who have not benefited from conventional amplification (hearing aids).

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

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

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

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

34. **Immunizations** – Immunizations and vaccines for international travel and/or required for work, insurance, school, marriage, adoption, immigration, camp, volunteer work, licensure, certification or registration, sports or recreational activities are not covered.

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

    - Surgical implantation or removal of breast implants for nonmedical reasons.
    - Replacement of breast implants when the initial surgery was done for nonmedical 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.

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

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

38. **Institutional Services and Supplies** – Except for skilled nursing services provided in a Skilled Nursing Facility, any services or supplies furnished by a Facility that is primarily a place of rest, a place for the aged, a nursing home or any similar institution, regardless of affiliation or denomination, are not covered. (Skilled nursing services are covered as described in this *Combined Evidence of Coverage and Disclosure Form* in the sections 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.

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

40. **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.

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

crisis intervention may also be available as an additional benefit. Please refer to the *Schedule of Benefits* for coverage, if any.

42. **Non-Physician Health Care Practitioners** – This Plan may not cover services of all Non-Physician Health Care Practitioners. Treatment by Non-Physician Health Care Practitioners, such as acupuncturists, 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.")

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

44. **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.

45. **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."

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

    - The drug is approved by the FDA;
    - The drug is prescribed by a Participating Provider for the treatment of a life-threatening condition or for a chronic and seriously debilitating condition;
    - The drug is Medically Necessary to treat the condition;
    - The drug has been recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following: *The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopoeia Dispensing Information, Volume 1,* or in two articles from major peer-reviewed medical journals that present data supporting the proposed off-label drug use or uses as generally safe and effective;
    - The drug is covered under the injectable drug benefit described in the "Outpatient Benefits" section of this *Combined Evidence of Coverage and Disclosure Form.*

    Nothing in this section shall prohibit PacifiCare from use of a Formulary or Copayment.

47. **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.

48. **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.")

49. **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. Computer searches of unrelated donors for Members who require a bone marrow or stem cell transplant are limited to $15,000 per procedure. Organ donor searches are only covered when performed by a Provider included in the "National Preferred Transplant Network Facility."

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

    - Transportation is limited to the transportation of the Member and one escort to a National Preferred Transplant Network Facility greater than 60 miles from the Member's Primary Residence as Preauthorized by PacifiCare. Transportation and other nonclinical expenses of the living donor are excluded, and are the responsibility of the Member, who is the recipient of the transplant. (See the definition for "National Preferred Transplant Network.")
    - Food and housing is not covered unless the National Preferred Transplant Network Center is located more than 60 miles from the Member's Primary Residence, in which case food and housing is limited to $125.00 a day to cover both the Member and escort, if any (excludes alcohol and tobacco) as 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 National Preferred Transplant Network Center is excluded, unless the Regional Organ Procurement Agencies are different for the two Facilities and the Member is accepted for listing by both Facilities. In these cases, organ transplant listing is limited to two National Preferred Transplant Network Facilities. If the Member is dual listed, his or her coverage is limited to the actual transplant at the second Facility. The Member is responsible for any duplicated diagnostic costs incurred at the second Facility. (See the definition for "Regional Organ Procurement Agency.")
    - Artificial and non-human organs 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**.

51. **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.

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

53. **Physical or Psychological Examinations** – Physical or psychological examinations for court hearings, travel, premarital, preadoption or other nonpreventive health reasons are not covered.

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

55. **Prosthetics and Corrective Appliances** – Replacement of prosthetics or corrective appliances which are lost or damaged by abuse beyond normal wear and tear are not covered. 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 please contact the PacifiCare Customer Service department at 1-800-624-8822.

56. **Pulmonary Rehabilitation Programs** – Pulmonary rehabilitation programs are covered only when determined to be medically necessary by a PacifiCare Medical Director or designee.

57. **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.

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

59. **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).
    - Exercise programs are only covered when they require the direct supervision of a licensed physical therapist and are part of an authorized treatment plan.
    - Activities that are motivational in nature or that are primarily recreational, social or for general fitness, are not covered.
    - Aquatic/pool therapy is not covered unless conducted by a licensed physical therapist and part of an authorized treatment plan.
    - Massage therapy is not covered.

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

    - Biofeedback (except as related to acute pelvic muscle rehabilitation)
    - Cognitive Therapy includes but is not limited to: educational, social, psychosocial, vocational, and behavioral nonmedical services.
    - Developmental and Neuroeducational Testing beyond initial diagnosis, except as Medically Necessary.
    - Hypnotherapy
    - Psychological Testing
    - Vocational Rehabilitation

    (Please refer to **Section 10** for definitions of capitalized terms.)

60. **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.

61. **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.

62. **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."

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

64. **Services While Confined or Incarcerated** – 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/incarcerated, or, if a juvenile, while detained in any 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 or county 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.

65. **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.

66. **Sex Transformations** – Procedures, services, medications and supplies related to sex transformations are not covered.

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

68. **Transportation** – Transportation is not a covered benefit except for ambulance transportation as defined in this *Combined Evidence of Coverage and Disclosure Form*. Also see "Organ Transplants" listed in "Other Exclusions and Limitations."

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

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

71. **Vision Training** – Vision therapy rehabilitation and ocular training programs (orthoptics) are not covered.

72. **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. Weight loss or weight gain programs and services associated with these programs, 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 your *Combined Evidence of Coverage and Disclosure Form*.

SECTION 6. PAYMENT RESPONSIBILITY

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

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

What are Premiums (Prepayment Fees)?

Premiums are fees an Employer Group pays to cover the basic costs of your health care package. An Employer Group usually pays these Premiums on a monthly basis. Often the Subscriber shares the cost of these Premiums with deductions from his or her salary.

If you are the Subscriber, you should already know if you're contributing to your Premium payment; if you aren't sure, contact your Employer Group's health benefits representative. He or she will know if you're contributing to your Premium, as well as the amount, method and frequency of this contribution.

What are Copayments (Other Charges)?

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

Annual Copayment Maximum

For certain Covered Services, a limit is placed on the total amount you pay for Copayments during a calendar year. This limit is called your Annual Copayment Maximum and when you reach it, for the remainder of the calendar year, you will not pay any additional Copayments for these Covered Services.

You can find your Annual Copayment Maximum in your *Schedule of Benefits*. If you've surpassed your Annual Copayment Maximum, submit all your health care Copayment receipts and a letter of explanation to:

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

Remember, it's important to send us **all** Copayment receipts along with your letter. They confirm that you've reached your Annual Copayment Maximum. You will be reimbursed by PacifiCare for Copayments you make beyond your individual or family Annual Copayment Maximum. Copayments paid for certain Covered Services are not applicable to a Member's Annual Copayment Maximum; these services are specified in the *Schedule of Benefits*. **Note:** The calculation of your Annual Copayment Maximum will not include supplemental benefits that may be offered by your Employer Group (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).

If You Get a Bill (Reimbursement Provisions)

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

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

2. Give the Provider your PacifiCare Health Plan information, including your name and PacifiCare Member number.

Forward the bill to:

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

Include your name, your PacifiCare ID number and a brief note that indicates you believe the bill is for a Covered Service. The note should also include the date of service, the nature of the service and the name of the Provider who authorized your care. No claim form is required. If you need additional assistance, call our Customer Service department.

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

What is a *Schedule of Benefits*?

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

Bills From Non-Participating Providers

If you receive a bill for a Covered Service from a Physician who is not one of our Participating Providers, and the service was Preauthorized and you haven't exceeded any applicable benefit limits, PacifiCare will pay for the service, less the applicable Copayment. (Preauthorization isn't required for Emergency Services and Urgently Needed Services. See **Section 3. Emergency and Urgently Needed Services**.) You may also submit a bill to us if a Non-Participating Provider has refused payment directly from PacifiCare.

You should file a claim within 90 days, or as soon as reasonably possible, of receiving any services and related supplies. Forward the bill to:

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

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

PacifiCare will make a determination within 30 working days from the date PacifiCare receives a claim containing all information reasonably necessary to decide the claim. PacifiCare will not pay any claim that is filed more than 180 days 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. 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."

Coordination of Benefits

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

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

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

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

Definitions

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

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

1. **Plan** includes: group insurance, closed panel (HMO, POS, PPO or EPO) coverage or other forms of group or group-type coverage (whether insured or uninsured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as Skilled Nursing Care; or other governmental benefits, as permitted by law (Medicare is not included as a "Plan" as defined here; however, PacifiCare does coordinate benefits with Medicare. Please refer to **Section 6**, "Important Rules for Medicare and Medicare Eligible Members."

2. **Plan** does not include: non-group coverage of any type, including, but not limited to, individual or family insurance; amounts of hospital indemnity insurance of $200 or less per day; school accident-type coverage; benefits for nonmedical components of group long-term care policies; Medicare supplement policies, a state-plan under Medicaid; and coverage under other governmental plans, unless permitted by law.

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

B. **Primary Plan or Secondary Plan** – The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when compared to another Plan covering the person.

When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other Plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the Primary Plan's benefits.

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

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

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

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

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

Order of Benefit Determination Rules

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

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

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

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

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

1. **Subscriber (Non-Dependent) or Dependent.** The Plan that covers the person other than as a Dependent; for example as an employee, Member, Subscriber or retiree, is primary, and the plan that covers the person as a Dependent is secondary.

2. **Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one plan is:

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

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

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

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

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

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

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

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

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

Effect on the Benefits of This Plan

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

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

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans.

PacifiCare may obtain the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. Each person claiming benefits under this Plan must give PacifiCare any facts it needs to apply those rules and determine benefits payable. PacifiCare may use and disclose a Member's protected health information for the purposes of carrying out treatment, payment or health care operations, including, but not limited to, diagnoses payment of health care services rendered, billing, claims management or other administrative functions of PacifiCare, without obtaining the Member's consent, in accordance with state and federal law.

PacifiCare's Right to Pay Others

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

Right of Recovery

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

Important Rules for Medicare and Medicare Eligible Members

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

If you are eligible for Medicare, but fail to enroll in Medicare, your PacifiCare coverage will be reduced by the amount you would have received from Medicare.

If you have questions about the coordination of Medicare benefits, contact your Employer Group or our Customer Service department. For questions regarding Medicare eligibility, contact your local Social Security office.

Workers' Compensation

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

If for any reason PacifiCare provides or arranges for benefits, services or supplies that are otherwise covered under the Workers' Compensation Act, the Member is required to reimburse PacifiCare for the benefits,

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

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

PacifiCare will not provide or arrange for benefits or services for a work-related illness or injury when the Member fails to file a claim within the filing period allowed by law or fails to comply with other applicable provisions 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 expressly excluded from coverage under this Health Plan. However, in all cases, PacifiCare will pay for the arrangement or provision of health care services for a Member that would have been Covered Services except that they were required due to a liable third party, in exchange for the agreement as expressly set forth in the section of the *Combined Evidence of Coverage and Disclosure Form* captioned "PacifiCare's Right to the Repayment of a Debt as a Charge Against Recoveries From Third Parties Liable for a Member's Health Care Expenses."

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

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

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

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

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

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

If you are receiving benefits as a result of automobile, accident or liability coverage, PacifiCare will not duplicate those benefits. It is your responsibility to take whatever action is necessary to receive payment under automobile, accident or liability coverage when such payments can reasonably be expected and to notify PacifiCare of such coverage when available. PacifiCare will provide Covered Services over and above your automobile, accident or liability coverage, if the cost of your health care services exceeds such coverage.

SECTION 7. MEMBER ELIGIBILITY

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

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

Who is a PacifiCare Member?

There are two kinds of PacifiCare Members: Subscribers and enrolled Family Members (also called Dependents). The Subscriber is the person who enrolls through his or her employer-sponsored health benefit plan. The Employer Group, in turn, has signed a Group Agreement with PacifiCare.

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 or the Subscriber's Spouse or the Domestic Partner (stepchildren) who are under the Limiting Age established by the employer (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 the Domestic Partner who are under the Limiting Age established by the employer;
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 and 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 the Employer Group and PacifiCare. PacifiCare's eligibility requirements are:

- Have a Primary Residence within California;
- Select a Primary Care Physician within a 30-mile radius of his or her Primary Residence or Primary Workplace (except children enrolled as a result of a qualified medical child support order);
- Meet any other eligibility requirements established by the Employer Group, such as exhaustion of a waiting period before an employee can enroll in PacifiCare. Employers will also establish the "Limiting Age," the age limit for providing coverage to unmarried children.

Eligible Family Members must enroll in PacifiCare at the same time as the Subscriber or risk not being eligible to enroll until the employer's next Open Enrollment Period, as explained below. Circumstances which allow

for enrollment outside the Open Enrollment Period are also explained below. All applicants for coverage must complete and submit to PacifiCare all applications, medical review questionnaires or other forms or statements that PacifiCare may reasonably request.

Enrollment is the completion of a PacifiCare enrollment form (or a nonstandard enrollment form approved by PacifiCare) by the Subscriber on his or her own behalf or on the behalf of any eligible Family Member. Enrollment is conditional upon acceptance by PacifiCare; the existence of a valid Employer Group Agreement; and the timely payment of applicable Health Plan Premiums. PacifiCare may in its discretion and subject to specific protocols accept enrollment data through an electronic submission.

Your effective date of enrollment in PacifiCare will depend on when and how you enroll. These circumstances are explained below. (**Please Note:** PacifiCare enrolls applicants in the order that they become eligible and up to our capacity for accepting new Members.)

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

Most Members enroll in PacifiCare during the "Open Enrollment Period" established by the Employer Group. This is the period of time established by the employer when its Eligible Employees and their eligible Family Members may enroll in the employer's health benefit plan. An Open Enrollment Period usually occurs once a year, and enrollment is effective based on a date agreed upon by the employer and PacifiCare.

Adding Family Members to Your Coverage

The Subscriber's Spouse or Domestic Partner and eligible children may apply for coverage with PacifiCare during the employer's Open Enrollment Period. If you are declining enrollment for yourself or your Dependents (including your Spouse or Domestic Partner) because of other Health Plan or insurance coverage, you may in the future be able to enroll yourself or your Dependents in PacifiCare, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. (Guardianship is not a qualifying event for other Family Members to enroll). Under the following circumstances, new Family Members may be added outside the Open Enrollment Period.

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

5. **Guardianship.** To enroll a Dependent child for whom the Subscriber, Subscriber's Spouse or Domestic Partner has assumed legal guardianship, the Subscriber must submit a Change Request Form to PacifiCare along with a certified copy of a court order granting guardianship within 30 days of when the Subscriber, Subscriber's Spouse or Domestic Partner assumed legal guardianship. Coverage will be retroactively effective to the date the Subscriber assumed legal guardianship.

Qualified Medical Child Support Order

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

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

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

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 established by the Employer Group 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 through the Limiting Age established by the employer for full-time students, if proof of such status is provided to PacifiCare on a periodic basis, as requested by us. 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 established by the employer, 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, 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. 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.

Late Enrollment

In addition to a special enrollment period due to the addition of a new Spouse, Domestic Partner or child, there are certain circumstances when employees and their eligible Family Members may enroll outside of the employer's Open Enrollment Period. These circumstances include:

1. The eligible employee (on his or her own behalf, or on behalf of any eligible Family Members) declined in writing to enroll in PacifiCare when they were first eligible because they had other health care coverage; and
2. PacifiCare cannot produce a written declination statement from the Employer Group or eligible employee stating that the eligible employee (on his or her own behalf, or on behalf of any eligible Family Members) was provided with and a signed acknowledgment of explicit written notice in boldface type specifying that failure to elect coverage with PacifiCare during the initial enrollment period permits the plan to impose an exclusion of coverage under the Health Plan for a period of 12 months from the date of election of coverage under the Health Plan, unless the eligible employee or Family Member can demonstrate that he or she meets the requirements for late enrollment.
3. The other health care coverage is no longer available due to:
   i. The employee or eligible Family Member has exhausted COBRA continuation coverage under another group Health Plan; or
   ii. The termination of employment or reduction in work hours of a person through whom the employee or eligible Family Member was covered; or
   iii. The termination of the other Health Plan coverage; or
   iv. The cessation of an employer's contribution toward the employee or eligible Family Member coverage; or
   v. The death, divorce or legal separation of a person through whom the employee or eligible Family Member was covered.
4. The Court has ordered health care coverage be provided for your Spouse or minor child.

If the employee or an eligible Family Member meets these conditions, the employee must request enrollment with PacifiCare no later than 30 days following the termination of the other Health Plan coverage. PacifiCare may require proof of loss of the other coverage. Enrollment will be effective the first day of the calendar month following receipt by PacifiCare of a completed request for enrollment.

Notifying You of Changes in Your Plan

Amendments, modifications or termination of the Group Agreement by either the Employer Group or PacifiCare do not require the consent of a Member. PacifiCare may amend or modify the Health Plan, including the applicable Premiums, at any time space after sending written notice to the Employer Group 30 days prior to the effective date of any amendment or modification. Your Employer Group may also change your Health Plan benefits during the contract year. In accordance with PacifiCare's Group Agreement, the Employer Group is obliged to notify employees who are PacifiCare Members of any such amendment or modification.

Updating Your Enrollment Information

Please notify your employer and 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 1-800-624-8822 or 1-800-442-8833 (TDHI).

Renewal and Reinstatement (Renewal Provisions)

Your Employer Group's Group Agreement with PacifiCare renews automatically, on a yearly basis, subject to all terms of the Group Agreement. PacifiCare or your Employer Group may change your Health Plan benefits and Premium at renewal. If the Group Agreement is terminated by PacifiCare, reinstatement is subject to all terms and conditions of the Group Agreement. In accordance with PacifiCare's Group Subscriber Agreement, the Employer Group is required to notify employees who are PacifiCare Members of any such amendment or modification.

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, any other Participating Provider.

Important Note: Any person using this card to receive benefits or services for which he or she is not entitled will be charged for such benefits or services. If any Member permits the use of his or her identification card by any other person, PacifiCare may immediately terminate that Member's membership.

Ending Coverage (Termination of Benefits)

Usually, your enrollment in PacifiCare terminates when the Subscriber or enrolled Family Member is no longer eligible for coverage under the employer's health benefit plan. In most instances, your Employer Group determines the date in which coverage will terminate. Coverage can be terminated, however, because of other circumstances as well, which are described below.

Continuing coverage under this Health Plan is subject to the terms and conditions of the employer's Group Agreement with PacifiCare.

When the Group Agreement between the Employer Group and PacifiCare is terminated, all Members covered under the Group Agreement become ineligible for coverage on the date of termination. If the Group Agreement is terminated by PacifiCare for nonpayment of Premiums, coverage for all Members covered under the Group Agreement will be terminated effective the last day for which Premiums were received. According to the terms of the Group Agreement, the Employer Group is responsible for notifying you if and when the Group Agreement is terminated, except in the event the Group Agreement is terminated for the nonpayment of Health Plan Premiums. In that circumstance, PacifiCare will notify you directly of such termination.

Cancellation of the Group Contract for Nonpayment of Premiums

If the Group Contract is cancelled because the Group failed to pay the required Premiums when due, then coverage for you and all your Dependents will end retroactively back to the last day of the month for which Premiums were paid; however, this retroactive period will not exceed the 60 days before the date the Plan mails you the Notice Confirming Termination of Coverage.

PacifiCare will mail your Employer a notice at least 15 days before any cancellation of coverage. This Prospective Notice of Cancellation will provide information to your employer regarding the consequences of your employer's failure to pay the Premiums due within 15 days of the date the notice was mailed.

If payment is not received from your employer within 15 days of the date the Prospective Notice of Cancellation is mailed, PacifiCare will cancel the Group Contract and mail you a Notice Confirming Termination of Coverage, which will provide you with the following information:

- That the Group Contract has been cancelled for nonpayment of Premiums.
- The specific date and time when your Group coverage ended.
- The Plan telephone number you can call to obtain additional information, including whether your Employer obtained reinstatement of the Group Contract. This confirmation of reinstatement will be available on request 16 days after the date the Notice Confirming Termination of Coverage is mailed.

- An explanation of your options to purchase continuation coverage, including coverage effective as of the retroactive termination date so you can avoid a break in coverage, and the deadline by which you must elect to purchase such continuation coverage, which will be 63 days after the date the Plan mails you the Notice Confirming Termination of Coverage.

Reinstatement of the Contract after Cancellation

If the Group Contract is cancelled for the group's nonpayment of Premiums, the Plan will permit reinstatement of the Group Contract once during any 12-month period if the group pays the amounts owed within 15 days of the date the Notice Confirming Termination.

Other Reasons for Termination of Coverage

In addition to terminating the Group Agreement, PacifiCare may terminate a Member's coverage for any of the following reasons:

- The Member no longer meets the eligibility requirements established by the Group Employer and/or PacifiCare.
- The Member establishes his or her Primary Residence outside the state of California.
- The Members establishes his or her Primary Residence outside the PacifiCare Service Area and does not work inside the PacifiCare Service Area (except for a child subject to a qualified child medical support order, for more information refer to "Qualified Medical Child Support Order" in this section).

Termination for Good Cause

PacifiCare has the right to terminate your coverage under this Health Plan in the following situations:

- **Failure to Pay.** Your coverage may be terminated if you fail to pay any required Copayments, Coinsurance or charges owed to a Provider or PacifiCare for Covered Services. To be subject to termination under this provision, you must have been billed by the Provider for two different billing cycles and have failed to pay or make appropriate payment arrangements with the Provider. PacifiCare will send you written notice, and you will be subject to termination if you do not pay or make appropriate payment arrangements within the 30-day notice period.
- **Fraud or Misrepresentation.** Your coverage may be terminated if you knowingly provide material false information (or misrepresent a meaningful fact) on your enrollment form (this includes adding dependents that do not meet the eligibility requirements of the Employer Group and PacifiCare as defined in this document and proof of eligibility may be requested at any time PacifiCare deems necessary); or fraudulently or deceptively use services or facilities of PacifiCare, its Participating Medical Group or other health care Providers (or knowingly allow another person to do the same), including altering a prescription. termination is effective immediately on the date PacifiCare mails the notice of termination, unless PacifiCare has specified a later date in that notice.
- **Disruptive Behavior.** Your coverage may be terminated if you threaten the safety of Plan employees, Providers, Members or other patients, or your repeated behavior has substantially impaired PacifiCare's ability to furnish or arrange services for you or other Members, or substantially impaired Provider(s) ability to provide services to other patients. termination is effective 15 days after the notice is mailed to the Subscriber.

If coverage is terminated for any of the above reasons, you forfeit all rights to enroll in the PacifiCare conversion plan (discussed below) or COBRA Plan and lose the right to re-enroll in PacifiCare in the future. **Under no circumstances will a Member be terminated due to health status or the need for health care services.** If a Member is Totally Disabled when the group's coverage ends, coverage for the Totally Disabling condition may be extended (please refer below to "Total Disability"). Any Member who believes his or her enrollment has been terminated due to the Member's health status or requirements for health care services may request a review of the termination by the California Department of Managed Health Care. For more information, contact our Customer Service department.

Note: If a Group Agreement is terminated by PacifiCare, reinstatement with PacifiCare is subject to all terms and conditions of the Group Agreement between PacifiCare and the employer.

Ending Coverage – Special Circumstances for Enrolled Family Members

Enrolled Family Members terminate on the same date of termination as the Subscriber. If there's a divorce, the Spouse loses eligibility at the end of the month in which a final judgment or decree of dissolution of marriage is entered. Dependent children lose their eligibility if they marry or reach the Limiting Age established by the employer and do not qualify for extended coverage as a student Dependent or as a disabled Dependent. Please refer to the section "Continuing Coverage for Certain Disabled Dependents." It may also end when a qualified student reaches the Limiting Age. Please refer to "Extending Your Coverage" for additional coverage which may be available to you.

Total Disability

If the Group Agreement providing the Subscriber coverage is terminated, and the Subscriber or any enrolled Family Members are Totally Disabled on the date the Group Agreement is terminated, federal law may require the group's succeeding carrier to provide coverage for the treatment of the condition causing Total Disability. However, in the event that the Subscriber's group does not contract with a succeeding carrier for health coverage, or in the event that federal law would allow a succeeding carrier to exclude coverage of the condition causing the Total Disability for a period of time, PacifiCare will continue to provide benefits to the Subscriber or any enrolled Family Member for Covered Services directly relating to the condition causing Total Disability existing at the time of termination, for a period of up to 12 successive months after the termination. The extension of benefits may be terminated by PacifiCare at such time the Member is no longer Totally Disabled, or at such time as a succeeding carrier is required by law to provide replacement coverage to the Totally Disabled Member without limitation as to the disabling condition.

Coverage Options Following Termination (Individual Continuation of Benefits)

If your coverage through this *Combined Evidence of Coverage and Disclosure Form* ends, you and your enrolled Family Members may be eligible for additional continuation coverage.

Federal COBRA Continuation Coverage

If the Subscriber's Employer Group is subject to the federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you may be entitled to temporarily extend your coverage for up to 36 months, based upon 102 percent of your former employer's Health Plan group rates, in certain instances where your coverage under the Health Plan would otherwise end. In the case of a Subscriber who is determined to be disabled under the Social Security Act, the Subscriber will pay 150 percent of the former employer's Health Plan group rate after the first 18 months of continuation coverage and up to the month in which the Subscriber becomes entitled to Medicare, generally 29 months after the disabling event occurred. However, if you are not entitled to Medicare by the 29th month, you may be able to extend your benefits. Please refer to "California Continuation Coverage After COBRA."

This discussion is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. However, your Employer Group, or in some situations a third-party administrator also known as a "COBRA administrator" that has entered into contract with your former employer to coordinate your enrollment and Premium payments, is legally responsible for informing you of your specific rights under COBRA. Therefore, please consult with your Employer Group regarding the availability and duration of COBRA continuation coverage.

COBRA Qualifying Events for Subscribers

If you are a Subscriber covered by this Health Plan, you have a right to choose COBRA continuation coverage for up to 18 months based upon 102 percent of your former employer's Health Plan group rates if you have a qualifying event described as:

1. You lose your group health coverage because the termination of your employment (for reasons other than gross misconduct on your part); or
2. The number of hours you actually work on a weekly basis are cut back to less than the number of hours required for continued group Health Plan eligibility, as determined by your employer.

If you are determined to be disabled under Title II or Title XVI of the United States Social Security Act within 60 days of your initial qualifying event, you must notify your former employer or COBRA administrator of this determination prior to the 18th month. You are required to pay to PacifiCare 150 percent of the group rate after the first 18 months and generally up to the 29th month. Your coverage under COBRA will end upon your Medicare entitlement. However, if you are not entitled to Medicare by the 29th month, you may be able to extend your benefits. Please refer to "California Continuation Coverage After COBRA."

COBRA Qualifying Events for Spouses

If you are the Spouse of a Subscriber covered by this Health Plan, you have the right to choose COBRA continuation coverage for up to 36 months based upon 102 percent of the Subscriber's employer's Health Plan group rates (150 percent beginning the 19th month if the Subscriber is determined disabled by the Social Security Administration) for yourself if you lose group health coverage under this Health Plan for any of the following four reasons:

1. The death of the Subscriber;
2. A termination of the Subscriber's employment (for reasons other than gross misconduct) or the number of hours the Subscriber actually works on a weekly basis are cut back to less than the number of hours required for continued group Health Plan eligibility, as determined by the Subscriber's employer;
3. Divorce or legal separation from the Subscriber; or
4. The Subscriber becomes entitled to Medicare. (In the case of a Subscriber who is determined to be disabled under the Social Security Act, the Spouse will pay 150 percent of the former employer's Health Plan group rate after the first 18 months of continuation coverage and up to a combined total of 36 months. In the case of a Subscriber who becomes entitled to Medicare and voluntarily terminates his or her group Health Plan coverage, the Spouse may have up to 36 months based upon 102 percent of the Subscriber's former employer's Health Plan group rates. The length of your COBRA coverage will be determined from the date the Subscriber became entitled to Medicare.)

COBRA Qualifying Events for Dependent Children

In the case of a Dependent child of a Subscriber enrolled in this Health Plan, he or she has the right to continuation coverage for up to 36 months based upon 102 percent of the Subscriber's former Employer Group Health Plan rates (150 percent beginning the 19th month if the Subscriber is determined disabled by the Social Security Administration) if group health coverage under this Health Plan is lost for any of the following five reasons:

1. The death of the Subscriber;
2. A termination of the Subscriber's employment (for reasons other than gross misconduct) or the number of hours the Subscriber actually works on a weekly basis are cut back to less than the number of hours required for continued group Health Plan eligibility, as determined by the Subscriber's former employer;
3. The Subscriber's divorce or legal separation; or
4. The Subscriber becomes entitled to Medicare; (In the case of a Subscriber who is determined to be disabled under the Social Security Act, the Dependent will pay 150 percent of the former employer's group Health Plan rate after the first 18 months of continuation coverage and up to a combined total of 36 months. In the case of a Subscriber who becomes entitled to Medicare and voluntarily terminates his or her group Health Plan coverage, the Dependent may have up to 36 months based upon 102 percent of the Subscriber's former employer's Health Plan group rates. The length of your COBRA coverage will be determined from the date the Subscriber became entitled to Medicare.
5. The Dependent child ceases to be a Dependent eligible for coverage under this Health Plan.

Notification of Qualifying Events

Under COBRA, the Subscriber or enrolled Family Member has the responsibility to inform the Employer Group (or, if applicable, its COBRA administrator) of a divorce, legal separation or a child losing Dependent status under the Health Plan within 60 days of the date of the event. Your former Employer Group has the

responsibility to notify its COBRA administrator or PacifiCare of the Subscriber's death, termination, the number of hours the Subscriber actually works on a weekly basis are cut back to less than the number of hours required for continued group Health Plan eligibility or Medicare entitlement. Similar rights may apply to certain retirees, Spouses and Dependent children if your former employer commences a bankruptcy proceeding and these individuals lose coverage. Your former Employer Group or COBRA administrator is responsible to notify you of your rights when you contact them as a result of one of these qualifying events.

COBRA Enrollment and Premium Information

When your former Employer Group or COBRA administrator is notified that one of these events has happened, your former Employer Group or COBRA administrator will in turn notify you that you have the right to choose continuation coverage. Under the law, you have at least 60 days from the date you would lose coverage because of one of the events described above to inform your former Employer Group or the COBRA administrator that you want continuation coverage.

If you do not choose continuation coverage on a timely basis, your group health insurance coverage under this Health Plan will end and you will be financially responsible for payment of any health care services that you have received after your terminating event, under the COBRA Health Plan.

If you choose continuation coverage, your Employer Group is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or Family Members. Your Premium may be increased or your benefits decreased each time your former Employer's Group benefit package renews or changes. COBRA permits you to maintain continuation coverage for up to 36 months, unless you lost group health coverage because of a termination of employment or the number of hours you actually work on a weekly basis are cut back to less than the number of hours required for continued group Health Plan eligibility, as determined by your employer. In that case, the required continuation coverage period is 18 months. This initial 18-month period may be extended for affected individuals up to a combined total of 36 months from termination of employment if other events (such as a death, divorce, legal separation or Medicare entitlement) occur during that initial 18-month period. In addition, the initial 18-month period may be extended up to a combined total of 29 months if you are determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage. However, if you are not entitled to Medicare by the 29th month, you may be able to extend your benefits. Please refer to "California Continuation Coverage After COBRA." Please contact your Employer Group or its COBRA administrator for more information regarding the applicable length of COBRA continuation coverage available.

A child who is born to or placed for adoption with the eligible Subscriber during a period of COBRA continuation coverage will be eligible to enroll as a COBRA qualified beneficiary. These COBRA qualified beneficiaries can be added to COBRA continuation coverage upon proper notification within 30 calendar days, to the Employer Group or COBRA administrator of the birth or adoption. Your new Dependent will be entitled to continue COBRA for only the time period you have remaining which is counted from the date of your initial qualifying event.

Termination of COBRA Continuation Coverage

However, under COBRA, the continuation coverage may be cut short for any of the following five reasons:

1. Your former Employer Group no longer provides group health coverage to any of its employees;
2. The Premium for continuation coverage is not paid on time;
3. The qualified beneficiary becomes covered after the date he or she elects COBRA continuation coverage under another group Health Plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA continuation coverage; or
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled. However, upon this final determination, you may be able to extend your benefits. Please refer to "California Continuation Coverage After COBRA."

Under the law, you may have to pay all of the Premium for your continuation coverage. Premiums for COBRA continuation coverage are generally 102 percent of the applicable Health Plan Premium. However, if you are on a disability extension, your cost will be 150 percent of the applicable Premium. You are responsible for the timely submission of the COBRA Premium to the Employer Group or COBRA administrator. Your Employer Group or COBRA administrator is responsible for the timely submission of Premium to PacifiCare. At the end of the 18-month, 29-month or 36-month continuation coverage period, qualified beneficiaries may be allowed to enroll in a PacifiCare Individual Conversion Health Plan. (See the explanation under "Extending Your Coverage: Converting to an Individual Plan.") You may also have additional coverage available under California Continuation Coverage or coverage under HIPAA. (See the explanation under "California Continuation Coverage After COBRA." or "Coverage Under the Health Insurance Portability and Accountability Act of 1996" (HIPAA)). Your new Premiums and benefits through Individual Conversion or HIPAA will be different from your previous group Health Plan coverage and will depend on the type of coverage you select.

If you have any questions about COBRA, please contact your Employer Group.

1401 Extended Continuation Coverage After COBRA

In the event your COBRA coverage began on or after January 1, 2003, and you have used all of your COBRA benefits as described above, you may be eligible to continue benefits under California Continuation Coverage at 110 percent of the Premium charged for similarly situated eligible employees currently working at your former employment. A notice will be provided to you by PacifiCare at the time your COBRA benefits will run out, allowing up to 18 more months under California Continuation COBRA. However, your California Continuation COBRA benefits will not exceed a combined total of 36 months from the date COBRA coverage began.

Example: As a result of termination from your former employer (for reasons other than gross misconduct), you applied for and received 18 continuous months of group Health Plan benefits under your federal COBRA benefits. California Continuation COBRA may extend your benefits another 18 consecutive months. Your combined total of benefits between COBRA and California Continuation COBRA is 36 months.

1401 Extended Continuation Coverage Enrollment and Premium Information After COBRA

You must notify PacifiCare within 60 days from the date your COBRA coverage terminated or will terminate because of your qualifying event if you wish to elect this continuation coverage, or within 60 days from the date you received notice from PacifiCare. If you fail to notify PacifiCare within 60 days of the date of your qualifying event, you will lose your rights to elect and enroll on California Continuation Coverage after COBRA. The 60-day period will be counted from the event which occurred last. Your request must be in writing and delivered to PacifiCare by first-class mail, or other reliable means of delivery, including personal delivery, express mail or private courier company. Upon receipt of your written request, an enrollment package to elect coverage will be mailed to you by PacifiCare. You must pay your initial Premiums to PacifiCare within 45 days from the date PacifiCare mails your enrollment package after you notified PacifiCare of your intent to enroll. Your first Premium must equal the full amount billed by PacifiCare. Your failure to submit the correct Premium amount billed to you within the 45-day period, which includes checks returned to PacifiCare by your financial institution for non-sufficient funds (NSF), will disqualify you from this available coverage and you will not be allowed to enroll.

Note: In the event you had a prior qualifying event and you became entitled to enroll on COBRA coverage prior to January 1, 2003, you are not eligible for an extension of these benefits under California Continuation COBRA , even if you enroll in PacifiCare on or after January 1, 2003. Your qualifying event is the first day in which you were initially no longer eligible for your group Health Plan coverage from your former employer, regardless of who your prior insurance carrier may have been at that time.

Termination of 1401 Extended Continuation Coverage After COBRA

Your coverage under California Continuation Coverage will terminate when:

1. You have received 36 months of continuation coverage after your qualifying event date; or
2. If you cease or fail to make timely Premiums; or

3. Your former employer or any successor employer ceases to provide any group benefit plan to his or her employees; or
4. You no longer meet eligibility for PacifiCare coverage, such as moving outside the PacifiCare Service Area; or
5. The contract for health care services between your employer and PacifiCare is terminated; or
6. You become entitled for Medicare. **Note:** If you were eligible for the 29-month extension as a result of disability and you are later determined by the Social Security Administration to no longer be disabled, your benefits will terminate the later of 36 months after your qualifying event or the first of the month following 31 days from date of the final Social Security Administration determination, but only if you send the Social Security Administration notice to PacifiCare within 30 days of the determination.
7. If you were covered under a prior carrier and your former employer replaces your prior coverage with PacifiCare coverage, you may continue the remaining balance of your unused coverage with PacifiCare, but only if you enroll with and pay Premiums to PacifiCare within 30 days of receiving notice of your termination from the prior group Health Plan.

If the contract between your former employer and PacifiCare terminates prior to the date your continuation coverage would terminate under California Continuation COBRA, you may elect continuation coverage under your former employer's new benefit plan for the remainder of the time period you would have been covered under the prior group benefit plan.

California Continuation Coverage After COBRA for Certain Employees and Their Spouses

California Continuation Coverage option is not available to a Member who does not meet the eligibility requirements for coverage prior to January 1, 2005. If you were not enrolled and eligible as of December 1, 2004, this extension is not available to you.

California law provides that certain former employees and their dependent Spouses (including a Spouse who is divorced from the employee and/or a Spouse who was married to the employee at the time of that employee's death) may be eligible to continue group coverage beyond the date their COBRA or 1401 Extended Continuation Coverage is scheduled to end. Prior to your reaching your combined benefit of 36 months, PacifiCare will offer the extended coverage to employees and dependent Spouses of employers that are subject to the existing COBRA and 1401 Extended Conversion Coverage after COBRA laws and to the former employees' dependent Spouses, including divorced or widowed Spouses as described above. This coverage is subject to the following conditions:

1. The former employee worked for the employer for the prior five years and was 60 years of age or older on the date his/her employment ended and,
2. The former employee was eligible for and elected COBRA for himself and his dependent Spouse or,
3. A former Spouse, (i.e., a divorced or widowed Spouse as defined above), is also eligible for continuation of group coverage after they have used all of their available COBRA benefit coverage. The former Spouse must elect such coverage by notifying PacifiCare in writing within 30 calendar days prior to the date that the initial COBRA benefits are scheduled to end. A former spouse or surviving spouse may continue Continuation COBRA for up to five continuous years upon the date the full 36 months of COBRA, regardless of the age or length of employment of the Subscriber.

If elected, this coverage will begin after your 36th month of COBRA coverage and will be administered under the same terms and conditions as if COBRA had remained in force. If you are already a California Continuation COBRA participant or will become eligible as of December 1, 2004, your extended coverage will remain in place until you are automatically terminated per the below section, "Termination of Continuation Coverage After COBRA for Certain Employees and their Spouses as Described in the Above Paragraph". As your former employer's premium is not adjusted for the age of the specific employee or Eligible Dependent, premiums for this coverage will be 213 percent of the current applicable group rate. Your premium may be increased or your benefit package decrease each time the Employer's Group's benefit package renews or changes. Payment is due at the time the Employer Group's payment is due.

For California Continuation Coverage, PacifiCare will bill you directly once we have received your election form. You are responsible for paying the Health Plan Premium directly to PacifiCare on a month basis and it must be delivered by first class mail or other reliable means.

The first month's California Continuation COBRA Health Plan Premium payment is due within 45 days of the date that you submit the election form to PacifiCare. This payment must be sufficient to pay all premiums due from the first month after the qualifying event through the current month. Failure to submit the correct premium amount will disqualify you from receiving California Continuation coverage. Please note, you will not be enrolled in California Continuation COBRA until PacifiCare receives both your election form and your first premium payment.

Thereafter, California Continuation Coverage premiums are due on the first day of the coverage month (i.e., January 1st for January coverage). If you fail to pay your premium when the premium payment is due, PacifiCare will send you a 15-day cancellation notice reminding you that your premium is overdue. If premium is received within 15 days of PacifiCare's cancellation notification you will experience no break in coverage and no changes in benefits. However if you do not pay your premium, enrollment will be cancelled effective 15 days after PacifiCare mailed the cancellation notice. A termination notice will be sent to you at this time, and any premium payments received after the 15 day notice period has expired for coverage after the effective date of cancellation will be refunded to you within 20 business days. However, you remain financially responsible for unpaid premium for coverage prior to the effective date of cancellation. If you are terminated for failing to make timely premium, you are not eligible for the PacifiCare Individual Conversion Plan described in the section entitled "Extending Your Coverage: Converting to an Individual Conversion Plan."

Termination of Continuation Coverage After COBRA for Certain Employees and Their Spouses as Described in the Above Paragraph

This coverage will end automatically on the earlier of:

1. The date the former employee, Spouse or former Spouse reaches 65;
2. The date in which the Group Agreement contract is terminated by either your former Employer Group or PacifiCare or the date your former employer ceases to provide coverage for any active employees through PacifiCare;
3. The date the former employee, Spouse or former Spouse is covered by another Health Plan;
4. The date the former employee, Spouse or former Spouse becomes entitled to Medicare;
5. For a Spouse or former Spouse, five years from the date the Spouse's COBRA coverage would end;
6. Fifteen days after PacifiCare mails notice to the former employee, Spouse or former Spouse that coverage is being cancelled for failure to pay Premium. If Premium is received within 15 days of PacifiCare's cancellation notification you will experience no break in coverage and no change in benefits. However, if you do not pay your Premium, enrollment will be cancelled effective 15 days after PacifiCare mailed the cancellation notice. A termination notice will be sent to you at that time and any Premium payments for coverage after the effective date of cancellation received after the 15-day notice period has expired will be refunded to you within 20 business days. However, you remain financially responsible for unpaid Premium for coverage prior to the effective date of cancellation.

For a Spouse or former Spouse that has used the available California continuation coverage period of 5 years, qualified beneficiaries may be allowed to enroll in a PacifiCare Individual Conversion Health Plan, unless you are eligible for Medicare. Other exclusions may apply. Please see the explanation under "Extending Your Coverage: Converting to an Individual Plan." You may also have additional coverage under HIPAA. Please see the explanation under "Coverage Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)."

Notification Requirements

The Employer Group is solely responsible for notifying former employees or Dependent Spouses (including former Spouses as defined above) of the availability of the coverage at least 90 calendar days before COBRA is

scheduled to end. **To elect this coverage, the former employee or Spouse must notify PacifiCare in writing at least 30 calendar days before COBRA is scheduled to end.**

Extending Your Coverage: Converting to an Individual Conversion Plan

If you have been enrolled in this Health Plan for three or more consecutive months, and you have been terminated by your employer which terminates your group Health Plan coverage, you and your currently enrolled Family Members may apply for the Individual Conversion plan issued by PacifiCare. The Employer Group is solely responsible for notifying you of the availability, terms and conditions of the Individual Conversion plan within 15 days of the termination of your group coverage.

An application for the conversion plan must be received by PacifiCare within 63 days of the date of termination of your group coverage. However, if the Employer Group terminates its Group Agreement with PacifiCare or replaces the PacifiCare group coverage with another carrier within 15 days of the date of termination of the Group coverage or the Subscriber's participation, transfer to the Individual Conversion Health Plan is not permitted. You also will not be permitted to transfer to the Individual Conversion Health Plan under any of the following circumstances:

1. You failed to pay any amounts due to the Health Plan;
2. You were terminated by the Health Plan for good cause or for fraud or misrepresentation as described in the section "Termination for Good Cause;"
3. You knowingly furnished incorrect information or otherwise improperly obtained benefits of the Health Plan;
4. You are covered or are eligible for Medicare;
5. You are covered or are eligible for hospital, medical or surgical benefits under state or federal law or under any arrangement of coverage for individuals in a group, whether insured or self-insured*;
6. The Employer Group's hospital, medical or surgical expense benefit program is self-insured; or
7. You are covered for similar benefits under an Individual policy or contract.

Please Note: If you were not previously eligible under the PacifiCare group Health Plan benefit as described above you may not enroll on PacifiCare's Individual Conversion Plan. This includes any future Dependents not currently enrolled as a Member of your PacifiCare group Health Plan under your former employer.

***Note also:** If you elect COBRA or California Continuation COBRA coverage, you are eligible for guaranteed issuance of a HIPAA individual contract at the time your COBRA or California Continuation COBRA coverage ends. However, if you select Individual Conversion coverage instead, you will not be eligible for a HIPAA guaranteed product.

Benefits or rates of an Individual Conversion plan Health Plan are different from those in your group plan. An Individual Conversion Health Plan is also available to:

1. Currently enrolled Dependents, if the Subscriber dies;
2. Dependents who are currently enrolled and are no longer eligible for group Health Plan coverage due either to marriage or exceeding the maximum age for Dependent coverage under the group plan, as determined by the employer;
3. Dependents who are currently enrolled and lose coverage as a result of the Subscriber entering military service;
4. Spouse of the Subscriber who is currently an enrolled Dependent under PacifiCare, if your marriage has terminated due to divorce or legal separation.

Written applications and the first Premium payment for all conversions must be received by PacifiCare within 63 days of the loss of group coverage. This is an additional option to PacifiCare Members. This means you do not need to enroll and use any benefits you may have access to through COBRA or California Continuation COBRA to be eligible. For more details, please contact our Customer Service department.

Individual Conversion Plan Premiums are due on the first day of the coverage month (i.e., January 1st for January coverage). If you fail to pay your Individual Conversion Plan Premium when the Premium payment is due, PacifiCare will send you a 15-day cancellation notice reminding you that your Premium is overdue. If Premium is received within 15 days of PacifiCare's cancellation notification you will experience no break in coverage and no change in benefits. However, if you do not pay your Premium, enrollment will be cancelled effective 15 days after PacifiCare mailed the cancellation notice. A termination notice will be sent to you at that time and any Premium payments for coverage after the effective date of cancellation received after the 15-day notice period has expired will be refunded to you within 20 business days. However, you remain financially responsible for unpaid Premium for coverage prior to the effective date of cancellation.

Certificate of Creditable Coverage

According to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a Certificate of Creditable Coverage will be provided to the Subscriber by either PacifiCare or the Employer Group when the Subscriber or a Dependent ceases to be eligible for benefits under the employer's health benefit plan. A Certificate of Creditable Coverage may be used to reduce or eliminate a pre-existing condition exclusion period imposed by a subsequent Health Plan. Creditable coverage information for Dependents will be included on the Subscriber's Certificate, unless the Dependent's address of record or coverage information is substantially different from the Subscriber's. Please contact the PacifiCare Customer Service department if you need a duplicate Certificate of Creditable Coverage. If you meet HIPAA eligibility requirements, you may be able to obtain individual coverage using your Certificate of Creditable Coverage.

Your Rights Under HIPAA Upon Termination of This Group Contract

HIPAA is the acronym for the federal law known as the Health Insurance Portability and Accountability Act of 1996. HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. California state law provides similar and additional protections.

If you lose your group health insurance coverage and meet certain important criteria, you are entitled to purchase coverage under an individual contract from any Health Plan that sells health insurance coverage to individuals. Significant protections come with the HIPAA individual contract: no pre-existing condition exclusions, guaranteed renewal at the option of the enrollee so long as the Plan offers coverage in the individual market and the enrollee pays the Premiums, and limitations on the amount of the Premium charged by the Health Plan.

Every Health Plan that sells health care coverage contracts to individuals must fairly and affirmatively offer, market, and sell HIPAA individual contracts to all Federally Eligible Defined Individuals. The plan may not reject an application from a Federally Eligible Defined Individual for a HIPAA individual contract if:

1. The Federally Eligible Defined Individual agrees to make the required Premium payments;
2. The Federally Eligible Defined Individual, and his or her Dependents to be covered by the plan contract, work or reside in the service area in which the plan operates. You are a Federally Eligible Defined Individual if, as of the date you apply for coverage:
3. You have 18 or more months of creditable coverage without a break of 63 days or more between any of the periods of creditable coverage or since the most recent coverage has been terminated;
4. Your most recent prior creditable coverage was under a group, government or church plan. (COBRA and California Continuation COBRA are considered Employer Group coverage);
5. You were not terminated from your most recent creditable coverage due to nonpayment of Premiums or fraud;
6. You are not eligible for coverage under a group Health Plan, Medicare, or Medi-Cal (Medicaid);
7. You have no other health insurance coverage; and
8. You have elected and exhausted fully any continuation coverage you were offered under COBRA or California Continuation COBRA.

There are important terms you need to understand, important factors you need to consider, and important choices you need to make in a very short time frame regarding the options available to you following termination of your group health care coverage. For example, if you are offered, but do not elect and exhaust COBRA or California Continuation COBRA coverage, you are not eligible for guaranteed issuance of a HIPAA individual contract. You should read carefully all of the information set forth in this section. If you have questions or need further information please contact PacifiCare Customer Service department.

If you believe your HIPAA rights have been violated, you should contact the Department of Managed Health Care at 1-888-HMO-2219 or visit the Department's Web site at **www.dmhc.ca.gov**.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

You may be eligible for the PacifiCare HIPAA Guaranteed Issue product, regardless of health status, if you:

1. Have had at least 18 months of prior creditable coverage, with the most recent prior creditable coverage under a group Health Plan, governmental plan or church plan, and with no break in creditable coverage greater than 63 days;
2. Are not currently entitled to coverage under a group Health Plan, Medicare or Medicaid*;
3. Do not currently have other health insurance coverage;
4. Your most recent creditable coverage was not terminated because of nonpayment of Premiums or fraud; and
5. If you were eligible, you elected and have used all federal COBRA continuation coverage available to you.

***Please note:** If you elect COBRA or California Continuation COBRA coverage, you are eligible for guaranteed issuance of a HIPAA individual contract at the time your COBRA or California Continuation COBRA ends. However, if you select Individual Conversion coverage instead, you will not be eligible for a HIPAA guaranteed product.

HIPAA-eligible individuals need not be under age sixty-five (65) or meet medically underwritten requirements, but must qualify under the criteria for guaranteed issuance under HIPAA. Please contact PacifiCare's Customer Service for more information.

Uniformed Services Employment and Reemployment Rights Act

Continuation of Benefits under USERRA

Continuation coverage under this Health Plan may be available to you through your employer under the Uniform Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). The continuation coverage is equal to, and subject to the same limitations as, the benefits provided to other Members regularly enrolled in this Health Plan. These benefits may be available to you if you are absent from employment by reason of service in the United States uniformed services, up to the maximum 18-month period if you meet the USERRA requirements. USERRA benefits run concurrently with any benefits that may be available through the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended. Your employer will provide written notice to you for USERRA continuation coverage.

If you are called to active military duty and are stationed outside of the Service Area, you or your eligible Dependents must still maintain a permanent address inside the Service Area and must select a Participating Medical Group within 30 miles of that address. To obtain coverage, all care must be provided or arranged in the Service Area by the designated Participating Medical Group, except for Emergency and Urgently Needed Services.

The Health Plan Premium for USERRA Continuation of benefits is the same as the Health Plan Premium for other PacifiCare Members enrolled through your employer plus a two percent additional surcharge or administrative fee, not to exceed 102 percent of your employer's active group Premium. Your employer is responsible for billing and collecting Health Plan Premiums from you or your Dependents and will forward your Health Plan Premiums to PacifiCare along with your employer's Health Plan Premiums otherwise due under this Agreement. Additionally, your employer is responsible to maintain accurate records regarding

USERRA Continuation Member Health Plan Premium, qualifying events, terminating events and any other information that may be necessary for PacifiCare to administer this continuation benefit.

SECTION 8. OVERSEEING YOUR HEALTH CARE DECISIONS

- **How PacifiCare Makes Important Decisions**
- **What to Do If You Have a Problem**
- **Quality of Care Review**
- **Appeals and Grievances**
- **Independent Medical Reviews**

This section explains how PacifiCare authorizes or makes changes to your health care services, how we evaluate new health care technologies and how we reach decisions about your coverage.

You will also find out what to do if you're having a problem with your health care plan, including how to appeal a health care decision by PacifiCare or one of our Participating Providers. You'll learn the process that's available for filing a formal Grievance, as well as how to request an expedited decision when your condition requires a quicker review.

How PacifiCare Makes Important Health Care Decisions

Authorization, Modification and Denial of Health Care Services

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

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

Member agrees that their Provider will be their "authorized representative" (pursuant to ERISA) regarding receipt of approvals of requests for healthcare services for purposes of medical management.

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

- Decisions to approve, modify or deny requests for authorization of health care services, based on Medical Necessity, will be made in a timely fashion appropriate for the nature of the Member's condition, not to exceed five business days from PacifiCare's or the Participating Medical Group's receipt of the information reasonably necessary and requested to make the decision.
- If the Member's condition poses an imminent and serious threat to their health, including, but not limited to, potential loss of life, limb or other major bodily function, or if lack of timeliness would be detrimental in regaining maximum function or to the Member's life or health, the decision will be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed 72 hours after PacifiCare's or Participating Medical Group's receipt of the information reasonably necessary and requested by PacifiCare or the Participating Medical Group to make the determination (an Urgent Request).

If the decision cannot be made within these time frame because (i) PacifiCare or the Participating Medical Group is not in receipt of all of the information reasonably necessary and requested or (ii) PacifiCare or the Participating Medical Group requires consultation by an expert reviewer or (iii) PacifiCare or the Participating Medical Group has asked that an additional examination or test be performed upon the Member, provided the examination or test is reasonable and consistent with good medical practice, PacifiCare or the Participating Medical Group will notify the Provider and the Member, in writing, upon the earlier of the expiration of the required time frame above or as soon as PacifiCare or the Participating Medical Group becomes aware that it will not be able to meet the required time frame.

The notification will specify the information requested but not received or the additional examinations or tests required, and the anticipated date on which a decision may be rendered following receipt of all reasonably necessary requested information. Upon receipt of all information reasonably necessary and requested by PacifiCare or the Participating Medical Group, PacifiCare or the Participating Medical Group shall approve, modify or deny the request for authorization within the time frame specified above as applicable.

PacifiCare and Participating Medical Groups notify requesting Providers of decisions to approve, modify or deny requests for authorization of health care services for Members within 24 hours of the decision. Members are notified of decisions to deny, delay or modify requested health care services, in writing, within two business days of the decision. The written decision will include the specific reason(s) for the decision, the clinical reason(s) for modifications or denials based on a lack of Medical Necessity, or reference to the benefit provision on which the denial decision was based, and information about how to file an appeal of the decision with PacifiCare. In addition, the internal criteria or benefit interpretation policy, if any, relied upon in making this decision will be made available upon request by the Member. PacifiCare's Appeals Process is outlined in the "General Information" section of this *Combined Evidence of Coverage and Disclosure Form.*

If the Member requests an extension of a previously authorized and currently ongoing course of treatment, and the request is an "Urgent Request" as defined above, 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 above.

If you would like a copy of PacifiCare's policy and procedure, a description of the processes utilized for the authorization, modification or denial of health care services, or are seeking information about the utilization management process and the authorization of care, you may contact the PacifiCare Customer Service department at 1-800-624-8822.

PacifiCare's Utilization Management Policy

PacifiCare distributes its policy on financial incentives to all its Participating Providers, Members and employees. PacifiCare also requires that Participating Providers and staff who make utilization decisions, and those who supervise them, sign a document acknowledging receipt of this policy. The policy affirms that a utilization management decision is based solely on the appropriateness of a given treatment and service, as well as the existence of coverage. PacifiCare does not specifically reward Participating Providers or other individuals conducting utilization review for issuing denials of coverage. Financial incentives for Utilization Management decision-makers do not encourage decisions that result in either the denial or modification of Medically Necessary Covered Services.

Medical Management Guidelines

The Medical Management Guidelines Committee (MMGC), consisting of PacifiCare Medical Directors, provides a forum for the development, review and adoption of medical management guidelines to support consistent, appropriate medical care determinations. The MMGC develops guidelines using evidenced-based medical literature and publications related to medical treatment or service. The Medical Management Guidelines contain practice and utilization criteria for use when making coverage and medical care decisions prior to, subsequent to or concurrent with the provisions of health care services.

Technology Assessment

PacifiCare regularly reviews new procedures, devices, and drugs to determine whether or not they are safe and efficacious for our Members. New procedures and technology that are safe and efficacious are eligible to become Covered Services. If the technology becomes a Covered Service it will be subject to all other terms and conditions of the plan, including Medical Necessity and any applicable Member Copayments, or other payment contributions.

In determining whether to cover a service, PacifiCare uses proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral health. When clinical necessity requires a

rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual Member, a PacifiCare Medical Director makes a Medical Necessity determination based on individual Member medical documentation, review of published scientific evidence and when appropriate seeks relevant specialty or professional opinion from an individual who has expertise in the technology.

Utilization Criteria

When a Provider or Member requests Preauthorization of a procedure/service requiring Preauthorization, an appropriately qualified licensed health professional reviews the request. The qualified licensed health professional applies the applicable criteria, including, but not limited to:

- Nationally published guidelines for utilization management (Specific guideline information available upon request.
- HCIA-Sachs Length of Stay© Guidelines (average length of hospital stays by medical or surgical diagnoses)
- Medical Management Guidelines (MMG) and Benefit Interpretation Policies (BIP).

Those cases that meet the criteria for coverage and level of service are approved as requested. Those not meeting the utilization criteria are referred for review to a Participating Medical Group's Medical Director or a PacifiCare Medical Director.

Denial, delay or modification of health care services based on Medical Necessity must be made by 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.

What to Do if You Have a Problem

PacifiCare's top priority is meeting our Members' needs, but sometimes you may have an unexpected problem. When this happens, your first step should be to call our Customer Service department. We'll assist you and attempt to find a solution to your situation.

If you have a concern about your treatment or a decision regarding your medical care, you may be able to request a second medical opinion. You can read more about requesting, as well as the requirements for obtaining a second opinion, in **Section 2. Seeing the Doctor**.

If you feel that we haven't assisted you 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 deliver a timely response and resolution to your Grievances. This is done through a process that includes a thorough and appropriate investigation. 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. To initiate an appeal or a request quality of care review, call our Customer Service department at 1-800-624-8822, where a Customer Service representative will document your oral appeal. You may also file an appeal using the Online Grievance form at **www.pacificare.com** or write to the Appeals Department at:

PacifiCare of California
Appeals and Grievance Department
Mail Stop CY44-157
5757 Plaza Drive
P.O. Box 6006
Cypress, CA 90630

This request will initiate the following Appeals Quality of Clinical Care and Quality of Service Review Process except in the case of "expedited reviews," as discussed below. You may submit written comments, documents, records and any other information relating to your appeal regardless of whether this information was submitted or considered in the initial determination. You may obtain, upon request and free of charge, copies of all documents, records and other information relevant to your appeal. The appeal will be reviewed by an individual who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person.

PacifiCare will review your appeal and if the appeal involves a clinical issue, the necessity of treatment or the type of treatment or level of care proposed or utilized, the determination will be made by a medical reviewer, 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, requiring review are investigated by PacifiCare's Health Services Department. Clinical complaints affecting your urgent condition are reviewed immediately. 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 timely manner, appropriate to the clinical urgency of you 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.

If your complaint also includes a claim for benefits or reimbursement, claim for benefits or reimbursement will be reviewed through the Appeals Process described below. Please refer to "Expedited Review Appeals Process" for 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.

The Appeals Process

PacifiCare's Health Services department will review your appeal within a reasonable period of time appropriate to the medical circumstances and make a determination within 30 calendar days of PacifiCare's receipt of the appeal. For appeals involving the delay, denial or modification of health care services related to Medical Necessity, PacifiCare's written response will include the specific reason for the decision, describe the criteria or guidelines or benefit provision on which the denial decision was based, and notification that upon request the Member may obtain a copy of the actual benefit provision, guideline protocol or other similar criterion on which the denial is based. For determinations delaying, denying or modifying health care services based on a finding that the services are not Covered Services, the response will specify the provisions in the *Combined Evidence of Coverage and Disclosure Form* that exclude that coverage. If the Grievance is related to quality of care, the Grievance will be reviewed through the procedure described in the section of this *Combined Evidence of Coverage and Disclosure Form* captioned "Quality Management Review."

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 appeal process. If your appeal requires expedited review, PacifiCare will immediately inform you of your review status and your right to notify the Department of Managed Health Care (DMHC) of the Grievance.

You and the DMHC will be provided a written statement of the disposition or pending status of the expedited review no later than three calendar days from receipt of the Grievance. You are not required to participate in the PacifiCare appeals process prior to contracting the DMHC regarding your expedited appeal.

Voluntary Mediation and Binding Arbitration

If you are dissatisfied with PacifiCare's Appeal Process determination, you 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

Any and all disputes of any kind whatsoever, including, but not limited to, 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) between Member (including any heirs, successors or assigns of Member) and PacifiCare, except for claims subject to ERISA, shall be submitted to binding arbitration. 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. Member and PacifiCare 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 Rules 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 to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within 30 days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules will be utilized.

Arbitration hearings shall be held in Orange County, California, or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration as provided by California law and the Code of Civil Procedure. 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 California law. The parties shall divide equally the expenses of JAMS and the arbitrator. 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. The approval or denial of the hardship application will be determined solely by JAMS. The Federal Arbitration Act, 9 U.S.C. sections 1-16, shall also apply to the arbitration.

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. Sections 1-16, shall also 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 ARBITRATION.

Experimental or Investigational Treatment

A PacifiCare medical director may deny a treatment if he or she determines it is Experimental or Investigational, except as described in "Cancer Clinical Trials" under **Section 5. Your Medical Benefits**. If you have a Terminal Illness, as defined below, you may request that PacifiCare hold a conference within 30 calendar days of receiving your request to review the denial. For purposes of this paragraph, Terminal Illness

means an incurable or irreversible condition that has a high probability of causing death within one year or less. The conference will be held within five days if the treating Physician determines, in consultation with the PacifiCare Medical Director and based on professionally recognized standards of practice, that the effectiveness of the proposed treatment or services would be materially reduced if not provided at the earliest possible date.

Independent Medical Review

If you believe that a health care service included in your coverage has been improperly denied, modified or delayed by PacifiCare or one of its Participating Providers, you may request an independent medical review (IMR) of the decision. IMR is available for denials, delays or modifications of health care services requested by you or your Provider based on a finding that the requested service is Experimental or Investigational or is not Medically Necessary. Your case also must meet the statutory eligibility criteria and procedural requirements discussed below. If your Complaint or appeal pertains to a Disputed Health Care Service subject to Independent Medical Review (as discussed below), you 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 Independent Medical Review System pursuant to Health and Safety Code Section 1370.4. Life-Threatening means either or both of the following: (a) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; (b) diseases or conditions with potentially fatal outcomes, where the endpoint of clinical intervention is survival. Seriously Debilitating means diseases or conditions that cause major irreversible morbidity.

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

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

If you have a life-threatening or seriously debilitating condition and PacifiCare denies your request for Experimental or Investigational therapy, PacifiCare will send a written notice of the denial within five business days of the decision. The notice will advise you of your right to request IMR, and include a Physician

certification form and an application form with a preaddressed envelope to be used to request IMR from the DMHC.

Disputed Health Care Services

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

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

1. (a) Your Provider has recommended a health care service as Medically Necessary; or (b) you have received Urgently Needed Services or Emergency Services that a Provider determined were Medically Necessary; or (c) you have been seen by 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.)

You may apply to the DMHC for IMR of a Disputed Health Care Service within six months of any of the events or periods described above, or longer if the DMHC determines that the circumstances of your case warrant an IMR review. PacifiCare will provide you an IMR application form with any Grievance disposition letter that denies, modifies or delays health care services based in whole or in part due to a finding that the service is not Medically Necessary. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against PacifiCare regarding the Disputed Health Care Service. The IMR process is in addition to any other procedures or remedies that may be available to you.

Independent Medical Review Procedures

Applying for Independent Medical Review Procedures

In the case of Experimental or Investigational coverage decisions, if you have a Life-Threatening or Seriously Debilitating condition, PacifiCare will include an application for IMR in its notice to you that the requested service has been denied and include a Physician certification form with a preaddressed envelope to the DMHC. Your Physician must provide the Physician certification and medical and scientific documentation required for Experimental and Investigational IMR, which may be included with your application, or mailed or faxed directly to the DMHC by your Physician. Either you or your Physician can provide the letter from PacifiCare or its Participating Provider denying the request for Experimental or Investigational treatment.

In the case of determinations that a Disputed Health Care Service is not Medically Necessary, PacifiCare will provide you with an IMR application form with any disposition letter resolving your appeal of the determination. Your application for IMR of a Disputed Health Care Service may include information or documentation regarding a Provider's recommendation that the service is Medically Necessary, medical information that a service received on an urgent care or emergency basis was Medically Necessary, and any other information you received from or gave to PacifiCare or its Participating Providers that you believe is relevant in support of your position that the Disputed Health Care Service was Medically Necessary.

Completed applications for IMR should be submitted to the DMHC. You pay no fee to apply for IMR. You, your Physician, or another designated representative acting on your behalf may request IMR. If there is any additional information or evidence you or your Physician wish to submit to the DMHC that was not previously provided to PacifiCare, you may include this information with the application for IMR. The DMHC fax number is (916) 229-0465. You may also reach the DMHC by calling 1-888-HMO-2219.

Accepted Applications for Independent Medical Review

Upon receiving your application for IMR, the DMHC will review your request and notify you whether your case has been accepted. If your case is eligible for IMR, the dispute will be submitted to an independent medical review organization (IRO) contracted with the DMHC for review by one or more expert reviewers, independent of PacifiCare, who will make an independent determination of whether or not the care should be provided. The IRO selects an independent panel of medical professionals knowledgeable in the treatment of your condition, the proposed treatment and the guidelines and protocols in the area of treatment under review. Neither you nor PacifiCare will control the choice of expert reviewers.

PacifiCare must provide the following documents to the IRO within three business days of receiving notice from the DMHC that you have successfully applied for an IMR:

1. The relevant medical records in the possession of PacifiCare or its Participating Providers;
2. All information provided to you by PacifiCare and any of its Participating Providers concerning PacifiCare and Provider decisions regarding your condition and care (including a copy of PacifiCare's denial notice sent to you);
3. Any materials that you or your Provider submitted to PacifiCare and its Participating Providers in support of the request for the health care services;
4. Any other relevant documents or information used by PacifiCare or its Participating Providers in determining whether the health care service should have been provided and any statement by PacifiCare or its Participating Providers explaining the reasons for the decision. The Plan shall provide copies of these documents to you and your Provider unless any information in them is found by the DMHC to be privileged.

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

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

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

The Independent Medical Review Decision

The independent review panel will render its analysis and recommendations on your IMR case in writing, and in layperson's terms to the maximum extent practical, within 30 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 Department 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 analyses 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 analyses 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.

The IRO will provide the DMHC, PacifiCare, you and your Physician with each of the experts' analyses and recommendations, and a description of the qualifications of each expert. The IRO will keep the names of the expert reviewers confidential, except in cases where the reviewer is called to testify and in response to court orders. In the case of an Experimental or Investigational determination, the experts' analyses will state the reasons the requested Experimental or Investigational therapy is or is not likely to be more beneficial for you than any available standard therapy and the reasons for recommending why the therapy should or should not be provided by PacifiCare, citing your specific medical condition, the relevant documents provided and the relevant medical and scientific evidence supporting the experts' recommendation. In the case of a review of a Disputed Health Care Services denied as not Medically Necessary, the experts' analyses will state whether the Disputed Health Care Service is Medically Necessary and cite your medical condition, the relevant documents in the record and the reviewers' relevant findings.

The recommendation of the majority of the experts on the panel will prevail. If the experts on the panel are evenly divided as to whether the health care service should be provided, the panel's decision will be deemed to be in favor of coverage. If the majority of the experts on the panel does not recommend providing the health care service, PacifiCare will not be required to provide the service.

When a Decision is Made

The DMHC will immediately adopt the decision of the IRO upon receipt and will promptly issue a written decision to the parties that will be binding on PacifiCare. PacifiCare will promptly implement the decision when received from the DMHC. In the case of an IRO determination requiring reimbursement for services already rendered, PacifiCare will reimburse either you or your Provider – whichever applies – within five 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 **1-800-642-8822**

or **1-800-442-8833 (TDHI)** and use your Health Plan's Grievance process before contacting the department. Utilizing this Grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a Grievance involving an emergency, a Grievance that has not been satisfactorily resolved by your Health Plan, or a Grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a Health Plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing- and speech-impaired. The department's Internet Web site **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**

What follows are answers to some common and uncommon questions about your coverage. If you have any questions of your own that haven't been answered, please call our Customer Service department.

What should I do if I lose or misplace my membership card?

If you should lose your card, simply call our Customer Service department. Along with sending you a replacement card, they can make sure there is no interruption in your coverage.

Does PacifiCare offer a translation service?

PacifiCare uses a telephone translation service for almost 140 languages and dialects. That's in addition to select Customer Service representatives who are fluent in Spanish. Translated Member materials are available upon request. Interpretation services may also be available at the Participating Provider office. Please contact the Participating Provider for specific language interpretation availability.

Does PacifiCare offer hearing- and speech-impaired telephone lines?

PacifiCare has a dedicated telephone number for the hearing and speech-impaired. This phone number is 1-800-442-8833.

How is my coverage provided under extraordinary circumstances?

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

How does PacifiCare compensate its Participating Providers?

PacifiCare itself is not a Provider of health care. PacifiCare typically contracts with independent medical groups to provide medical services to its Members, and with hospitals to provide Hospital Services. Once they are contracted, they become PacifiCare Participating Providers.

Participating Medical Groups in turn employ or contract with individual Physicians. None of the Participating Medical Groups or Participating Hospitals, or their Physicians or employees, are employees or agents of PacifiCare. Likewise, neither PacifiCare nor any employee of PacifiCare is an employee or agent of any Participating Medical Group, Participating Hospital or any other Participating Provider.

Most of our Participating Medical Groups receive an agreed-upon monthly payment from PacifiCare to provide services to our Members. This monthly payment may be either a fixed dollar amount for each Member or a percentage of the monthly Premium received by PacifiCare. The monthly payment typically covers professional services directly provided, or referred and authorized, by the Participating Medical Group.

Some of PacifiCare's Participating Hospitals receive similar monthly payments in return for providing Hospital Services for Members. Other Participating Hospitals are paid on a discounted fee-for-service or fixed charge per day of hospitalization. Most acute care, Subacute and Transitional Care and Skilled Nursing Facilities are paid on a fixed charge per day basis for inpatient care.

At the beginning of each year, PacifiCare and its Participating Medical Groups agree on a budget for the cost of services for all PacifiCare Members assigned to the Participating Medical Group. At the end of the year, the

actual cost of services for the year is compared to the agreed-upon budget. If the actual cost of services is less than the agreed-upon budget, the Participating Medical Group shares in the savings.

The Participating Hospital and Participating MedicalGroup 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 clergy. There are many resources that can provide the information you need to make a responsible decision.

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

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

How can I learn more about being an organ and tissue donor?

To get your donor card and information on organ and tissue donation call 1-800-355-SHARE or 1-800-633-6562. You can also request donor information from your local Department of Motor Vehicles (DMV).

On the Internet, contact:

- All About Transplantation and Donation(**www.transweb.org**)
- Department of Health and Human Services(**www.organdonor.gov**)
- Once you get a donor card, be sure to sign it in your family's presence. Have your family sign as witnesses and pledge to carry out your wishes, then keep the card with you at all times where it can be easily found.

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

How can I participate in the establishment of PacifiCareís public policy participation?

PacifiCare gives its Members the opportunity to participate in establishing the public policy of the Health Plan. One third of PacifiCare of California's Board of Directors is comprised of Health Plan Members. If you are

interested in participating in the establishment of the Health Plan's public policy, please call or write our Customer Service department.

SECTION 10. DEFINITIONS

PacifiCare is dedicated to making its services easily accessible and understandable. To help you understand the precise meanings of many terms used to explain your benefits, we have provided the following definitions. These definitions apply to the capitalized terms used in your Combined Evidence of Coverage and Disclosure Form, as well as the Schedule of Benefits.

Annual Copayment Maximum – The maximum amount of Copayments a Member is required to pay for certain Covered Services in a calendar year. (Please refer to your *Schedule of Benefits*.)

Binding Arbitration – The submission of a dispute to one or more impartial persons for a final and binding decision, except for fraud or collusion on the part of the arbitrator. This means that once the arbitrator has issued a decision, neither party may appeal the decision. Any such dispute will not be resolved by a lawsuit or resort to court process, except as California law provides for judicial review of arbitration proceedings.

Biofeedback – Biofeedback therapy provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition. Biofeedback therapy often uses electrical devices to transform bodily signals indicative of such functions as heart rate, blood pressure, skin temperature, salivation, peripheral vasomotor activity, and gross muscle tone into a tone or light, the loudness or brightness of which shows the extent of activity in the function being measured.

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

Chronic Condition – A medical condition that is continuous or persistent over an extended period of time and requires ongoing treatment for its management.

Claim Determination Period – A calendar year.

Cognitive Therapy – Neurocognitive therapy is performed for the treatment of patients with conditions such as traumatic brain injury, cerebrovascular disease, chemical exposure, infections, anoxia/hypoxia, electrical shock and autoimmune disorders. 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."

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 (i) Non-Participating Provider for newly enrolled Member who, at the time of his or her coverage became effective with PacifiCare, was receiving Covered Services from the Non-Participating Provider, for one of the Continuity of Care Conditions, as limited and described below:

1. **An Acute Condition** – a medical condition, including medical and Mental Health[1], that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of Covered Services will be provided for the duration of the Acute Condition.
2. **A Serious Chronic Condition** – a medical condition due to disease, illness, or other medical or mental health problem[2]or medical or mental health[2] disorder that is serious in nature, and that persists without full cure or worsens over an extended period of time, or requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services will be provided for the period of time necessary to complete the active course of treatment and to arrange for a clinically safe transfer to a Participating Provider, as determined by a PacifiCare Medical Director in consultation with the Member, and either (i) the Terminated Provider or (ii) the Non-Participating Provider and as applicable, the receiving Participating Provider, consistent with good professional practice. Completion of Covered Services for this condition will not exceed twelve (12) months from the agreement's Termination date or twelve (12) months from the effective date of coverage for a newly enrolled Member.
3. **A pregnancy** diagnosed and documented by (i) the Terminated Provider prior to Termination of the agreement, or (ii) by the Non-Participating Provider prior to the newly enrolled Member's effective date of coverage with PacifiCare. Completion of Covered Services will be provided for the duration of the pregnancy and the immediate postpartum period.
4. **A Terminal Illness** – an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Completion of Covered Services will be provided for the duration of the Terminal Illness, not to exceed twelve (12) months, provided that the prognosis of death was made by the: (i) Terminated Provider prior to the agreement Termination date or (ii) Non-Participating Provider prior to the newly enrolled Member's effective date of coverage with PacifiCare.
5. **The Care of a Newborn** – Services provided to a child between birth and age thirty-six (36) months. Completion of Covered Services will not exceed twelve (12) months from the: (i) Provider agreement Termination date, or (ii) the newly enrolled Member' s effective date of coverage with PacifiCare, or (iii) extend beyond the child's third (3rd) birthday.
6. **Surgery or Other Procedure** – Performance of a surgery or Other Procedure that has been authorized by PacifiCare or the Member's assigned Participating Provider as part of a documented course of treatment and has been recommended and documented by the: (i) Terminating Provider to occur within 180 calendar days of the agreement's Termination date, or (ii) Non-Participating Provider to occur within 180 calendar days of the newly enrolled Member's effective date of coverage with PacifiCare.

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 – The fee that a Member is obligated to pay, if any, at the time he or she receives a Covered Service. Copayments may be a specific dollar amount or a percentage of the cost of the Covered Services. Copayments are fees paid by the Member in addition to the Premium paid by an Employer Group and any payroll contributions required by the Member's Employer Group.

Covered Services – Medically Necessary services or supplies provided under the terms of this *Combined Evidence of Coverage and Disclosure Form*, your *Schedule of Benefits* and supplemental benefit materials.

Custodial Care – Care and services that assist an individual in the activities of daily living. Examples include: assistance in walking, getting in or out of bed, bathing, dressing, feeding and using the toilet; preparation of

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[1] Except pursuant to the CA Health and Safety Code 1374.72, inpatient coverage for Behavioral Health is not a covered benefit under the PacifiCare HMO/POS Commercial core coverage.

[2] PacifiCare Behavioral Health, Inc. (PBH) will coordinate Continuity of Care for Members whose employer has purchased supplemental benefits and for Members requesting continued care with a terminated or Non-Participating Provider for "Serious Mental Illnesses" and "Serious Emotional Disturbances of a Child" as defined in CA Health and Safety Code, Section 1374.72.

special diets; and supervision of medication that usually can be self-administered. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring skilled nursing. Custodial Care does not require the continuing attention of trained medical or paramedical personnel.

Dependent – A Member of a Subscriber's family who is enrolled with PacifiCare after meeting all of the eligibility requirements of the Subscriber's Employer Group and PacifiCare and for whom applicable Health Plan Premiums have been received by PacifiCare.

Developmental and Neurodevelopmental Testing – Developmental and neurodevelopmental testing is a battery of diagnostic tests for the purpose of determining a child's developmental status and need for early intervention services. This may include, but is not limited to, psychological and behavioral developmental profiles.

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

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

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

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

Emergency Services – Medical screening, examination and evaluation by a Physician or other personnel – to the extent provided by law – to determine if an Emergency Medical Condition or psychiatric Emergency Medical Condition exists. If this condition exists, Emergency Services include the care, treatment and/or surgery by a Physician necessary to relieve or eliminate the Emergency Medical Condition or psychiatric Emergency Medical Condition within the capabilities of the Facility. (For a detailed explanation of Emergency Services, see **Section 3. Emergency and Urgently Needed Services.**)

Employer Group – The single employer, labor union, trust, organization or association through which you enrolled for coverage.

Experimental or Investigational – Defined in the "Exclusions and Limitations of Benefits" section of this *Combined Evidence of Coverage and Disclosure Form.*

Family Member – The Subscriber's Spouse or Domestic Partner and any person related to the Subscriber 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 the Subscriber's Employer Group and PacifiCare, and for whom Premiums have been received by PacifiCare. An eligible Family Member is a Family Member who meets all the eligibility requirements of the Subscriber's Employer Group and PacifiCare.

Grievance (Complaint) – A written or oral expression of dissatisfaction regarding the plan and/or Provider, including quality of care concerns, and shall include a Complaint, dispute, request for reconsideration or appeal made by a Member or the Member's representative.

Group Agreement – The Medical and Hospital Group Subscriber Agreement entered into between PacifiCare and the employer, labor union, trust, organization or association through which you enroll for coverage.

Health Plan – Your benefit plan as described in this *Combined Evidence of Coverage and Disclosure Form, Schedule of Benefits* and supplemental benefit materials.

Health Plan Premiums (or Premiums) – Amounts established by PacifiCare to be paid to PacifiCare by Employer on behalf of Subscriber and his or her Dependents in consideration of the benefits provided under this Health Plan.

Home Health Aide – A person who has completed Home Health Aide training as required by the state in which the individual is working. Home Health Aides must work under a plan of care ordered by a physician and under the supervision of a licensed nurse or licensed therapist.

Home Health Aide Services – Medically Necessary personal care such as bathing, exercise assistance and light meal preparation, provided by trained individuals and ordered along with skilled nursing and/or therapy visits.

Home Health Care Visit – Defined as up to two (2) hours of skilled services by a registered nurse or licensed vocational nurse or licensed therapist or up to four (4) hours of Home Health Aide Services.

Hospice – Specialized form of interdisciplinary health care for a Member with a life expectancy of a year or less due to a Terminal Illness. Hospice programs or services are designed to provide palliative care; alleviate the physical, emotional, social and spiritual discomforts of a Member who is experiencing the last phase of life due to the existence of a terminal disease; and provide supportive care to the primary caregiver and family of the Member receiving Hospice services.

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

Hypnotherapy – Medical Hypnotherapy is treatment by hypnotism or inducing sleep.

Infertility – Either: (1) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception; or (2) the presence of a demonstrated condition recognized by a licensed Physician who is a Participating Provider as a cause of Infertility.

Intramuscular – Injection into the muscle.

Intravenous – Injection into the vein.

Late Enrollee – An employee who declined enrollment in the PacifiCare Health Plan when offered and who subsequently requests enrollment outside the designated Open Enrollment Period.

Learning Disability – A Learning Disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized mental retardation, educational or psychosocial deprivation, psychiatric disorder, or sensory loss.

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

Medically Necessary (or Medical Necessity) refers to an intervention, if, as recommended by the treating Physician and determined by the Medical Director of PacifiCare or the Participating Medical Group, it is all of the following: safely and effectively to the Member. "Cost-effective" does not necessarily mean lowest price.

a. A health intervention for the purpose of treating a medical condition;

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

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

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

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

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

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

ii. A *health intervention* is an item or service delivered or undertaken primarily to treat (that is, prevent, diagnose, detect, treat or palliate) a medical condition or to maintain or restore functional ability. A *medical condition* is a disease, illness, injury, genetic or congenital defect, pregnancy or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation. A health intervention is defined not only by the intervention itself, but also by the medical condition and the patient indications for which it is being applied.

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

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

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

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

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

Medicare (Original Medicare) – The Hospital Insurance Plan (Part A) and the supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.

Medicare Eligible – Those Members who meet eligibility requirements under Title XVIII of the Social Security Act, as amended.

Member – The Subscriber or any Dependent who is eligible, enrolled and covered by PacifiCare.

Mental Retardation and Related Conditions – An individual is determined to have mental retardation based on the following three criteria: Intellectual functioning level (IQ) is below 70-75; significant limitations exist in two or more adaptive skill areas; and the condition is present from childhood (defined as age 18 or less).

National Preferred Transplant Network – A network of transplant Facilities that are:

- Licensed in the in State of California;
- Certified by Medicare as a transplant Facility for a specific organ transplant;
- Designated by PacifiCare as a transplant Facility for a specific organ program;
- Able to meet the reasonable access standards for organ transplantation based on the Regional Organ Procurement Agency statistics within the transplant Facility's geographic location. A Regional Organ Procurement Agency is a geographic area designated by a state-licensed organ procurement organization for transplants in the State of California.

Non-Participating Providers – A hospital or other health care entity, a Physician or other health care professional, or a health care vendor that has not entered into a written agreement to provide Covered Services to PacifiCare's Members.

Non-Physician Health Care Practitioners include but are not limited to: psychologists, acupuncturists, optometrists, podiatrists, chiropractors, licensed clinical social workers, marriage and family therapists and nurse midwives.

Open Enrollment Period – The time period determined by PacifiCare and the Subscriber's Employer Group when all Eligible Employees and their eligible Family Members may enroll in PacifiCare.

Participating Hospital – Any general acute care hospital licensed by the State of California that has entered into a written agreement with PacifiCare to provide Hospital Services to PacifiCare's Members.

Participating 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 Provider – A hospital or other health care entity, a Physician or other health care professional, or a health care vendor who has entered into a written Agreement with the network of Providers from whom the Member is entitled to receive Covered Services.

Physician – Any licensed allopathic or osteopathic Physician.

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

Primary Care Physician – A Participating Provider who is a Physician trained in internal medicine, general practice, family practice, pediatrics or obstetrics/gynecology and who has accepted primary responsibility for coordinating a Member's health care services.

Primary Residence – The home or address where the Member actually lives most of the time. A residence will no longer be considered a Primary Residence if: (1) the Member moves without intent to return; (2) the Member is absent from the residence for 90 consecutive days, or (3) the Member is absent from the residence for more than 100 days in any six-month period.

Primary Workplace – The Facility or location where the Member works most of the time and to which the Member regularly commutes. If the Member does not regularly commute to one location, then the Member does not have a Primary Workplace.

Private-Duty Nursing Services – Private-Duty Nursing Services encompass nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or Skilled Nursing Facility.

Provider – A person, group, Facility or other entity that is licensed or otherwise qualified to deliver any of the health care services described in this *Combined Evidence of Coverage and Disclosure Form* and supplemental benefit materials.

Prudent Layperson – A person without medical training who reasonably draws on practical experience when making a decision regarding whether Emergency Services are needed.

Psychological Testing – Psychological Testing includes the administration, interpretation, and scoring of tests such as WAIS-R, Rorschach, MMPI and other medically accepted tests for evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation, and other factors influencing treatment and prognosis.

Rehabilitation Services – The combined and coordinated use of medical, social, educational and vocational measures for training or retraining individuals disabled by disease or injury.

Schedule of Benefits – An important part of your *Combined Evidence of Coverage and Disclosure Form* that provides benefit information specific to your Health Plan, including Copayment information.

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

1. Has one or more mental disorders as defined by the *Diagnostic and Statistical Manual (DSM-IV)*, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms;
2. Is under the age of 18 years old; and
3. Meets one or more of the following criteria:
   a. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning; family relationships or ability to function in the community; and either of the following occur:
      i. the child is at risk of removal from home or has already been removed from the home;
      ii. the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or
   b. The child displays one of the following: psychotic features, risk of suicide or risk or violence due to a mental disorder; or
   c. The child meets special education eligibility requirement under Chapter 26.5 commencing with Section 7570 of Division 7 of Title 1 of the California Government Code.

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

- Anorexia nervosa;
- Bipolar disorder;
- Bulimia nervosa;
- Major depressive disorder;
- Obsessive-compulsive disorder;
- Panic disorder;
- Pervasive developmental disorder or autism;

- Schizoaffective disorder;
- Schizophrenia.

Service Area – A geographic region in the State of California where PacifiCare is authorized by the California Department of Managed Health Care to provide Covered Services to Members.

Skilled Nursing Care – The care provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a home health aide.

Skilled Nursing Facility – A comprehensive free-standing rehabilitation Facility or a specially designed unit within a hospital licensed by the state of California to provide Skilled Nursing Care.

Skilled Rehabilitation Care – The care provided directly by or under the direct supervision of licensed nursing personnel or a licensed physical, occupational or speech therapist.

Spouse – The Subscriber's husband or wife who is legally recognized as a husband or wife under the laws of the state of California.

Subacute and Transitional Care – Subacute and Transitional Care are levels of care needed by a Member who does not require hospital acute care but who requires 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 for whom the appropriate Health Plan Premiums have been received by PacifiCare and whose employment or other status, except for family dependency, is the basis for enrollment eligibility.

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.

Totally Disabled or Total Disability – For Subscribers, the persistent inability to reliably engage in any substantially gainful activity by reason of any medically determinable physical or mental impairment resulting from an injury or illness. For Dependents, Totally Disabled is the persistent inability to perform activities essential to the daily living of a person of the same age and sex by reason of any medically determinable physical or mental impairment resulting from an injury or illness. Determination of Total Disability will be made by a Participating Medical Group Physician on the basis of a medical examination of the Member and upon concurrence by PacifiCare's Medical Director.

Transitional Care – See "Subacute Care."

Urgently Needed Services – Covered Services that are provided when the Member's Participating Medical Group is temporarily unavailable or inaccessible. This includes when the Member is temporarily absent from the geographic area served by their Participating Medical Group. These services must be Medically Necessary and cannot be delayed because of an unforeseen illness, injury or condition.

Usual and Customary Charges (U&C) means charges for medical services or supplies for which PacifiCare is legally liable and which do not exceed the average charged rate charged for the same or similar services or supplies in the geographic region where the services or supplies are received. Usual and Customary Charges are determined by referencing the 80th percentile of the most current survey published by Medical Data

Research (MDR) for such services or supplies. The MDR survey is a product of Ingenix, Inc., formerly known as Medicode.

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

Vocational Rehabilitation – The process of facilitating an individual in the choice of or return to a suitable vocation. When necessary, assisting the patient to obtain training for such a vocation. Vocational Rehabilitation can also mean preparing an individual regardless of age, status (whether U.S. citizen or immigrant), or physical condition to cope emotionally, psychologically, and physically with changing circumstances in life, including remaining at school or returning to school, work or work equivalent (homemaker).

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

PacifiCare of California
P.O. Box 6006
Cypress, CA 90630-5028

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

Visit our Web site @ www.pacificare.com

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HMO Schedule of Benefits

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

General Features

Calendar Year Deductible	-0-
Maximum Benefits	Unlimited
Annual Copayment Maximum[1] *(3 individual maximum per family)*	$1,000/individual
Office Visits	$10 Copayment
Hospitalization	Paid in full
Emergency Services	$50 Copayment waived if admitted as an inpatient
Urgently Needed Services *(Medically Necessary services required outside geographic area served by your Participating Medical Group. Please consult your brochure for additional details.)*	$50 Copayment waived if admitted as an inpatient
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	Paid in full
Bone Marrow Transplants *(donor searches limited to $15,000 per procedure)*	Paid in full
Cancer Clinical Trials[2,3]	Paid at contracting rate Balance (if any) is the responsibility of the Member
Hospice Care *(prognosis of life expectancy of one year or less)*	Paid in full
Hospital Benefits *(autologous (self-donated) blood up to $120.00 per unit)*	Paid in full
Mastectomy/Breast Reconstruction *(after mastectomy and complications from mastectomy)*	Paid in full
Maternity Care	Paid in full
Newborn Care[4]	Paid in full
Physician Care	Paid in full
Reconstructive Surgery	Paid in full
Rehabilitation Care *(including physical, occupational and speech therapy)*	Paid in full
Skilled Nursing Care *(up to one hundred (100) consecutive calendar days from the first treatment per disability)*	Paid in full
Voluntary Interruption of Pregnancy *(medical/medication and surgical)*	
– 1st trimester	$75 Copayment
– 2nd trimester (12–20 weeks)	$150 Copayment
– After 20 weeks	Not covered unless mother's life is in jeopardy or fetus not viable

Benefits Available on an Outpatient Basis	
Alcohol, Drug or Other Substance Abuse – Detoxification	Paid in full
Allergy Testing/Treatment *(serum is not covered unless an allergy serum rider was purchased by your employer)*	$10 Copayment
Ambulance	Paid in full
Cancer Clinical Trials[2,3]	Paid at contracting rate Balance (if any) is the responsibility of the Member
Cochlear Implants *(outpatient surgery or inpatient hospitalization and outpatient rehabilitation therapy Copayments may apply)*	Paid in full
Crisis Intervention *(up to twenty (20) visits for Crisis Intervention per calendar year)*	$35 Copayment
Dental Treatment Anesthesia *(additional charges for outpatient and inpatient surgery may apply)*	$10 Copayment
Durable Medical Equipment, Corrective Appliances and Prosthetics	Paid in full
Family Planning/Voluntary Interruption of Pregnancy	
– Vasectomy	$50 Copayment
– Tubal ligation[5]	$100 Copayment
– Insertion/removal of Intra-Uterine Device (IUD)	$10 Copayment
– Intra-Uterine Device (IUD)	50% of cost Copayment[6]
– Removal of Norplant	$10 Copayment
– Depo-Provera injection	$10 Copayment
– Depo-Provera medication (Limited to one Depo-Provera injection every 90 days)	$35 Copayment
– Voluntary interruption of pregnancy (medical/medication and surgical)	
– 1st trimester	$75 Copayment
– 2nd trimester (12–20 weeks)	$150 Copayment
– After 20 weeks	Not covered unless mother's life is in jeopardy or fetus not viable
Health Education Services	Paid in full
Hearing Screening	$10 Copayment
Hemodialysis *(Physician office visit Copayment may apply)*	$10 per treatment
Home Health Care	Paid in full
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)*	$10 Copayment
Infertility Services	50% of cost Copayment[6]
Laboratory and Radiology *(when available through and authorized by the Member's Participating Medical Group)*	Paid in full
Maternity Care, Tests and Procedures	Paid in full
Mental Health Services *(As required by state law, coverage includes treatment for Severe Mental Illnesses (SMI) of adults and children and for children 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.)*	$10 Copayment per visit
Oral Surgery Services	Paid in full
Outpatient Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility *(including physical, occupational and speech therapy)*	$10 Copayment
Outpatient Surgery	Paid in full
Periodic Health Evaluations *Physician, laboratory, radiology and related services as recommended by the American Academy of Pediatrics (AAP) and U.S. Preventive Services Task Force and authorized through 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 Copayment

Benefits Available on an Outpatient Basis (Continued)

Physician Care *(for children under two years of age, refer to Well-Baby Care)*	$10 Copayment
Vision Refractions	$10 Copayment
Vision Screening	$10 Copayment
Well-Baby Care *Preventive health service, including immunizations recommended by the American Academy of Pediatrics (AAP) and U.S. Preventive Services Task Force and authorized through your Primary Care Physician in your Participating Medical Group for children under two years of age. (The applicable office visit Copayment applies to infants that are ill at time of services)*	Paid in full
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.*	$10 Copayment

[1] Annual Copayment Maximum does not include Copayments for pharmacy and supplemental benefits.
[2] Cancer Trial. Services require preauthorization by PacifiCare.
[3] If you participate 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, 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.
[4] The newborn care Copayment does not apply when the newborn is discharged with the mother within 48 hours of the normal vaginal delivery or 96 hours of the cesarean delivery. Please see the *Combined Evidence of Coverage and Disclosure Form* for more details.
[5] Copayment 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.
[6] Percentage Copayment amounts are based upon PacifiCare's contracted rate.

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 *Schedule of Benefits* and its enclosures constitute only a summary of the Health Plan.

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

P.O. Box 6006
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Infertility Basic Diagnosis and Treatment Supplement to the Combined Evidence of Coverage and Disclosure Form

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

Benefits

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

Diagnosis of Infertility

a. Complete medical history.

b. Female general medical examinations. Examples include but are not limited to:
   - Pelvic exam;
   - Routine laboratory investigation for hormonal disturbances (e.g. FSH, LH, prolactin);
   - Cultures for infectious agents;
   - Serum progesterone determination;
   - Laparoscopy;
   - Hysterosalpingogram.

c. Male general medical examination. Examples include but are not limited to:
   - Semen analysis up to 3 times following 5 days of abstinence;
   - Huhner's Test or Post Coital Examinations;
   - Laboratory studies (e.g. FSH, LH, prolactin, serum testosterone);
   - Testicular biopsy when Member has demonstrated azoospermia;
   - Scrotal ultrasound, when appropriate for azoospermia;
   - Electrical Assistance for Recovery of Sperm (EARS), when medically indicated, as when the Member is a paraplegic or quadriplegic, as approved by PacifiCare's Medical Director or designee;
   - HIV, Hepatitis B surface antibody, Hepatitis C antibody, HTLV-1 and syphilis testing of male partner prior to artificial insemination.

Treatment of Infertility

a. Insemination Procedures are limited to 6 procedures, per lifetime unless the Member conceives, in which case the benefit renews.

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

c. Injectable medications and syringes for the treatment of infertility are covered as part of this Supplemental Infertility Benefit and are not a covered pharmaceutical through PacifiCare's supplemental pharmacy coverage. Examples include:
   - Pergonal;
   - Profasi;
   - Metrodin;
   - Urofollitropin;
   - Coverage for other injectable drugs not listed above will be reviewed based on Medical Necessity for the specific Member, and FDA recommendations, including off-label use for the drug requested.

Coverage

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

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

Exclusions

- Services not authorized and directed by the Participating Medical Group or the Advantage Participating Medical Group (for Advantage participants).
- Medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, anorgasmy or hyporgasmy.
- Infertility service after a previous elective vasectomy or tubal ligation, whether or not a reversal has been attempted or completed.
- Reversal of a previous elective vasectomy or tubal ligation.
- All Medical and Hospital infertility services and supplies for a Member whose fertility is impaired due to an elective sterilization. This includes any supplies, medications, services and/or procedures used for an excluded benefit, e.g. GIFT, ZIFT or IVF.
- Further infertility treatment when either or both partners are unable due to an identified exclusion in this Supplemental Benefit or unwilling to participate in the treatment plan prescribed by the infertility physician.
- Treatment of female sterility in which a donor ovum would be necessary (e.g. post-menopausal syndrome).
- Insemination with semen from a partner with an infectious disease which, pursuant to guidelines of the Society of Artificial Reproductive Technology, has a high risk of being transmitted to the female partner and/or infecting any resulting fetus. This exclusion would not prohibit the Member's purchase of donor sperm or from obtaining a donor with appropriate testing, at the Member's expense, to receive the eligible infertility benefits.
- Microdissection of the zona or sperm microinjection.
- Experimental and/or Investigational diagnostic studies or procedures, as determined by PacifiCare's Medical Director or Designee.
- Advanced infertility procedures, as well as In-Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT) and procedures performed in conjunction with advanced infertility procedures, IVF, GIFT and ZIFT.
- Infertility services for non-members (e.g. surrogate mothers who are not PacifiCare Members).
- Maternity care and services for non-members.
- Intravenous Gamma Globulin (IVIG).
- Any costs associated with the collection, preparation, storage of or donor fees for the use of donor sperm that may be used during a course of artificial insemination. This includes HIV testing of donor sperm when male factor infertility exists; e.g. use of another male relative's sperm.
- Artificial insemination procedures in excess of 6, when a viable infant has not been born as a result of infertility treatment(s) or unless the Member conceives. The benefit will renew if the Member conceives.
- Ovum transplants, ovum or ovum bank charges.

Definitions

1. Infertility is defined as either:
   a. The presence of a demonstrated medical condition recognized by a licensed physician or surgeon as a cause of infertility; or
   b. The inability of a woman to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception;
2. Basic Infertility Services are the reasonable and necessary services associated with the diagnosis and treatment as disclosed in this document, unless the PacifiCare Medical Director or designee determines that:
   a. Continued treatment has no reasonable chance of producing a viable pregnancy; or
   b. Advanced Reproductive Therapy services are necessary, which are excluded under this supplemental benefit.
   c. The Member has received the lifetime benefit maximum of 6 artificial insemination procedures; cumulatively under 1 or more PacifiCare Health Plans has occurred.
3. Advanced Reproductive Therapy, as excluded under this Basic Infertility Services benefit are:
   a. In-Vitro Fertilization (IVF). A highly sophisticated infertility treatment that involves obtaining mature eggs (oocytes) by surgical or nonsurgical procedures and combining the eggs and sperm in a laboratory setting. If fertilization and cell division occur, the resulting embryo(s) are transferred to the uterine cavity where implantation and pregnancy may occur.
   b. Gamete Intrafallopian Transfer (GIFT). An infertility treatment that involves obtaining eggs (through medical and surgical procedures) and sperm, loading the eggs and sperm into a catheter, then emptying the contents of the catheter into the fallopian tube. The intent of this procedure is to have fertilization occur in the fallopian tubes as it would in a fertile woman.
   c. Zygote Intrafallopian Transfer (ZIFT). An infertility treatment that involves obtaining mature eggs (oocytes) by surgical or nonsurgical procedures and combining the eggs and sperm in a laboratory setting. The fertilized oocytes, or zygotes, are transferred to the fallopian tube before cell division occurs. The intent of this procedure is to have the zygote travel to the uterus via the fallopian tube as it would in a fertile woman.

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

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Customer Service:
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CM-404-62921.50
PC9563-003 Rev. 4/04

PacifiCare®

Chiropractic and Acupuncture Schedule of Benefits

Benefit Plan:
$10 Copayment per Visit
40 Visit Annual Maximum Benefit

PacifiCare makes available to you and your eligible dependents a complementary health benefits program for chiropractic and acupuncture. This program is provided through an arrangement with American Specialty Health Plans of California, Inc. (ASH Plans). ASH Plans monitors the quality of the care provided by Participating ASH Plans Providers.

How to Use the Program

With ASH Plans, you have direct access to more than 2,300 credentialed chiropractors and 800 credentialed acupuncturists servicing California. You never need to predesignate an ASH Plans provider or obtain a medical referral from a primary care physician. And, you may change Participating Chiropractors or Acupuncturists at any time.

ASH Plans is designed for your convenience. You simply pay your Copayment or Coinsurance at each visit. There are no Deductibles or claim forms to fill out. Your ASH Plans provider coordinates authorization of all services and billings directly with ASH Plans.

Annual Benefits

Benefits include Chiropractic Services and Acupuncture Services that are Medically Necessary Services rendered by a Participating Provider. In a case of Acupuncture Services, the services must be for the treatment of carpal tunnel syndrome, headaches, menstrual cramps, osteoarthritis, stroke rehabilitation and tennis elbow. All Covered Services – except for:

1. An initial examination by a Participating Provider and the provision or commencement, in the initial examination, of Medically Necessary Services that are Covered Services, to the extent consistent with professionally recognized standards of practice; and
2. Emergency Services – require authorization by ASH Plans. When ASH Plans approves a treatment plan, the approved services for the subsequent office visits covered by the approved treatment plan include not only the authorized services but also a brief re-examination in each subsequent office visit, if deemed necessary by the Participating Provider, without additional approval by ASH Plans.

Calculation of Annual Maximum Benefit Limits

Each visit to a Participating Provider, as described below, requires a Copayment by the Member. A maximum number of visits to either a Participating Chiropractor or a Participating Acupuncturist, or any combination of both, per Calendar Year will apply to each Member.

Chiropractic Services: Adjunctive therapy is allowed at each office visit, if authorized by ASH Plans. If adjunctive therapy is provided without an adjustment, the adjunctive therapy will count as an office visit toward the Maximum Benefit. If an examination or re-examination is supplied without an adjustment, the examination or re-examination will count as an office visit toward the Maximum Benefit.

Acupuncture Services: Adjunctive therapy is allowed at each office visit, if authorized by ASH Plans. If adjunctive therapy is provided without acupuncture treatment, the adjunctive therapy will count as an office visit toward the Maximum Benefit. If an examination or re-examination is supplied without acupuncture treatment, the examination or re-examination will count as an office visit toward the Maximum Benefit.

Provider Eligibility

ASH Plans only contracts with duly licensed California chiropractors, acupuncturists, chiropractic radiologists, radiology groups, clinical laboratory groups, medical radiologists, medical pathologists and hospitals. Members must use Participating Providers.

Questions? Call ASH Plans Member Service Department at 1-800-678-9133
Monday through Friday, 5 a.m. - 8 p.m.

Types of Covered Services

Chiropractic Services:

1. An initial examination is performed by the Participating Chiropractor to determine the nature of the Member's problem, and to provide or commence, in the initial examination, Medically Necessary Services that are Covered Services, to the extent consistent with professionally recognized standards of practice, and to prepare a treatment plan of services to be furnished. An initial examination will be provided to a Member if the Member seeks services from a Participating Chiropractor for any injury, illness, disease, functional disorder or condition with regard to which the Member is not, at that time, receiving services from the Participating Chiropractor. A Copayment will be required for such examination.
2. Subsequent office visits, as set forth in a treatment plan approved by ASH Plans, may involve an adjustment, a brief re-examination and other services, in various combinations. A Copayment will be required for each visit to the office.
3. Adjunctive therapy, as set forth in a treatment plan approved by ASH Plans, may involve therapies, such as ultrasound, hot packs, cold packs, electrical muscle stimulation and other therapies.
4. A re-examination may be performed by the Participating Chiropractor to assess the need to continue, extend or change a treatment plan approved by ASH Plans. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a Copayment will be required.
5. X-rays and laboratory tests are payable in full when referred by a Participating Chiropractor and authorized by ASH Plans. Radiological consultations are a covered benefit when authorized by ASH Plans as Medically Necessary Services and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or hospital which has contracted with ASH Plans to provide those services.
6. Chiropractic appliances are payable up to a maximum of $50 per year when prescribed by a Participating Chiropractor and authorized by ASH Plans which include: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle braces, knee braces, rib supports, and wrist braces or other related services.

Acupuncture Services:

1. An initial examination is performed by the Participating Acupuncturist to determine the nature of the Member's problem and to provide or commence, in the initial examination, Medically Necessary Services that are Covered Services, to the extent consistent with professionally recognized standards of practice, and to prepare a treatment plan of services to be furnished. An initial examination will be provided to a Member if the Member seeks services from a Participating Acupuncturist for any injury, illness, disease, functional disorder or condition with regard to which the Member is not, at that time, receiving services from the Participating Acupuncturist. A Copayment will be required for such examination.
2. Subsequent office visits, as set forth in a treatment plan approved by ASH Plans, may involve acupuncture treatment, a brief re-examination and other services, in various combinations. A Copayment will be required for each visit to the office.
3. Adjunctive therapy, as set forth in a treatment plan approved by ASH Plans, may involve therapies, such as acupressure, breathing techniques, exercise, nutrition and oriental massage.
4. A re-examination may be performed by the Participating Acupuncturist to assess the need to continue, extend or change a treatment plan approved by ASH Plans. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a Copayment will be required.

X-rays and laboratory tests are payable in full when referred by a Participating Acupuncturist and authorized by ASH Plans. Radiological consultations are a covered benefit when authorized by ASH Plans as Medically Necessary Services.

Exclusions and Limitations

Benefits do not include services that are not described under "Benefit Plan" and "Types of Covered Services" above and do not include, without limitation, services for treatment of asthma or addiction (including, without limitation, smoking cessation). In addition to any other applicable limitations contained elsewhere in the *Evidence of Coverage* provided to a Member, ASH Plans shall not be required to furnish benefits in connection with the following:

1. Any services or treatments not authorized by ASH Plans, except for (a) an initial examination by a Participating Provider and the provision or commencement, in the initial examination, of Medically Necessary Services that are Covered Services, to the extent consistent with professionally recognized standards of practice, and (b) Emergency Services. When ASH Plans authorizes a treatment plan, the authorized services for the subsequent office visits covered by the approved treatment plan include not only the authorized services but also a brief re-examination in each subsequent office visit, if deemed necessary by the Participating Provider without additional authorization by ASH Plans.

2. Any services or treatments not delivered by a Participating Provider for the delivery of chiropractic or acupuncture care to Members, except for Emergency Services or services that are not available and accessible to a Member and are provided upon a referral by ASH Plans or, with regard to radiology and clinical laboratory services for acupuncture enrollees, upon referral by a Participating Acupuncturist.
3. Services for examinations and/or treatments for conditions other than those related to Neuromusculo-skeletal Disorders, nausea or pain from Participating Acupuncturists, including, without limitation, services for examinations and/or treatments for asthma or addiction, including, without limitation, smoking cessation and services for examinations and/or treatments for conditions other than those related to Neuromusculo-skeletal Disorders from Participating Chiropractors.
4. Hypnotherapy, behavior training, sleep therapy and weight programs.
5. Thermography.
6. Services, lab tests, X-rays and other treatments not documented as Medically Necessary as appropriate or classified as Experimental or Investigational and/or as being in the research stage, as determined in accordance with professionally recognized standards of practice. If ASH Plans denies coverage for a therapy for a Member who has a life-threatening or seriously debilitating condition based on a determination by ASH Plans that the therapy is Experimental or Investigational, the Member may be able to request an independent medical review of ASH Plans' determination. The Member should contact ASH Plans' Member Services department at 1-800-678-9133 for more information.
7. Services and/or treatments which are not documented as Medically Necessary Services.
8. Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology and any types of diagnostic radiology other than covered plain film studies.
9. Transportation costs including local ambulance charges.
10. Education programs, nonmedical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing.
11. Services or treatments for pre-employment physicals or vocational rehabilitation.
12. Any services or treatments caused by or arising out of the course of employment or covered under a final judgment, compromise or settlement as a result of injuries caused by a third party.
13. Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all chiropractic appliances or durable medical equipment, except as defined elsewhere in this *Schedule of Benefits*.
14. Prescription drugs or medicines, including a non-legend or proprietary medicine or medication not requiring a prescription order.
15. Services provided by a chiropractor or an acupuncturist practicing outside the state of California, except for Emergency Services.
16. Hospitalization, anesthesia, manipulation under anesthesia or other related services.
17. All auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunication devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.
18. Adjunctive therapy not associated with spinal, muscle or joint manipulation.
19. Vitamins, minerals or other similar products.
20. Services that are not within scope of licensure for a licensed chiropractor or a licensed acupuncturist in California, including, without limitation, ear coning and Tui Na. Ear coning, also sometimes called "ear candling," involves the insertion of one end of a long, flammable cone (the "ear cone") into the ear canal. The other end is ignited and allowed to burn for several minutes. The ear cone is designed to cause smoke from the burning cone to enter the ear canal to cause the removal of earwax and other materials. Tui Na, also sometimes called "Oriental Bodywork" or "Chinese Bodywork Therapy," utilizes the traditional Chinese medical theory of *Qi* but is taught as a separate but equal field of study in the major traditional Chinese medical colleges and does not constitute acupuncture.

P.O. Box 509002
San Diego, CA 92150-9002

Member Services:
800-678-9133
www.ashplans.com

CM-703-48164.10
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PacifiCare®

CALIFORNIA

Combined Evidence of Coverage and Disclosure Form

Chiropractic and Acupuncture Benefits

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American Specialty Health Plans
8989 Rio San Diego Drive, Suite 250
San Diego, CA 92108
(800) 678-9133
(619) 297-8100

American Specialty Health
Plans of California

This *Combined Evidence of Coverage and Disclosure Form* (this "*Combined EOC*") discloses the terms and conditions of coverage.

This *Combined EOC* should be read completely and carefully, and individuals with special health care needs should read carefully those sections that apply to them. A Member or applicant for membership may call 1-800-678-9133 to receive additional information about the benefits of the Health Plan described in this *Combined EOC*.

This *Combined EOC* constitutes only a summary of the Health Plan contract offered by American Specialty Health Plans of California, Inc (ASH Plans). The Health Plan contract must be consulted to determine the exact terms and conditions of coverage. A specimen copy of the contract is available from your employer group or ASH Plans upon request.

Questions? Call the Customer Service Department at 1-800-678-9133.

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Definitions

ASH Plans means American Specialty Health Plans of California, Inc.

Acupuncture Services are services rendered by an acupuncturist for the treatment of Neuromusculo-skeletal Disorders, Nausea and Pain.

Administrative Review Program is the program and procedures utilized by ASH Plans to review administrative decisions, such as denial of authorization forms or claims due to late or untimely submission to ASH Plans by Participating Providers.

Agreement means the Agreement ASH Plans signed with an Employer Group under which Members are entitled to receive Covered Services.

Combined EOC means this *Chiropractic and Acupuncture Benefit Combined Evidence of Coverage and Disclosure Form*, including the *Schedule of Benefits* and *Premium Table* attached to and incorporated by reference into this *Combined EOC*.

Chiropractic Appliances are support-type devices prescribed by a Participating Chiropractor. These shall be restricted to the following items to the exclusion of all others: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle braces, knee braces, rib supports and wrist braces.

Chiropractic Services are services rendered or made available to a Member by a chiropractor for treatment or diagnosis of Neuromusculo-skeletal Disorders.

Copayments are payments to be collected directly by a Participating Provider from a Member for Covered Services.

Covered Services are Chiropractic Services and/or Acupuncture Services as described in the *Schedule of Benefits* that are Medically Necessary Services and are preauthorized by ASH Plans, except for (a) an initial examination by a Participating Provider and the provision or commencement, in the initial examination, of Medically Necessary Services that are Chiropractic Services or Acupuncture Services, to the extent consistent with professionally recognized standards of practice, and (b) Emergency Services. When ASH Plans authorizes a treatment plan, the authorized services for the subsequent office visits covered by the approved treatment plan include not only the authorized services but also a brief re-examination in each subsequent office visit, if deemed necessary by the Participating Provider, without additional authorization by ASH Plans.

Dependent is a Subscriber's enrolled, eligible spouse and/or each enrolled, eligible Dependent.

Emergency Services consist of "Emergency Chiropractic Services" and "Emergency Acupuncture Services." "Emergency Chiropractic Services" are Covered Services that are Chiropractic Services rendered for the sudden and unexpected onset of an injury or condition affecting the neuromuscular-skeletal system, which manifests itself by acute symptoms of sufficient severity, including severe pain, for which a delay of immediate chiropractic attention could decrease the likelihood of maximum recovery. "Emergency Acupuncture Services" are Covered Services that are Acupuncture Services rendered for the sudden and unexpected onset of an injury or condition affecting the neuromuscular-skeletal system, Nausea or Pain, which manifests itself by acute symptoms of sufficient severity for which a delay of immediate acupuncture attention could decrease the likelihood of maximum recovery.

Employer Group is an employer group, union, association or other entity which contracts with ASH Plans for the provision of Covered Services to Members.

Experimental or Investigational is chiropractic or acupuncture care that is investigatory or an unproven chiropractic or acupuncture procedure or treatment regimen that does not meet professionally recognized standards of practice.

Grievance Procedures are ASH Plans' procedures for reviewing Member complaints.

Health Plan is the Health Plan contract offered by ASH Plans and described in this brochure.

Health Plan Premiums are the monthly amounts paid by an Employer Group on behalf of Members for the benefits provided under the Health Plan.

Maximum Benefit is the maximum amount which ASH Plans will pay for Covered Services provided on an annual basis to a Member by Participating Providers.

Definitions

Medically Necessary Services are Chiropractic Services and/or Acupuncture Services which are:

1. Necessary for the treatment of Neuromusculo-skeletal Disorders, Pain (acupuncture only) or Nausea (acupuncture only).
2. Established as safe and effective and furnished in accordance with professionally recognized standards of practice for chiropractic or acupuncture treatment of Neuromusculo-skeletal Disorders, Pain (acupuncture only), or Nausea (acupuncture only).

Medicare is the name commonly used to describe health insurance benefits for the aged and disabled provided under Public Law 89-97, as amended.

Member is any Subscriber or Dependent.

Member Services Department is the person or persons designated by ASH Plans to whom oral and written Member questions, concerns or complaints may be addressed. The Member Services Department may be contacted by telephone at 1-800-678-9133 or by writing to the Member Services Department at:

American Specialty Health Plans of California, Inc.
P.O. Box 509002
San Diego, CA 92150-9002

Nausea means an unpleasant sensation in the abdominal region associated with the desire to vomit that may be appropriately treated by a Participating Acupuncturist in accordance with professionally recognized standards of practice and includes adult post-operative nausea and vomiting, chemotherapy nausea and vomiting, and nausea of pregnancy.

Neuromusculo-skeletal Disorders are conditions with associated signs and symptoms related to the nervous, muscular and/or skeletal systems. Neuromusculo-skeletal Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunction of the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related to neurological manifestations or conditions.

Pain means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder or condition. Pain includes low back pain, post-operative pain, and post-operative dental pain.

Participating Acupuncturist is an acupuncturist duly licensed to practice acupuncture in California and who has entered into an agreement with ASH Plans to provide Covered Services to Members.

Participating Chiropractor is a chiropractor duly licensed to practice chiropractic in California and who has entered into an agreement with ASH Plans to provide Covered Services to Members.

Participating Provider is a Participating Chiropractor, Participating Acupuncturist or other licensed health care provider under contract with ASH Plans, as appropriate.

Quality Improvement Program are the procedures and standards established and administered by ASH Plans to ensure that Covered Services rendered by a Participating Provider comply with professionally recognized standards of practice.

Schedule of Benefits is the schedule of Covered Services available to a Member under the Health Plan that is attached to and incorporated by reference into this *Combined EOC*.

Service Area is the geographic area in which ASH Plans is licensed to provide or arrange Chiropractic Services and Acupuncture Services in the State of California by the California Department of Managed Health Care.

Subscriber is the person whose employment or other status, except for family dependency, is the basis for eligibility for membership under the Health Plan.

Utilization Management Program is an ASH Plans program to promote the efficient use of resources and maintain the quality of care which includes, but is not limited to, the prospective, concurrent and retrospective review of Covered Services.

Choice of Providers; Access to Participating Providers

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY RECEIVE COVERED SERVICES.

General

Except as otherwise indicated in this *Combined EOC*, a Member must receive Covered Services from a Participating Provider. A Member will have direct access to Participating Chiropractors and Participating Acupuncturists without obtaining a physician referral. A Member may simply call a Participating Chiropractor or Participating Acupuncturist to schedule an initial examination. After the initial examination – except for services provided pursuant to a treatment plan approved by ASH Plans and Emergency Services – the Member's Participating Chiropractor or Participating Acupuncturist must obtain preauthorization for any additional Covered Services to a Member. When ASH Plans authorizes a treatment plan, the authorized services for the subsequent office visits covered by the approved treatment plan include not only the authorized services but also a brief re-examination in each subsequent office visit, if deemed necessary by the Participating Provider, without additional authorization by ASH Plans. Except as otherwise indicated in this *Combined EOC*, the Participating Provider will be responsible for filing all claims with ASH Plans.

A Member may receive Covered Services from any Participating Provider. Except for Emergency Services and in certain circumstances in counties in which there are no Participating Providers, ASH Plans will not pay non-Participating Providers for any services. A non-Participating Provider is an acupuncturist or chiropractor who has not entered into an agreement with ASH Plans to provide Covered Services to Members. Please note the following:

- A Member may receive Emergency Services from any acupuncturist or chiropractor, including a non-Participating Provider, if the delay caused by seeking immediate acupuncture or chiropractic attention from a Participating Provider could decrease the likelihood of maximum recovery. ASH Plans will pay the non-Participating Providers for the Emergency Services to the extent they are Covered Services.
- If a Member lives in a county in which there are no licensed acupuncturists or chiropractors or no Participating Acupuncturists or Participating Chiropractors, ASH Plans will refer the Member to a Participating Acupuncturist or Participating Chiropractor in a neighboring county. If the Member requests access to a non-Participating Acupuncturist located nearer to the Member's home, ASH Plans will refer the Member to a non-Participating Acupuncturist who is located nearer to the Member's home and will pay the non-Participating Acupuncturist for any services rendered to the Member to the extent they are Covered Services.

Filing and Payment of Member Claims (Reimbursement Provisions); Member Liability

ASH Plans will pay claims for Emergency Services that are Covered Services and for other Covered Services that are not available and accessible to a Member and are provided upon a referral by ASH Plans or, with regard to radiology and clinical laboratory services for acupuncture enrollees, are provided upon referral by a Participating Acupuncturist.

A Member may be liable to a provider for such Covered Services if the provider is not a Participating Provider with ASH Plans. If a Member must pay for such Covered Services, ASH Plans will reimburse the Member. When a Member receives a bill from a provider for such Covered Services, the Member must file a claim with ASH Plans. If the Member has not paid the bill, ASH Plans will pay the provider. If the Member has paid the bill, ASH Plans will pay that amount to the Member. The Member must pay the Copayment for any such Covered Services.

Members must file claims for Emergency Services or other Covered Services within ninety (90) days after receiving the Emergency Services or other Covered Services. If it is not reasonably possible for a Member to file a claim for Emergency Services or other Covered Services within ninety (90) days, the Member must file the claim as soon as reasonably possible after the end of the ninety (90)-day period. A Member must use ASH Plans' forms in filing a claim and should send the claim form to ASH Plans at the address listed in the claim form or to ASH Plans at:

American Specialty Health Plans of California, Inc.
Attention: Claims Department
P.O. Box 509002
San Diego, CA 92150-9002

Choice of Providers; Access to Participating Providers

ASH Plans will give claim forms to Members on request. For more information regarding claims and to obtain an ASH Plans claim form, Members may call ASH Plans at 1-800-678-9133 or write ASH Plans at the address given on page 5. ASH Plans' Vice President of Chiropractic Services and/or Director of Chiropractic Services, as appropriate, will decide whether Chiropractic Services are or were Medically Necessary Services and therefore are or were Covered Services. ASH Plans' Director of Acupuncture Services will decide whether Acupuncture Services are or were Medically Necessary Services and, therefore, are or were Covered Services. ASH Plans may use utilization review procedures that it has developed for this purpose. ASH Plans will disclose to a Member, on request, the process that it uses to approve or deny services under the Health Plan. ASH Plans must approve the provision of any services other than an initial examination by a Participating Provider and the provision or commencement, in the initial examination, of Medically Necessary Services that are Covered Services, to the extent consistent with professionally recognized standards of practice, or Emergency Services, including, without limitation, any referral of a Member for X-ray services, radiological consultations or laboratory services. When ASH Plans authorizes a treatment plan, the authorized services for the subsequent office visits covered by the approved treatment plan include not only the authorized services but also a brief re-examination in each subsequent office visit, if deemed necessary by the Participating Provider, without additional authorization by ASH Plans.

Second Opinions

If a Member would like a second opinion with regard to Covered Services provided by a Participating Chiropractor or Participating Acupuncturist, the Member will have direct access to any other Participating Chiropractor or Participating Acupuncturist. The Member's visit to a Participating Chiropractor or Participating Acupuncturist for purposes of obtaining a second opinion generally will count as one visit, for purposes of any Maximum Benefit, and the Member must pay any Copayment that applies for that visit on the same terms and conditions as a visit to any other Participating Provider. However, a visit to a second Participating Acupuncturist to obtain a second opinion will not count as a visit, for purposes of the annual Maximum Benefit, if the Member was referred to the second Participating Acupuncturist by another Participating Acupuncturist (the first Participating Acupuncturist). The visit to the first Participating Acupuncturist will count toward the annual Maximum Benefit.

Payments to Participating Providers

ASH Plans pays each Participating Provider a negotiated fee for Covered Services provided to ASH Plans' Members. ASH Plans will not pay a bonus to anyone to deny, reduce, limit or delay the provision of Covered Services that are Medically Necessary Services.

A Member may request additional information about these issues from ASH Plans. A Member also may request such information from a Participating Provider. To request information from ASH Plans, please call 1-800-678-9133 or please write to Member Services Department, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

Member's Financial Responsibility

If a Member receives services that are not Covered Services, the provider of those services may bill the Member directly and the Member – not ASH Plans – must pay the provider. The Member will have no right to request reimbursement from ASH Plans in such a situation, and ASH Plans will have no obligation to reimburse a Member for any such services.

There are various instances in which a Member might receive services from a provider that are not Covered Services, including, but not limited to, the following:

- The Member receives Covered Services, other than Emergency Services, from a non-Participating Provider without authorization from ASH Plans.
- The Member receives services that are not Covered Services. This might occur, for example, if a Member desires to receive services from a Participating Provider that are excluded from coverage, such as services for the treatment of asthma or addiction.

In situations such as those described in the two bullet points set forth immediately above, ASH Plans will have no obligation to pay the provider of those services or to pay or reimburse the Member for those services.

There are other instances in which a Member might receive services that are not Covered Services, including, but not limited to, the following:

- The person who received the services was not a Member at the time he or she received the services. This might occur, for example, if an individual receives services before he or she meets the eligibility requirements established by the Employer Group or if an individual receives services after termination of the Member's coverage under the Health Plan. It also might occur, for example, if the individual is not properly enrolled pursuant to the Agreement signed by ASH Plans and the Employer Group or if the individual is not listed on an eligibility tape provided to ASH Plans by the Employer Group.
- The services exceed the Maximum Benefit. This might occur if the *Schedule of Benefits* includes a maximum number of office visits. For example, if the Maximum Benefit provides coverage for a maximum number of office visits per year (e.g. 20) and a Member receives Covered Services beyond that limit, the Member must pay the provider for each office visit after reaching the limit (e.g. for each office visit after the 20th office visit). Each Member should review the *Schedule of Benefits*, which is attached to and incorporated by reference into this EOC, to determine the nature and extent of any applicable Maximum Benefit.

In situations such as those described in the two bullet points set forth immediately above, ASH Plans will have no obligation to pay or reimburse the Member for those services.

ASH Plans distinguishes between "eligibility" for services and "authorization" of services. "Eligibility" depends on an individual's status as a Member and the availability of Covered Services to the Member within any applicable Maximum Benefit. "Authorization" relates to any required approval of Covered Services as Medically Necessary Services.

If ASH Plans authorizes the provision of services to an individual, including a Member, and subsequently determines that the individual was not eligible for those services, ASH Plans will have no obligation to pay or reimburse the individual for those services. The individual who received the services will be responsible for paying for them.

General Information

A MEMBER IS RESPONSIBLE FOR KNOWING WHETHER HE OR SHE IS ELIGIBLE TO RECEIVE COVERED SERVICES. IF AN INDIVIDUAL RECEIVES SERVICES FOR WHICH HE OR SHE IS NOT ELIGIBLE, INCLUDING SERVICES RECEIVED BY A MEMBER, TO THE EXTENT THEY EXCEED ANY APPLICABLE MAXIMUM BENEFIT AND SERVICES RECEIVED BY AN INDIVIDUAL AT A TIME WHEN HE OR SHE WAS NOT A MEMBER, THAT INDIVIDUAL MUST PAY FOR THOSE SERVICES, EVEN IF ASH PLANS AUTHORIZED THEM, AND THE PROVIDER MAY BILL THE INDIVIDUAL FOR THOSE SERVICES DIRECTLY. IF ASH PLANS HAS PAID FOR THE SERVICES IN ANY SUCH SITUATION OR HAS REIMBURSED AN INDIVIDUAL OR A MEMBER FOR THE COST OF THE SERVICES IN ANY SUCH SITUATION, ASH PLANS MAY SEEK REIMBURSEMENT FROM THE INDIVIDUAL OR THE MEMBER FOR THE AMOUNT PAID BY ASH PLANS TO THE PROVIDER, THE INDIVIDUAL OR THE MEMBER.

Continuity of Care

A Member receiving Covered Services from a Participating Chiropractor and/or a Participating Acupuncturist at the time that Participating Provider's contract terminates with ASH Plans may be able to continue to receive Covered Services from that provider for a period of time. The Member must be receiving Covered Services for an acute condition, a serious chronic condition, or a pregnancy at the time the provider's contract with ASH Plans terminates. A Member's ability to receive continuity of care in these situations will depend on a number of other factors, including whether the provider voluntarily terminated his or her contract with ASH Plans and whether the provider agrees in writing to be subject to the same contract terms that existed prior to termination. A Member should contact ASH Plans in writing or by telephone to request continuity of care in such a situation. ASH Plans can be reached by calling 1-800-678-9133 or by writing to Member Services Department, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

Eligibility and Enrollment

A Subscriber and the Subscriber's Dependents may enroll in ASH Plans if the Subscriber and Dependents meet the eligibility requirements of the Employer Group and reside within the Service Area. A Subscriber or Dependent should contact his or her Employer Group regarding eligibility for ASH Plans.

Enrollment

A Subscriber or Dependent must enroll in ASH Plans through the Subscriber's Employer Group. Most Employer Groups have an established open enrollment period when eligible individuals may enroll in ASH Plans. An eligible individual may have the option of enrolling in ASH Plans by enrolling in a Health Plan which offers ASH Plans.

A Subscriber's Employer Group will notify the Subscriber and his or her Dependents when coverage under the Health Plan begins.

Terms of Coverage

Prepayment Fees: The Employer Group will pay ASH Plans the Health Plan Premium on Member's behalf. A Subscriber should contact his or her Employer Group regarding any required employee contribution.

ASH Plans will cover only Chiropractic Services and Acupuncture Services that are Covered Services. Please note that the services listed in the "General Exclusions and Limitations" section of the *Schedule of Benefits* are not covered.

ASH Plans may change any provision of the Health Plan, including the Covered Services, Health Plan Premiums and Copayments after thirty (30) days' written notice of such change has been given to the Employer Group, subject to review and approval by the California Department of Managed Health Care.

Other Charges

A Member receiving Covered Services will only be responsible for applicable Copayments or deductibles described in the *Schedule of Benefits*. Such Copayments and deductibles must be paid by the Member to the Participating Provider when the services are rendered. Copayments and deductibles are listed in the *Schedule of Benefits*. A Member may also obtain services not covered by ASH Plans at the Member's own expense.

Coordination of Benefits

If a Member is covered by ASH Plans and another plan or contract providing chiropractic or acupuncture benefits or services, including Medicare, ASH Plans' benefits and services shall be coordinated with such other plan or contract in accordance with state and federal laws and regulations. Members must inform ASH Plans if they are covered by any other chiropractic or acupuncture benefit

plan, including Medicare. If ASH Plans pays benefits in excess of those required under coordination of benefits laws and regulations, ASH Plans or a Participating Provider may recover an excess payment from a Member or the other plan. ASH Plans may also reduce its coverage of a Member to avoid duplication of benefits available under Medicare. A Member who is eligible for Medicare coverage, but elects not to enroll in Medicare, may have his or her benefits reduced as though he or she received Medicare benefits.

Renewal Provisions

The Health Plan contract entered into by ASH Plans and the Employer Group sets forth the Member's rights and benefits. That contract will automatically renew unless terminated by ASH Plans or the Employer Group. Members should contact their Employer Group with questions regarding the renewal or termination of that contract. At the time of renewal, ASH Plans has the right to change the Health Plan Premiums or any other provision of that contract.

Covered Services

For a detailed listing of Covered Services, Members should review the *Schedule of Benefits*. Please note that the amount of Covered Services will be limited based on the *Schedule of Benefits*.

Acupuncture Services that are Covered Services include Medically Necessary Services rendered by an acupuncturist for treatment of carpal tunnel syndrome, headaches, menstrual cramps, osteoarthritis, stroke rehabilitation and tennis elbow.

Acupuncture Services that are Covered Services do not include services for treatment of asthma or addiction (including, without limitation, smoking cessation).

All Covered Services – except for (a) an initial examination by a Participating Provider and the provision or commencement, in the initial examination, of Medically Necessary Services that are Covered Services, to the extent consistent with professionally recognized standards of practice, and (b) Emergency Services – require preauthorization by ASH Plans. When ASH Plans approves a treatment plan, the approved services for the subsequent office visits covered by the approved treatment plan include not only the authorized services but also a brief re-examination in each subsequent office visit, if deemed necessary by the Participating Provider, without additional approval by ASH Plans.

Emergency Services

ASH Plans covers Emergency Services to the extent they comprise Emergency Chiropractic or Emergency Acupuncture Services. Because ASH Plans arranges only Chiropractic Services and Acupuncture Services, if a Member believes the Member requires medical services in an emergency, ASH Plans recommends that the Member consider contacting his or her primary care physician or another physician or calling 911. Members are encouraged to use appropriately the 911 emergency response system in areas where the system is established and operating when they have an emergency medical condition that requires an emergency response. ASH Plans will not cover any services as Emergency Services unless the chiropractor or acupuncturist rendering such services can show that the services in fact were Emergency Services.

Copayments or Deductibles

A Member must pay Copayments or deductibles at the time Covered Services are rendered. The Copayment or deductible will be a specific dollar amount. The *Schedule of Benefits* attached to and incorporated by reference into this *Combined EOC* sets forth the applicable Copayments or deductibles under the heading "Benefit Plan."

Maximum Benefit

A Member will be limited to a Maximum Benefit which is outlined in the *Schedule of Benefits*.

ASH Plans Payments

ASH Plans will pay each Participating Provider directly. California law provides, by statute, that each contract between ASH Plans and a Participating Provider must provide that, if ASH Plans fails to pay the Participating Provider, no Member shall be liable to the Participating Provider for any sums owed by ASH Plans.

Member's Liability

A Member may be liable to a Participating Provider for services not covered under the Health Plan. A Member will be liable to a non-Participating Provider for the cost of services if a Member chooses to receive services from a non-Participating Provider, other than: (a) Emergency Services; (b) services pursuant to a referral by ASH Plans in a situation in which there are no Participating Providers in the county in which the Member lives who are available and accessible to the Member, but there

are non-Participating Providers located in that county who are available and accessible to the Member; and (c) services pursuant to a referral by ASH Plans in a situation in which there are no Participating Providers in the county in which the Member lives who are available and accessible to the Member, but there are non-Participating Providers located in a neighboring county who are available and accessible to the Member.

■ Termination of Benefits

A Member's coverage under the Health Plan will terminate upon the occurrence of any of the following:

1. Employer Group voluntarily terminates the Agreement. Membership will terminate at the end of the month for which the last Health Plan Premium is received by ASH Plans on Member's behalf.

2. A. ASH Plans does not receive the applicable Health Plan Premium for Member within fifteen (15) days after Employer Group receives a notice of termination for nonpayment from ASH Plans, provided that the notice shall state that receipt by ASH Plans of the applicable Health Plan Premium within that fifteen (15)-day period shall cause ASH Plans to revoke the notice. Except as otherwise provided in the immediately preceding sentence, termination shall take effect at the end of that fifteen (15)-day period.

   B. Member fails to pay any Copayment or Member fails to reimburse ASH Plans for fees for services paid by ASH Plans that ASH Plans did not authorize, other than (a) an initial examination by a Participating Provider or the provision or commencement, in the initial examination, of Medically Necessary Services that are Covered Services, to the extent consistent with professionally recognized standards of practice; or (b) Emergency Services, provided that Member shall have fifteen (15) days after receiving a request from ASH Plans to pay any Copayment or to provide any required reimbursement. Except as otherwise provided in the immediately preceding sentence, termination shall take effect upon the expiration of that fifteen (15)-day period.

3. Member either is absent from the Service Area for 90 consecutive days or moves out of the Service Area without the intent to return. Termination shall be effective on the last day of the month in which Member receives a termination notice from ASH Plans.

4. Member's eligibility ceases, subject to the provisions set forth below under "Individual Continuation of Benefits." Termination shall be effective on the last day of the month in which Member's eligibility ceases.

5. Fraud or deception by Member in the use of the services or facilities of ASH Plans or Member knowingly permitting such fraud or deception by someone else. Termination shall take effect on the day after the Member receives a written notice of termination from ASH Plans.

6. If Member's behavior is of a violent or seriously abusive nature that may seriously threaten or jeopardize the safety of ASH Plans, any employee or agent of ASH Plans, any Participating Provider, or any employee, agent or patient of a Participating Provider. Termination shall take effect on the day after the Member receives a written notice of termination from ASH Plans.

7. Member voluntarily disenrolls, provided Employer Group allows voluntary disenrollment. Termination shall take effect on the last day of the month in which Member voluntarily disenrolls.

In all of the circumstances described above, termination of benefits shall apply to all benefits, including benefits for a Member who is hospitalized or undergoing treatment for an ongoing condition, to the extent the Member receives those benefits after the effective date of the termination.

■ Reinstatement of Benefits

A Member may re-enroll in ASH Plans if his or her coverage has terminated, and the Member is eligible for re-enrollment through an Employer Group. The Member must, however, submit a new enrollment application during an open enrollment period.

■ Individual Continuation of Benefits

Upon request by an Employer Group, ASH Plans shall make available continuation coverage under the Health Plan to Members entitled to continuation coverage based upon the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

Questions, Concerns or Complaints?

If a Member has a question, concern or complaint regarding the services received from ASH Plans or a Participating Provider, the Member should call ASH Plans at 1-800-678-9133 or write ASH Plans at the following address:

American Specialty Health Plans of California, Inc.
Member Services Department
P.O. Box 509002
San Diego, CA 92150-9002

A Member may also obtain a Member complaint form from any Participating Provider.

Grievance Procedures and Arbitration

Member Services Department

If a Member calls ASH Plans, the Member Services department is ready to assist the Member with filing a complaint. Such assistance includes helping the Member in writing the complaint.

Grievance Procedures

ASH Plans will work with the Member to resolve the complaint. ASH Plans will follow its Grievance Procedures in this regard.

ASH Plans' Grievance Procedures, which ASH Plans has filed with the Department of Managed Health Care, provide that a complaint or grievance that might involve a quality of care issue or any other clinical issue with regard to chiropractic or acupuncture services (a "clinical complaint") will be reviewed by an ASH Plans Chiropractic Senior Case Manager or an Acupuncture Case Manager, as appropriate, each of whom is a licensed chiropractor or a licensed acupuncturist, respectively. If a complaint or grievance does not involve a quality-of-care issue or any other clinical issue (an "administrative complaint"), a First Level Review Committee composed of two members of ASH Plans' Administrative Review Committee will review the complaint or grievance. The Administrative Review Committee includes officers, directors and employees of ASH Plans.

Clinical Complaints

ASH Plans will resolve each clinical complaint within thirty (30) days. If a clinical complaint involves an imminent and serious threat to the health of a Member – including, but not limited to, severe pain, potential loss of life, limb or major bodily function – ASH Plans will review the clinical complaint on an expedited basis and will send the Member (and, if appropriate, the Department of Managed Health Care) a written statement that sets forth the disposition or status of the clinical complaint within three (3) days from receipt of the clinical complaint.

If a Member is dissatisfied with the initial determination of a clinical complaint made by an ASH Plans Chiropractic Senior Case Manager or an Acupuncture Case Manager, the Member may request a redetermination by ASH Plans' Vice President of Chiropractic Services and/or Director of Chiropractic Services or Director of Acupuncture Services, as appropriate, each of whom is a licensed chiropractor or a licensed acupuncturist, respectively. The Member may do so by submitting a written request to ASH Plans' Vice President of Chiropractic Services and/or Director of Chiropractic Services or Director of Acupuncture Services, as appropriate, within thirty (30) days from the Member's receipt of a written statement that sets forth the initial determination made by the Chiropractic Senior Case Manager or the Acupuncture Case Manager. ASH Plans' Vice President of Chiropractic Services and/or Director of Chiropractic Services or Director of Acupuncture Services, as appropriate, shall send the Member a written statement of the redetermination made by ASH Plans' Vice President of Chiropractic Services and/or Director of Chiropractic Services or Director of Acupuncture Services, as appropriate, and shall do so within thirty (30) days from the date of receipt of the request for redetermination.

If the Member is dissatisfied with the redetermination made by ASH Plans' Vice President of Chiropractic Services and/or Director of Chiropractic Services or Director of Acupuncture Services, as appropriate, the Member may request a final redetermination by ASH Plans' Chiropractic Quality Improvement Committee (the "Chiropractic QIC") or ASH Plans' Acupuncture Quality Improvement Committee (the "Acupuncture QIC"), as appropriate, or ASH Plans' Chiropractic Utilization Management Committee (the "Chiropractic UMC") or ASH Plans' Acupuncture Utilization Management Committee (the "Acupuncture UMC"), as appropriate. The Member may do so by submitting a written request to the Chiropractic QIC or Acupuncture QIC, as appropriate, or the Chiropractic UMC or

Acupuncture UMC, as appropriate, within thirty (30) days from the Member's receipt of a written statement that sets forth the redetermination made by ASH Plans' Vice President of Chiropractic Services and/or Director of Chiropractic Services or Director of Acupuncture Services, as appropriate. The Chiropractic QIC or the Acupuncture QIC, as appropriate, or the Chiropractic UMC or the Acupuncture UMC, as appropriate, shall send the Member a written statement of final redetermination made by the Chiropractic QIC, Acupuncture QIC, Chiropractic UMC or Acupuncture UMC and shall do so within thirty (30) days from the date of receipt of the request for final redetermination.

The written statement of redetermination from ASH Plans' Vice President of Chiropractic Services and/or Director of Chiropractic Services or Director of Acupuncture Services, as appropriate, will indicate whether a request for final redetermination should go to the Chiropractic QIC, Acupuncture QIC, Chiropractic UMC or Acupuncture UMC. The Chiropractic QIC or Acupuncture QIC will make any final redetermination of a clinical complaint to the extent it does not involve a determination as to the status of services as Medically Necessary Services, and the Chiropractic UMC or the Acupuncture UMC will make any final redetermination of a clinical complaint to the extent it does involve a determination of the status of services as Medically Necessary Service. The Chiropractic QIC and the Chiropractic UMC each is composed solely of licensed chiropractors. The Acupuncture QIC and the Acupuncture UMC are composed solely of licensed acupuncturists.

If the Member is still dissatisfied, the Member may submit the clinical complaint to binding arbitration, as discussed below, and, as also discussed above, a Member may submit a clinical complaint to the Department of Managed Health Care, even if the Member has not submitted the dispute to binding arbitration. If the Member does not submit a request for binding arbitration within sixty (60) days from the Member's receipt of the written statement of final redetermination by the Chiropractic QIC, Acupuncture QIC, Chiropractic UMC or Acupuncture UMC, the final redetermination made by the Chiropractic QIC, Acupuncture QIC, Chiropractic UMC or Acupuncture UMC shall be final and binding.

Administrative Complaints

ASH Plans will resolve each administrative complaint within thirty (30) days. If an administrative complaint involves an imminent and serious threat to the health of a Member – including, but not limited to, severe pain, potential loss of life, limb or major bodily function – ASH Plans will review the administrative complaint on an expedited basis and will send the Member (and, if appropriate, the Department of Managed Health Care) a written statement that sets forth the disposition or status of the clinical complaint within three (3) days from receipt of the clinical complaint.

If a Member is dissatisfied with the initial determination of an administrative complaint made by the First Level Review Committee, the Member may request a redetermination by the entire Administrative Review Committee. The Member may do so by submitting a written request to the Administrative Review Committee within thirty (30) days from the Member's receipt of a written statement that sets forth the initial determination made by the First Level Review Committee. The Administrative Review Committee shall send the Member a written statement of the redetermination made by Administrative Review Committee and shall do so within thirty (30) days from the date of receipt of the request for redetermination.

If the Member is dissatisfied with the redetermination made by the Administrative Review Committee, the Member may request a final redetermination by the Executive Review Committee. The Member may do so by submitting a written request to the Executive Review Committee within thirty (30) days from the Member's receipt of a written statement that sets forth the redetermination made by the Administrative Review Committee. The Executive Review Committee shall send the Member a written statement of final redetermination made by the Executive Review Committee and shall do so within thirty (30) days from the date of receipt of the request for final redetermination. The Executive Review Committee includes ASH Plans' President, Chief Operating Officer and a Quality Improvement Committee Provider Participant.

If the Member is still dissatisfied, the Member may submit the administrative complaint to binding arbitration, as discussed below, and, as also discussed below, a Member may submit an administrative complaint to the Department of Managed Health Care even if the Member has not submitted the dispute to binding arbitration. If the Member does not submit a request for binding arbitration within sixty (60) days from the Member's receipt of the written statement of

final redetermination made by the Executive Review Committee, the final redetermination made by the Executive Review Committee shall be final and binding.

Binding Arbitration

As discussed above, if a Member is dissatisfied with the final redetermination of a clinical complaint or an administrative complaint, the Member may submit the matter to binding arbitration after the Member completes ASH Plans' Grievance Procedures.

The requirement that a Member submit a dispute to binding arbitration applies broadly, including to settle any claim of malpractice against ASH Plans. A Member's claims against a Participating Provider are not subject to ASH Plans Grievance Procedures, except to the extent the Member and the Participating Provider agree to follow and/or be bound by ASH Plans' Grievance Procedures. If a Member has a claim against a Participating Provider, the Member may seek any available remedy against the Participating Provider.

The Member and ASH Plans will follow applicable law with regard to arbitration and ASH Plans' arbitration policies. California law may require, for a dispute involving $200,000 or less, that the Member and ASH Plans select a single, neutral arbitrator. In that situation, the arbitrator will not have the power to award more than $200,000.

At a Member's request, ASH Plans will send the Member a copy of ASH Plans' arbitration policies. Those policies, as ASH Plans may amend them from time to time, will bind the Member and ASH Plans.

If a Member seeks to arbitrate a dispute under or with regard to the Agreement, the Member must give notice to ASH Plans, and, if ASH Plans seeks to arbitrate a dispute, ASH Plans must give notice to the Member. The notice must contain a demand for arbitration and must describe the dispute, the issues involved, the amount of any claim and the remedy sought.

Any arbitration under the Health Plan will be held in accordance with the Commercial Arbitration Rules of the American Arbitration Association (AAA) and must be submitted to the AAA in accordance with those procedures. Any arbitration under the Agreement will be held in California at a location mutually acceptable to the parties, provided that, if the parties cannot agree on a location for the arbitration, the AAA shall specify the location. In cases of extreme hardship, ASH Plans will pay all or a part of a Member's fees and expenses for a neutral arbitrator.

Department of Managed Health Care

In some cases, a Member may file a complaint with the Department of Managed Health Care, and a Member may submit a complaint to the Department of Managed Health Care even if the Member has not submitted the dispute to binding arbitration. California law sets forth this right in the following statement:

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll-free telephone number **(1-888-HMO-2219)** to receive complaints regarding Health Plans. The hearing and speech impaired may call the Department's direct toll-free telephone number at **1-877-688-9891 (TDD)** or the California Relay Service's toll-free telephone numbers **(1-800-735-2929** or **1-888-877-5378 TTY)**. The Department's facsimile number is **(916) 229-4328**. The Department's Internet Web site **(http://www.hmohelp.ca.gov)** has complaint forms and instructions online. If you have a grievance against your Health Plan, you should first telephone your plan at **1-800-678-9133** and use the plan's grievance process before contacting the Department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. The plan's grievance process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these procedures does not preclude your use of any other remedy provided by law.

A Member may submit a complaint or grievance to the Department of Managed Health Care for review after the Member has participated in ASH Plans' grievance process for at least 30 days. If the Member's grievance involves an imminent and serious threat to his or her health – including, but not limited to, severe pain, potential loss of life, limb or major bodily functions – the Member may submit the grievance to the Department of Managed Health Care without waiting 30 days. In such a situation, ASH Plans also will provide the Member and, as appropriate, the Department of Managed Health Care with a written statement of the status or disposition of the complaint within three (3) days of receipt of the complaint.

Member Rights

Independent Medical Review of Delays, Denials or Modifications of Experimental or Investigational Therapies

Covered Services do not include services, lab tests, X-rays and other treatments classified as Experimental or Investigational and/or as being in the research stage, as determined in accordance with professionally recognized standards of practice. If ASH Plans denies coverage for services for a Member based on a determination by ASH Plans that the services are Experimental or Investigational, the Member may be able to request an independent medical review of ASH Plans' determination in accordance with the requirements of California Health and Safety Code Section 1370.4.

California Health and Safety Code Section 1370.4 applies only if five specified criteria are met:

1. The Member has a life-threatening or seriously debilitating condition;
2. Standard therapies are ineffective or inappropriate for that condition or are not more beneficial to the Member than the Experimental or Investigational services;
3. The Experimental or Investigational services are more likely to be beneficial to the Member;
4. ASH Plans has denied coverage for the Experimental or Investigational services;
5. Except for that denial, the Experimental or Investigational services otherwise would be Covered Services.

If ASH Plans denies coverage for Experimental or Investigational services, ASH Plans will notify the Member in writing of the opportunity to request an independent medical review within five (5) business days of the decision to deny coverage. ASH Plans will provide the Member with an application to be submitted to the California Department of Managed Health Care, and the review will be conducted by an independent medical review organization that has contracted with the Department of Managed Health Care to provide such reviews.

Cancellation

If a Member believes that his or her Health Plan enrollment was cancelled or not renewed because of the Member's health status or requirements for health care services, such Member may seek a review of the cancellation by the California Commissioner of Corporations.

Member Participation In ASH Plans Public Policy

ASH Plans has established a Public Policy Committee to make recommendations regarding ASH Plans' public policy. To participate in this committee or to request additional information regarding the development of ASH Plans' public policies, please call ASH Plans at 1-800-678-9133.

Confidentiality of Medical Records

A statement describing ASH Plans' policies and procedures for preserving the confidentiality of medical records is available and will be furnished to you upon request.

To request a copy call ASH Plans Member Services at 1-800-678-9133.

Patients' Rights and Responsibilities

We acknowledge that you, our patients, entrust us with your special care and needs. Because of this, we have adopted the following list of patients' rights and responsibilities. As a patient you have the right to:

1. Considerate and respectful care.
2. Receive information about your illness in understandable terms so that you may give informed consent (except in emergencies, this information should include the proposed course of treatment, alternatives, possibilities of nontreatment, prospects for recovery and clinical risks involved).
3. Use the information you have received to participate – to the extent permitted by law – in decisions regarding care, including the right to refuse treatment.
4. Full consideration of privacy, including case discussion, consultation, examination and treatment, all of which are confidential and should be conducted discreetly, with your consent to the presence of any third parties.
5. Reasonable continuity of care and advance notification of the appointment time and location as well as the identity of the person(s) providing care.
6. Be advised of and refuse treatment if your health care provider engages in experimental studies/ procedures affecting your care or treatment.
7. Be informed of continuing health care requirements following discharge from treatment.
8. Receive Medically Necessary and appropriate care and services, as defined in your Member benefit plan.
9. File complaints and grievances when dissatisfied with the treatment you have received.
10. Request and receive any available information about health education, promotion and prevention services; community services that may help to assist with your health problems; and the appropriate use of treatments, regardless of their relationship to your health care benefits.
11. Have these rights apply to the person who has legal responsibility for making decisions regarding your medical care.
12. Exercise these rights without regard to gender; ethnic, cultural, economic, educational or religious background; or the source of payment for care.

As a patient, you must also take responsibility to:

13. Give your health care provider and/or Health Plan the information necessary to provide you with the best possible care.
14. Follow the treatment plan and instructions for care upon which you and your health care provider have agreed.

Notes

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P.O. Box 9002
San Diego, CA 92150-9002

Customer Service:
800-678-9133
619-578-2000

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AMERICAN SPECIALTY HEALTH PLANS
GROUP SUBSCRIBER AGREEMENT

American Specialty Health Plans of California, Inc., a California Corporation (hereinafter called "ASHP"), and the employer, association, labor union trust, or other entity specified as "GROUP" on the Cover Sheet (hereinafter called "Group"), agree as follows:

RECITAL OF FACTS

ASHP is a specialized health care service plan which provides or arranges Chiropractic Services and Acupuncture Services for Members. Group is an employer, association, labor union trust, or other entity which desires to arrange Covered Services for its eligible Members. In consideration of the Group's application for the benefits provided under this Agreement and the periodic payment of Health Plan Premiums by Group to ASHP on behalf of Members, ASHP agrees to provide or arrange for Covered Services subject to all the terms and conditions of this Agreement.

1. DEFINITIONS

1.01 **Acupuncture Services** are services rendered or made available to a Member by an acupuncturist for treatment or diagnosis of Neuromusculo-skeletal Disorders, Nausea, and Pain. As of the date of this Agreement, Section 4927 of the California Business and Professions Code defines "Acupuncture" to mean "the stimulation of a certain point or points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions, including pain control, for the treatment of certain diseases or dysfunctions of the body and includes the techniques of electroacupuncture, cupping and moxibustion."

Adjunctive therapies or modalities - - such as acupressure, breathing techniques, exercise, nutrition, and oriental massage - - are available as a part of Acupuncture Services only if "Acupuncture," as defined in the California Business and Professions Code, is available to a Member as a Covered Service. However, if (a) a Participating Acupuncturist would recommend "Acupuncture" for a Member as a Covered Service but cannot do so in accordance with professionally recognized standards of practice because the insertion of needles is contraindicated (e.g., for a patient with an infectious disease that may be transmitted through blood or other bodily fluids) and (b) professionally recognized standards of practice indicate that acupressure would be efficacious in the treatment of the Member, then Acupuncture Services shall be deemed to include acupressure in that circumstance even if "Acupuncture," as defined in Section 4927 of the California Business and Professions Code, is not provided to the Member at the same time and the Member shall be entitled to receive other adjunctive therapies or modalities in conjunction with the provision of acupressure in that circumstance to the same extent as would be the case if the Member were receiving "Acupuncture," as defined in Section 4927 of the California Business and Professions Code.

1.02 **Administrative Review Program** is the program and procedures utilized by ASHP to review administrative decisions, such as denial of authorization forms or claims due to late or untimely submission to ASHP by Participating Providers.

1.03 **Agreement** is this Group Subscriber Agreement, including the Cover Sheet, and Attachment A, and any amendments hereto.

1.04 **ASHP Enrollment Packet** is the packet of information supplied by ASHP to prospective Members which summarizes this Agreement and may contain an enrollment form.

1.05 **Chiropractic Appliances** are support type devices prescribed by a Participating Chiropractor. These shall be restricted to the following items to the exclusion of all others: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle braces, knee braces, rib supports, and wrist braces.

1.06 **Chiropractic Services** are services rendered or made available to a Member by a chiropractor for treatment or diagnosis of Neuromusculo-skeletal Disorders.

1.07 **Copayments** are payments to be collected directly by a Participating Provider from a Member for Covered Services.

1.08 **Cover Sheet** is the Group Subscriber Agreement Cover Sheet which is attached to and incorporated into this Agreement.

1.09 **Covered Services** are Chiropractic Services and/or Acupuncture Services which are the benefits, excluding the limitations, under this Agreement and which are disclosed as benefits herein and on Attachment A that are Medically Necessary Services and are pre-authorized by ASHP, except for (a) an initial examination by a Participating Provider and the provision or commencement, in the initial examination, of Medically Necessary Services that are Chiropractic Services or Acupuncture Services, to the extent consistent with professionally recognized standards of practice, and (b) Emergency Services. When ASHP authorizes a treatment plan, the authorized services for the subsequent office visits covered by the approved treatment plan include not only the authorized services but also a brief re-examination in each subsequent office visit, if deemed necessary by the Participating Provider, without additional authorization by ASHP. ASHP has the final determination of whether Chiropractic Services or Acupuncture Services are Covered Services.

1.10 **Dependent** is any spouse or unmarried child (including a step-child or adopted child) of Subscriber.

1.11 **Eligibility Tape** is a database provided to ASHP by Group on a monthly basis which contains a list of all Subscribers and Dependents who are Members for the applicable month.

1.12 **Emergency Services** consist of "Emergency Chiropractic Services" and "Emergency Acupuncture Services." "Emergency Chiropractic Services" are Covered Services that are Chiropractic Services rendered for the sudden and unexpected onset of an injury or condition affecting the neuromuscular-skeletal system which manifests itself by acute symptoms of sufficient severity, including severe pain, for which a delay of immediate chiropractic attention could decrease the likelihood of maximum recovery. "Emergency Acupuncture Services" are Covered Services that are Acupuncture Services rendered for the sudden and unexpected onset of an injury or condition affecting the neuromuscular-skeletal system, nausea, or pain which manifests itself by acute symptoms of sufficient severity for which a delay of immediate acupuncture attention could decrease the likelihood of maximum recovery.

1.13 **Enrollment** is the acceptance of an enrollment form or similar form by ASHP, conditional upon the execution of this Agreement by Group and ASHP and the timely payment of applicable Health Plan Premiums by Group.

1.14 **Experimental or Investigational** is chiropractic or acupuncture care that is essentially investigatory or an unproven chiropractic or acupuncture procedure or treatment regimen that does not meet professionally recognized standards of practice.

1.15 **Grievance Procedures** are ASHP's procedures for reviewing Member complaints.

1.16 **Group** is the employer, association, labor union trust identified, or other entity specified as "Group" on the Cover Sheet.

1.17 **Health Plan Premiums** are amounts set forth in the Cover Sheet to be paid to ASHP by Group on behalf of Members in consideration of the benefits provided under this Agreement.

1.18 **Maximum Benefit** is the maximum amount which ASHP will pay for any Covered Services provided on an annual basis to a Member by Participating Providers.

1.19 **Medically Necessary Services** are Chiropractic Services and/or Acupuncture Services which are:

1) Necessary for the treatment of Neuromusculo-skeletal Disorders; Pain (acupuncture only); or Nausea (acupuncture only); and

2) Established as safe and effective and furnished in accordance with professionally recognized standards of practice for chiropractic or acupuncture treatment of Neuromusculo-skeletal Disorders; Pain (acupuncture only); or Nausea (acupuncture only).

1.20 **Medicare** is the name commonly used to describe health insurance benefits for the aged and disabled provided under Public Law 89-97, as amended.

1.21 **Member** is any Subscriber or Dependent who has gone through Enrollment and for whom ASHP has received the applicable Health Plan Premiums.

1.22 **Member Services Department** is the person or persons designated by ASHP to whom oral and written Member complaints may be addressed. The Member Services Department may be contact by telephone at 1-800-678-9133 or by writing to the Member Services Department, at:

American Specialty Health Plans of California, Inc.
P.O. Box 509002
San Diego, CA 92150-9002

1.23 **Nausea** means an unpleasant sensation in the abdominal region associated with the desire to vomit that may be appropriately treated by a Participating Acupuncturist in accordance with professionally recognized standards of practice and includes adult post-operative nausea and vomiting, chemotherapy nausea and vomiting, and nausea of pregnancy.

1.24 **Neuromusculo-skeletal Disorders** are conditions with associated signs and symptoms related to the nervous, muscular and/or skeletal systems. Neuromusculo-skeletal Disorders are conditions typically categorized as structural, degenerative or inflammatory disorders, or biomechanical dysfunction of the joints of the body and/or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related neurological manifestations or conditions.

1.25 **Open Enrollment Period** is the period agreed upon by ASHP and Group during which all Subscribers and their eligible Dependents may enroll as Members under this Agreement.

1.26 **Pain** means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder, or condition. Pain includes low back pain, post-operative pain, and post-operative dental pain.

1.27 **Participating Acupuncturist** is an acupuncturist who is duly licensed to practice acupuncture in California and who has entered into an agreement with ASHP to provide Covered Services to Members.

1.28 **Participating Chiropractor** is a chiropractor duly licensed to practice chiropractic in California and who has entered into an agreement with ASHP to provide Covered Services to Members.

1.29 **Participating Provider** is a Participating Chiropractor, Participating Acupuncturist or other licensed health care provider under contract with ASHP, as appropriate.

1.30 **Quality Improvement Program** consists of the procedures and standards established and administered by ASHP to ensure that Covered Services rendered by a Participating Provider comply with professionally recognized standards of practice.

1.31 **Schedule of Benefits** is the schedule of Covered Services which may be provided to a Member under this Agreement. The Schedule of Benefits is incorporated herein and attached hereto as Attachment A.

1.32 **Service Area** is the geographic area in which ASHP is licensed to provide or arrange for Chiropractic Services and Acupuncture Services in the State of California by the California Department of Managed Health Care.

1.33 **Subscriber** is the person whose employment or other status, except for family dependency, is the basis for eligibility for membership under this Agreement

1.34 **Utilization Management Program** is an ASHP program to promote the efficient use of resources and maintain the quality of health care which includes, but is not limited to, the prospective, concurrent and retrospective review of Covered Services.

2. ELIGIBILITY AND ENROLLMENT

2.01 **Enrollment Procedure.** ASHP will provide or arrange Covered Services to Members who meet the eligibility requirements stated in this Agreement, who are properly enrolled pursuant to this Agreement and who are listed on the Eligibility Tape provided by Group. A Member may receive Covered Services from any Participating Provider at any time and is not required to pre-designate, at any time, the Participating Provider from whom the Member will receive Covered Services. A Member must receive Covered Services from a Participating Provider, except that (a) a Member may obtain Emergency Services from any provider, including a non-Participating Provider, and (b) if Covered Services are not available and accessible to a Member, the Member may obtain Covered Services from a non-Participating Provider who is available and accessible to the Member upon referral by ASHP. No services or benefits under this Agreement shall be available to any person not specifically enrolled as a Member.

2.01.01 **Enrollment Form.** A properly completed enrollment form provided by ASHP or other documentation as determined by ASHP must be submitted to ASHP by Group for each Subscriber on behalf of the Subscriber and any Dependents.

2.01.02 **Time of Enrollment.** An enrollment form shall be submitted by a Subscriber to Group during an Open Enrollment Period, except that Group employees and their eligible Dependents who were not eligible during the previous Open Enrollment Period may apply for enrollment within thirty (30) days after becoming eligible. All applications for Enrollment which are not received timely, as described above, by Group may be rejected by ASHP. Group shall provide notice to Members of the applicable Open Enrollment Periods.

2.02 **Subscriber Eligibility**. Subscribers who meet the eligibility requirements stated in this Agreement may enroll as Members under this Agreement. Loss of eligibility shall terminate Subscriber's membership under this Agreement. A Subscriber must meet each of the following eligibility requirements:

a. The Subscriber must permanently reside within the Service Area.

b. Subscriber must meet all eligibility requirements of Group for membership under this Agreement.

2.03 **Dependent Eligibility.** A Dependent's eligibility for Enrollment is contingent upon the Dependent's Subscriber's eligibility for enrollment under this Agreement, i.e., a Dependent child of an

eligible Subscriber who meets the eligibility requirements set forth in Section 2.02 may be enrolled as a Member.

Coverage for newborn children of a Subscriber begins at birth. Coverage for adopted children of a Subscriber begins from the date of adoption. The "date of adoption" is the date the Subscriber or his or her husband or wife first has the right to control health care for the child. In order for coverage to continue beyond thirty-one (31) days after the date of birth, or, in the case of adoption, thirty-one (31) days past the date of adoption, an enrollment form for the Dependent must be submitted to Group within thirty-one (31) days of the date of birth, or in the case of adoption, the date of adoption. Newborn care is not a covered benefit at any time if the mother of the newborn child is a Dependent child of the Subscriber.

ASHP will not end the membership of a Dependent child upon reaching the limiting age set forth on the Cover Sheet if he or she is incapable of self-sustaining employment because of a mental retardation or physical handicap. ASHP may require proof of the child's incapacity and dependency. A Subscriber must provide that proof within 31 days of request from ASHP. If the child is age 21 or older, ASHP will not request this information more than once each year.

ASHP will not end the membership of a Dependent child upon reaching the limiting age set forth on the Cover Sheet if he or she is a full-time student at an accredited secondary school, trade school, college, or university. ASHP may require proof of the child's full-time status. "Full-time status" means the child is taking courses for at least 12 credit hours in each academic period. A Subscriber must provide that proof within 31 days of request from the Plan. A full-time student may continue as a Member even if he or she lives outside the Service Area. The Plan will not continue membership for a full-time student after the second limiting age set forth on the Cover Sheet.

2.04 **Commencement of Coverage.** Coverage for a Member under this Agreement shall begin on his or her Enrollment if the Eligibility Tape includes his or her name. Enrollment is contingent upon ASHP's receipt of the applicable Health Plan Premium.

2.05 **Member's Eligibility Not Affected by Health Status.** A Member otherwise eligible and duly enrolled under this Agreement shall not have his or her membership terminated due to the Member's health status or need for Covered Services.

3. GROUP OBLIGATIONS. NOTICES AND HEALTH PREMIUMS.

3.01 **Non-Discrimination.** Group shall allow ASHP to market coverage under this Agreement to all Subscribers and shall offer all Subscribers an opportunity to enroll as a Member under this Agreement on terms no less favorable than Group offers enrollment in other health care services plans or employee health benefits plans.

3.02 **Notices to ASHP.** Group shall forward all completed or amended enrollment forms or other required documents to ASHP for processing within thirty (30) days after Group receives the form from a Subscriber or a Member. Group acknowledges that any enrollment forms or other required documentation not forwarded to ASHP within thirty (30) days may be rejected by ASHP. Group shall forward all notices of termination to ASHP within thirty (30) days after a Member loses eligibility or elects to terminate membership under this Agreement. Group shall be responsible for Health Plan Premiums for any Members through the last day of the month in which notice of termination is received by ASHP. Group shall also submit to ASHP on or before the first Friday of each month an Eligibility Tape.

3.03 **Notices to Members.** In the event of the termination of this Agreement pursuant to Section 9.02 herein, Group shall promptly notify all Members of the termination of their membership under this Agreement. Group shall provide such notice by delivering to each Subscriber a true, legible copy of the Notice of Termination sent from ASHP to Group at the Subscriber's last known address. Group shall promptly provide ASHP with a copy of the Notice of Termination delivered to each Subscriber, along with evidence of the date the notice was provided. In the event of an increase in Copayments or Health Plan Premiums or a reduction in the benefits provided under this Agreement for any reason, Group shall provide

notice to all Members of such benefit reduction or Health Plan Premium or Copayment increase within thirty (30) days of Group's receipt of such notice from ASHP. ASHP shall have no responsibility to Members in the event Group fails to provide notices required by this Section 3.03.

3.04 **Rates.** ASHP shall provide or arrange Covered Services for each Member for which Health Plan Premiums are received by ASHP. Health Plan Premiums are set forth on the Cover Sheet. The applicability of any employee contribution toward Health Plan Premiums shall be determined by Group.

3.05 **Due Date.** Health Plan Premiums are due on a monthly basis and shall be paid directly by Group to ASHP on or before the first day of the month of coverage for which Covered Services may be provided or arranged.

3.06 **Modification of Rates and Benefits.** The Health Plan Premiums set forth on the Cover Sheet and the benefits set forth in Attachment A and in the ASHP Enrollment Packet may be modified by ASHP in its sole discretion upon thirty (30) days written notice mailed postage prepaid to Group, subject to the jurisdiction and approval of the California Department of Managed Health Care. Any such modification shall take effect commencing the first full month following the expiration of the 30-day notice period. In addition, if the State of California or any other taxing authority imposes upon ASHP a tax or license fee which is levied upon or measured by the monthly amount of Health Plan Premiums or by ASHP's gross receipts or any portions of either, then ASHP may modify the Health Plan Premiums in the same manner which shall take effect in the same manner as specified above in this Section 3.06 to include a pro rata amount sufficient to cover all such taxes and license fees attributable to the Health Plan Premiums or gross receipts paid or payable by Group to ASHP, rounded to the nearest cent, and shall remit payment of such amount in accordance with the written instructions provided by ASHP to Group.

This Agreement may be amended or modified without the consent of any Member.

3.07 **Payments Made in Error.** If ASHP pays any fees for services which were not authorized by ASHP as required by this Agreement or which were not provided (a) in an initial examination by a Participating Provider or in the provision or commencement, in the initial examination, of Medically Necessary Services that are Covered Services, to the extent consistent with professionally recognized standards of practice, or (b) as Emergency Services, the Member who received those services shall reimburse ASHP for such payment. When ASHP authorizes a treatment plan, the authorized services for the subsequent office visits covered by the treatment plan include not only the authorized services, but also a brief re-examination in each subsequent office visit without additional authorization by ASHP. Failure to reimburse ASHP or reach reasonable accommodations with ASHP concerning repayment within thirty (30) days after ASHP's request for reimbursement shall be grounds for termination of Member's membership pursuant to the Subparagraph 10.01.01 of this Agreement. The exercise of ASHP's right to terminate a Member's membership shall not affect ASHP's right to reimbursement from Member.

3.08 **Effect of Payment.** Except as otherwise provided in this Agreement, only Members for whom Health Plan Premiums are received by ASHP are entitled to receive Covered Services, and then only for the period for which such payment is received.

3.09 **Notice of Provider Termination.** ASHP shall provide written notice to Group within thirty (30) days if a Participating Provider terminates or materially breaches an agreement with ASHP or becomes unable to perform under such agreement if, in the reasonable estimation of ASHP, Group may be materially or adversely affected thereby. If any of ASHP's agreements with its Participating Providers is terminated, ASHP shall continue to be liable for payment for Covered Services rendered by the applicable provider, less Copayments, to Members under such provider's care at the time of termination until such services are completed, unless ASHP makes reasonable and medically appropriate provisions for the assumption of those Covered Services by another Participating Provider.

3.10 **Executive Order.** Group hereby agrees to comply with Executive Order 11246, as amended, and its implementing regulations (including the Equal Opportunity clause set forth in Section 202 of such Order) and Section 60-1.4 (a) of the regulations of the Secretary of Labor, Title 41 CFR, Chapter 60, Parts

1-60, which are incorporated into this Agreement by reference. In addition, this Agreement incorporates by reference the Affirmative Action clauses of the Rehabilitation Act of 1973 at 41 CFR Section 60-741.1, and the Vietnam Era Veterans Readjustment Act of 1974, at CFR Section 60-2050.4, as amended.

4. BENEFITS AND CONDITIONS FOR COVERAGE.

4.01 **Benefits.** Subject to all terms, conditions, exclusions, and limitations set forth in this Agreement, all Members, upon receipt by ASHP of all applicable monthly Health Plan Premium payments, shall be entitled to Covered Services under this Agreement.

4.02 **Pre-Authorization for Covered Services.** Except for (a) an initial examination by a Participating Provider and the provision or commencement, in the initial examination, of Medically Necessary Services that are Covered Services, to the extent consistent with professionally recognized standards of practice and (b) Emergency Services, all Covered Services received by a Member must be pre-authorized by ASHP. When ASHP authorizes a treatment plan, the authorized services for the subsequent office visits covered by the approved treatment plan include not only the authorized services but also a brief re-examination in each subsequent office visit, if deemed necessary by Participating Provider, without additional authorization by ASHP.

ASHP will apply its Utilization Management Program to the pre-authorization process. ASHP's Vice President of Chiropractic Services and/or Director of Chiropractic Services will decide whether Chiropractic Services are or were Medically Necessary Services and therefore are or were Covered Services. ASHP's Director of Acupuncture Services will decide whether Acupuncture Services are or were Medically Necessary Services and therefore are or were Covered Services. ASHP may use utilization review procedures that it has developed for this purpose. ASHP will disclose to Group or to a Member, on request, the process that it uses to approve or deny services under this Agreement. ASHP must approve the provision of any services other than (a) an initial examination by a Participating Provider and the provision or commencement, in the initial examination, of Medically Necessary Services that are Covered Services, to the extent consistent with professionally recognized standards of practice and (b) Emergency Services, including, without limitation, any referral of a Member for x-ray services, radiological consultations, or laboratory services. When ASHP authorizes a treatment plan, the authorized services for the subsequent office visits covered by the approved treatment plan include not only the authorized services but also a brief re-examination in each subsequent office visit, if deemed necessary by Acupuncturist, without additional authorization by ASHP.

4.03 **Payment of Claims (Reimbursement Provisions).** ASHP will pay claims for Emergency Services that are Covered Services and for other Covered Services that are not available and accessible to a Member and either are provided upon a referral by ASHP or, with regard to radiology and clinical laboratory services for acupuncture enrollees, are provided upon referral by a Participating Acupuncturist.

A Member may be liable to a provider for such Covered Services if the provider is not a Participating Provider. If a Member must pay for such Covered Services, ASHP will reimburse the Member. When a Member receives a bill from a provider for such Covered Services, the Member must file a claim with ASHP. If the Member has not paid the bill, ASHP will pay the provider. If the Member has paid the bill, ASHP will pay that amount to the Member. The Member must pay the Co-payment for any such Covered Services.

Members must file claims for Emergency Services or other Covered Services within ninety (90) days after receiving the Emergency Services or other Covered Services. If it is not reasonably possible for a Member to file a claim for Emergency Services or other Covered Services within ninety (90) days, the Member must file the claim as soon as reasonably possible after the end of the ninety (90) day period. A Member must use ASHP's forms in filing a claim and should send the claim form to ASHP at the address listed in the claim form or to ASHP at:

American Specialty Health Plans of California, Inc.
P.O. Box 509002
San Diego, CA 92150-9002

Attention: Claims Department

ASHP will give claim forms to Members on request. For more information regarding claims, and to obtain an ASHP claim form, Members may call ASHP at 1-800-678-9133 or write ASHP at the address given immediately above.

4.04 **Program Identification Stickers.** Identification stickers issued by ASHP to Members are for identification. To be entitled to Covered Services, the holder of an identification sticker must be a Member on whose behalf all applicable Health Plan Premiums have been received by ASHP.

4.05 **Copayments.** Copayments, when applicable, must be paid by a Member at the time Covered Services are rendered. A schedule of the applicable Copayments is set forth in the Schedule of Benefits, incorporated herein and attached hereto as Attachment A.

4.06 **Payment for Non-Covered Services.** ASHP or the Participating Provider may collect directly from the Member for non-covered services or for services rendered due to fraud or misrepresentation by Member.

4.07 **Emergency Services.** Emergency Services may be provided to a Member without pre-authorization from ASHP. If ASHP decides that the services rendered to Member were not Emergency Services, ASHP shall have no responsibility to cover such services. Continuing or follow-up treatment after Emergency Services have been rendered must be pre-authorized and coordinated by ASHP.

4.08 **Continuity of Care**. A Member receiving Covered Services from a Participating Chiropractor or a Participating Acupuncturist at the time that Participating Provider's contract terminates with ASHP may continue to receive Covered Services from that provider for a period of time on the terms set forth in this Section 4.08. The Member must be receiving Covered Services for an acute condition, a serious chronic condition, or a pregnancy at the time the provider's contract with ASHP terminates. ASHP need not allow the Member to continue to receive Covered Services from that provider if the provider voluntarily terminated his or her contract with ASHP or if the provider does not agree in writing to be subject to the same contract provisions that existed before termination. A Member may contact ASHP in writing or by telephone to request continuity of care in such a situation. ASHP can be reached by calling 800-678-9133 or by writing to Member Services Department, American Specialty Health Plans of California, Inc., P.O. Box 509002, San Diego, CA 92150-9002.

5. LIMITATION OF BENEFITS

5.01 **Acts Beyond ASHP's Control.** In the event of circumstances not reasonably within the control of ASHP, such as any major disaster, epidemic, earthquakes, complete or partial destruction of ASHP, war, riot, or civil insurrection, which results in the unavailability of ASHP's personnel or the Participating Providers, ASHP and the Participating Providers shall provide or arrange Covered Services insofar as practical, according to their best judgment, within the limitation of such ASHP personnel and the Participating Providers. Neither ASHP nor any Participating Provider shall have any liability or obligation for delay or failure to provide or arrange for Covered Services if such delay or failure is the result of any of the circumstances described above.

6. PARTIES AFFECTED BY THIS AGREEMENT: RELATIONSHIPS BETWEEN PARTIES

6.01 **Member Non-Liability.** California law provides, by statute, that each contract between ASHP and a Participating Provider must provide that, if ASHP fails to pay the Participating Provider, no Member shall be liable to the Participating Provider for any sums owed by ASHP.

6.02 **Participating Provider are Independent Contractors.** ASHP and the Participating Providers are independent contractors. None of the Participating Providers or their employees or agents are employees or agents of ASHP, and none of ASHP's employees or agents are employees or agents of any Participating Provider.

6.03 **Relationship to Parties to this Agreement.** Group is not the agent or representative of ASHP and shall not be liable for any acts or omissions of ASHP, its agents, employees, or independent contractors, or any other person or organization with which ASHP has made, or hereafter shall make, arrangements for the performance of services under this Agreement. No Member is an agent or representative of ASHP, and no Member shall be liable for any acts or omissions of ASHP, its agents or employees.

7. GRIEVANCE PROCEDURE AND DISPUTE RESOLUTION

7.01 **General.** If a dispute arises under this Agreement that involves a Member, the Member may file a grievance with ASHP under ASHP's Grievance Procedures by calling ASHP at 1-800-678-9133 or by writing ASHP at:

American Specialty Health Plans of California, Inc.
Member Services Department
P.O. Box 509002
San Diego, CA 92150-9002

A Member also may request an ASHP grievance form from any Participating Provider. Section 7.02, below, describes ASHP's Grievance Procedures. ASHP shall not discriminate against a Member solely on the grounds that the Member filed a grievance or quality of care complaint.

If the dispute is not resolved through ASHP's Grievance Procedures and the Member wishes to continue to pursue the resolution of the dispute, the Member must submit the dispute to binding arbitration in accordance with the provisions of Article 16 of this Agreement. Group and ASHP each agrees and acknowledges that Health and Safety Code Section 1363.1 requires that disclosure of the requirement for binding arbitration appear as a separate article in this Agreement.

In some cases, a Member may file a complaint with the Department of Managed Health Care, and a Member may submit a complaint to the Department of Managed Health Care even if the Member has not submitted the dispute to binding arbitration. California law sets forth this right in substantially the following statement:

> The California Department of Managed Health Care is responsible for regulating health care service plans. The department has a toll-free telephone number **(1-800-400-0815)** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers (**1-800-735-2929 (TTY)** or **1-888-877-5378 (TTY)**) to contact the department. The department's Internet website **(http://www.hmohelp.ca.gov)** has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at **1-800-678-9133** and use the plan's grievance process before contacting the department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. The plan's grievance process and the department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

7.02 **ASHP Grievance Process.** ASHP shall respond to any complaint or grievance received from a Member in accordance with ASHP's Grievance Procedures, as filed with the California Department of Managed Health Care under the Knox-Keene Health Care Service Plan Act of 1975.

7.02.01 As of the date of this Agreement, ASHP's Grievance Procedures, which ASHP has filed with the Department of Managed Health Care, provide that a complaint or grievance that might involve a quality of care issue or any other clinical issue with regard to chiropractic or acupuncture services (a "clinical complaint") will be reviewed by an ASHP Chiropractic Senior Case Manager or an Acupuncture Case Manager, as appropriate, each of whom is a licensed chiropractor or a licensed acupuncturist, respectively. If a complaint or grievance does not involve a quality of care issue or any other clinical issue (an "administrative complaint"), a First Level Review Committee composed of two members of ASHP's Administrative Review Committee will review the complaint or grievance. The Administrative Review Committee includes officers, directors, and employees of ASHP.

7.02.02 ASHP will resolve each clinical complaint within thirty (30) days. If a clinical complaint involves an imminent and serious threat to the health of a Member—including, but not limited to, severe pain, potential loss of life, limb, or major bodily function—ASHP will review the clinical complaint on an expedited basis and will send the Member (and, if appropriate, the Department of Managed Health Care) a written statement that sets forth the disposition or status of the clinical complaint within three (3) days from receipt of the clinical complaint.

If a Member is dissatisfied with the initial determination of a clinical complaint made by an ASHP Chiropractic Senior Case Manager or an Acupuncture Case Manager, the Member may request a redetermination by ASHP's Vice President of Chiropractic Services and/or Director of Chiropractic Services or Director of Acupuncture Services, as appropriate, each of whom is a licensed chiropractor or a licensed acupuncturist, respectively. The Member may do so by submitting a written request to ASHP's Vice President of Chiropractic Services and/or Director of Chiropractic Services or Director of Acupuncture Services, as appropriate, within thirty (30) days from the Member's receipt of a written statement that sets forth the initial determination made by the Chiropractic Senior Case Manager or the Acupuncture Case Manager. ASHP's Vice President of Chiropractic Services and/or Director of Chiropractic Services or Director of Acupuncture Services shall send the Member a written statement of the redetermination made by ASHP's Vice President of Chiropractic Services and/or Director of Chiropractic Services or Director of Acupuncture Services and shall do so within thirty (30) days from the date of receipt of the request for redetermination.

If the Member is dissatisfied with the redetermination made by ASHP's Vice President of Chiropractic Services and/or Director of Chiropractic Services or Director of Acupuncture Services, the Member may request a final redetermination by ASHP's Chiropractic Quality Improvement Committee (the "Chiropractic QIC") or ASHP's Acupuncture Quality Improvement Committee (the "Acupuncture QIC"), as appropriate, or ASHP's Chiropractic Utilization Management Committee (the "Chiropractic UMC") or ASHP's Acupuncture Utilization Management Committee (the "Acupuncture UMC"), as appropriate. The Member may do so by submitting a written request to the Chiropractic QIC or Acupuncture QIC, as appropriate, or the Chiropractic UMC or Acupuncture UMC, as appropriate, within thirty (30) days from the Member's receipt of a written statement that sets forth the redetermination made by ASHP's Vice President of Chiropractic Services and/or Director of Chiropractic Services or Director of Acupuncture Services. The Chiropractic QIC or the Acupuncture QIC, as appropriate, or the Chiropractic UMC or the Acupuncture UMC, as appropriate, shall send the Member a written statement of final redetermination made by the Chiropractic QIC, Acupuncture QIC, Chiropractic UMC, or Acupuncture UMC and shall do so within thirty (30) days from the date of receipt of the request for final redetermination.

The written statement of redetermination from ASHP's Vice President of Chiropractic Services and/or Director of Chiropractic Services or Director of Acupuncture Services, as appropriate, will indicate whether a request for final redetermination should go to the Chiropractic QIC, Acupuncture QIC, Chiropractic UMC, or Acupuncture UMC. The Chiropractic QIC or Acupuncture QIC will make any final redetermination of a clinical complaint to the extent it does not involve a determination as to the status of services as Medically Necessary Services, and the Chiropractic UMC or the Acupuncture UMC will make any final redetermination of a clinical complaint to the extent it does involve a determination of the status of services as Medically Necessary Service. The Chiropractic QIC and the Chiropractic UMC each is composed solely of licensed

chiropractors. The Acupuncture QIC and the Acupuncture UMC each is composed solely of licensed acupuncturists.

If the Member is still dissatisfied, the Member may submit the clinical complaint to binding arbitration, as discussed above, and, as also discussed above, a Member may submit a clinical complaint to the Department of Managed Health Care even if the Member has not submitted the dispute to binding arbitration. If the Member does not submit a request for binding arbitration within sixty (60) days from the Member's receipt of the written statement of final redetermination by the Chiropractic QIC, Acupuncture QIC, Chiropractic UMC, or Acupuncture UMC, the final redetermination made by the Chiropractic QIC, Acupuncture QIC, Chiropractic UMC, or Acupuncture UMC shall be final and binding.

7.02.03 ASHP will resolve each administrative complaint within thirty (30) days. If an administrative complaint involves an imminent and serious threat to the health of a Member—including, but not limited to, severe pain, potential loss of life, limb, or major bodily function—ASHP will review the administrative complaint on an expedited basis and will send the Member (and, if appropriate, the Department of Managed Health Care) a written statement that sets forth the disposition or status of the clinical complaint within three (3) days from receipt of the clinical complaint.

If a Member is dissatisfied with the initial determination of an administrative complaint made by the First Level Review Committee, the Member may request a redetermination by the entire Administrative Review Committee. The Member may do so by submitting a written request to the Administrative Review Committee within thirty (30) days from the Member's receipt of a written statement that sets forth the initial determination made by the First Level Review Committee. The Administrative Review Committee shall send the Member a written statement of the redetermination made by Administrative Review Committee and shall do so within thirty (30) days from the date of receipt of the request for redetermination.

If the Member is dissatisfied with the redetermination made by the Administrative Review Committee, the Member may request a final redetermination by ASHP's President. The Member may do so by submitting a written request to ASHP's President within thirty (30) days from the Member's receipt of a written statement that sets forth the redetermination made by the Administrative Review Committee. ASHP's President shall send the Member a written statement of final redetermination made by ASHP's President and shall do so within thirty (30) days from the date of receipt of the request for final redetermination.

If the Member is still dissatisfied, the Member may submit the administrative complaint to binding arbitration, as discussed above, and, as also discussed above, a Member may submit an administrative complaint to the Department of Managed Health Care even if the Member has not submitted the dispute to binding arbitration. If the Member does not submit a request for binding arbitration within sixty (60) days from the Member's receipt of the written statement of final redetermination by ASHP's President, the final redetermination made by ASHP's President shall be final and binding.

7.02.04 ASHP shall provide Group with a copy of ASHP's Grievance Procedures, as filed with the California Department of Managed Health Care, at any time on request by Group.

7.03 **Arbitration of Disputes Arising from Complaints.** ASHP and Group agree and acknowledge that, to the extent ASHP's Grievance Procedures require or permit arbitration of a dispute that arises from a Member complaint, Article 16 of this Agreement sets forth standards and requirements that will apply to the arbitration.

7.04 **Member Claims Against Participating Providers.** Group acknowledges ASHP's Participating Providers are independent contractors and that ASHP does not assume responsibility for the acts of its Participating Providers.

A Member's claims for damages as a result of an injury caused or alleged to have been caused by an act or failure to act by a Participating Provider are not governed by this Agreement. A Member may seek appropriate legal action against such Participating Provider.

In the event of dispute between a Member and a Participating Provider which is not governed by this Agreement, upon mutual agreement between the Member and the Participating Provider, ASHP agrees to make available its Grievance Procedures for resolution of such dispute. In such instance, the decisions made under the Grievance Procedures shall not be binding upon the parties except upon agreement between the parties. Such grievances shall not be subject to binding arbitration, except upon agreement between the parties.

7.05 **Group Referral of Complaints.** Group shall refer all Member complaints related to Covered Services to ASHP. Group shall also provide Members who contact Group with a complaint or concern regarding Covered Services with ASHP's toll-free number, 1-800-678-9133.

7.06 **Disputes Between ASHP and Group.** All disputes between Group and ASHP shall be resolved by binding arbitration before the American Arbitration Association. Upon submission of a dispute to the American Arbitration Association, Group and ASHP agree to be bound by the rules of procedure and decision of the American Arbitration Association. The provisions of California Code of Civil Procedure, Section 1283.05, permitting the taking of depositions and the obtaining of discovery, shall be incorporated into and made applicable to this Agreement.

8. TERM OF AGREEMENT: AUTOMATIC RENEWAL

8.01 **Term: Automatic Renewal.** The term of this Agreement shall be one (1) year commencing on the date of execution of this Agreement, unless otherwise indicated on the Cover Sheet. This Agreement shall automatically renew for a one (1) year term on each anniversary of the date of commencement of this Agreement, or as indicated on the Cover Sheet, unless terminated as provided herein.

9. TERMINATION OF GROUP COVERAGE.

9.01 **Termination by Group.** Group may terminate this Agreement by giving ASHP thirty (30) days prior written notice of termination. Group shall continue to be liable for Health Plan Premiums for all Members until this Agreement terminates.

9.02 **Termination by ASHP.**

9.02.01 **For Nonpayment of Health Plan Premiums.** ASHP may terminate this Agreement if Group or its designee fails to remit Health Plan Premiums to ASHP by the required date by giving Group written notice of termination of this Agreement. Such notice shall specify that payment of all unpaid Health Plan Premiums must be received by ASHP within fifteen (15) calendar days of the date of receipt of the notice and that, if payment is not received within such fifteen (15) calendar day period, no further notice shall be given and coverage for all Members enrolled under this Agreement shall terminate effective at the end of the month for which premiums have been actually received by ASHP. Reinstatement of this Agreement may occur only by submitting a new application for Enrollment for each Member in accordance with current eligibility and Enrollment requirements and execution of a new agreement. Group shall be liable for any unpaid Health Plan Premiums due for coverage prior to the effective date of Group termination.

9.02.02 **For Breach of Material Term.** ASHP may terminate this Agreement if Group breaches any material term, covenant or condition of this Agreement and fails to cure such breach within thirty (30) days of receiving written notice of such breach from ASHP. ASHP's written notice of breach shall make specific reference to Group's action causing such breach. If Group fails to cure its breach to ASHP's satisfaction within thirty (30) days of receiving notice of breach from ASHP, ASHP may terminate this Agreement at the end of the thirty (30) day notice period.

9.02.03 **For Providing Misleading or Fraudulent Information.** ASHP may terminate this Agreement upon thirty (30) days written notice to Group if Group provides misleading or fraudulent information to ASHP in any Group questionnaires or enrollment forms.

9.03 **Proration of Health Plan Premiums.** Any portion of the Health Plan Premium received by ASHP or payable to ASHP which corresponds to any unexpired full month for which payment is received or is payable, shall be prorated and returned by Group together with any other amounts due, less any offsets, within thirty (30) days of termination.

10. TERMINATION OF MEMBERSHIP.

10.01 **Termination.** The rights of a Member under this Agreement shall terminate upon occurrence of any of the following:

10.01.01 **Termination of Agreement by Group.** If Group voluntarily terminates this Agreement pursuant to Subparagraph 9.01 of this Agreement. Each Member's membership under this Agreement shall terminate at the end of the month for which the last Health Plan Premium is received by ASHP from Group on the Member's behalf.

10.01.02 **Nonpayment of Health Plan Premiums, Copayments or Fees for Non-covered Services.** Any Member for whom the applicable Health Plan Premium is not paid may have his or her membership under this Agreement terminated by ASHP within fifteen (15) days after mailing written notice of termination for nonpayment to the Group. Such notice shall state that the receipt by ASHP of the applicable Health Plan Premium within fifteen (15) days shall cause ASHP to revoke the notice. The notice of termination shall be revoked and membership under this Agreement shall continue without interruption upon the receipt of the applicable Health Plan Premium.

The failure of any Member to pay any Copayment or to reimburse ASHP for payments made in error by ASHP within fifteen (15) days after the mailing of written notice of termination from ASHP shall result in the termination of Member's membership under this Agreement. To reinstate coverage, Member must submit a new application for membership and comply with all applicable eligibility requirements.

If ASHP terminates the membership of any Member based on non-payment of Health Plan Premiums, the Member's benefits shall cease fifteen (15) days after the Group's receipt of the written notice of termination for non-payment from ASHP. Termination of benefits shall apply to all benefits, including benefits for a Member who is hospitalized or undergoing treatment for an on-going condition, to the extent the Member receives those benefits after the effective date of the termination.

10.01.03 **Member Permanently Moves Out of Service Area.** A Member's membership under this Agreement shall terminate in the event either: (1) Member is absent from the Service Area for 90 consecutive days, or (b) Member moves from the Service Area without the intent to return. Termination shall be effective the last day of the month in which Member receives notice of termination from ASHP. Notice sent to the Member's last-known address shall be deemed effective notice for purposes of this Section 10.01.03.

10.01.04 **Member's Loss of Eligibility.** A Member's membership under this Agreement shall terminate on the last day of the month in which Member's eligibility ceases. The Member shall be eligible for continuing benefits as set forth in Article 11.

a. **Dissolution of Subscriber's Marriage. Dependent Eligibility.** A spouse's membership as a Dependent of a Subscriber shall terminate on the first day of the month following the month in which a final judgment or decree of dissolution of marriage is entered. A child's membership as a Dependent of the Subscriber shall continue notwithstanding dissolution of Subscriber's marriage for as long as Dependent child remains eligible and Health Plan Premiums are received by ASHP.

10.01.05 **Fraud or Deception.** ASHP may terminate a Member's membership under this Agreement immediately for fraud or deception in the use of the services or facilities of ASHP or knowingly permitting such fraud or deception by another. Fraud or deception shall include, without limitation, when a Member allows someone else to use his or her identification card or identification sticker or otherwise assisting anyone who is not entitled to receive Covered Services to receive Covered Services. The termination shall take effect on the day after the Member receives written notice of the termination from ASHP.

10.01.06 **Disenrollment for Cause.** A Member's membership under this Agreement may be terminated for cause if the Member's behavior is of a violent or seriously abusive nature that may seriously threaten or jeopardize the safety of ASHP, any employee or agent of ASHP, any Participating Provider, or any employee, agent, or patient of a Participating Provider. A termination for cause under this Section 10.01.06 shall take effect on the day after the Member receives written notice of the termination from ASHP.

10.01.07 **Voluntary Disenrollment by Member.** A Member may voluntarily disenroll by submitting a writing request for disenrollment to Group in a manner to be determined by Group; provided Group allows for such voluntary disenrollment. Group shall forward all such requests to ASHP for processing. Group shall be responsible for any Member premiums through the last day of the first full month after notice of disenrollment is received by ASHP.

10.02 **Written Notice of Termination.** A Member who alleges that his or her membership has been cancelled or not renewed because of the Member's health status or requirements for health care services may request a review of the cancellation by the Commissioner of Managed Health Care. When a written notice of termination is sent to the Member pursuant to Article 9 or 10 of this Agreement, it shall be dated and state:

a. The cause of termination with specific reference to the Section of this Agreement giving rise to the right of termination:

b. That the cause for termination was not the Member's health status or requirements for health care services;

c. The effective date of termination;

d. That notwithstanding the Grievance Procedures, the Member may request a review before the Commissioner of Managed Health Care for the State of California, if Member believes that his or her membership has been cancelled or not renewed because of Member's health status or requirements for health care services.

10.03 **No Liability After Termination.** Upon termination of this Agreement for any reason, ASHP shall have no further liability to provide benefits to any Member under this Agreement, other than continuity of care benefits in accordance with the provisions of Section 4.08 of this Agreement. A Member's rights to receive benefits hereunder shall cease upon the effective date of termination.

11. CONTINUATION OF BENEFITS.

11.01 **Continuation of Benefits Under COBRA.** ASHP shall make available continuation coverage under this Agreement to Members entitled to continuation: provided that Group requests such coverage and the coverage is required under the Consolidation Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended. The continuation coverage under this Section 11.01 shall be equal to, and subject to the same limitations as, the benefits provided to other Members enrolled by Group under this Agreement.

12. **THIRD PARTY LIABILITY.**

12.01 **Third Party Liability.** In the case of injuries caused by any act or omission of a third party, and any complications incident thereto, the benefits of this Agreement shall be furnished by ASHP to Member. The Member shall reimburse ASHP, or its nominee, for the cost of all such services and benefits immediately upon obtaining a monetary recovery, whether due to a final judgment, compromise or settlement agrement, on account of such injury. The cost shall equal any reasonable costs actually paid by ASHP to perfect the lien plus the amounts paid by ASHP pursuant to this Agreement to any treating provider. The Member shall hold any such sum in trust for ASHP, but, notwithstanding the foregoing, said sum shall not exceed one-third of the moneys due to the Member under any final judgment, compromise, or settlement agreement if the Member engaged an attorney or one-half of the moneys due to the Member under any final judgment, compromise, or settlement agreement if the Member did not engage an attorney. Where a final judgment includes a special finding by a judge, jury or arbitrator that a Member was partially at fault, the lien shall be reduced by the same comparative fault percentage by which the Member's recovery was reduced. ASHP's lien is subject to a pro rata reduction commensurate with the Member's reasonable attorney's fees and costs in accordance with the common fund doctrine. The restrictions set forth in this paragraph shall not apply to a lien made against a workers' compensation claim, a lien for Medi-Cal benefits pursuant to Article 3.5 (commencing with Section 14124.70) of Chapter 7 of Part 3 of Division 9 of the California Welfare and Institutions Code, or a lien for hospital services pursuant to Chapter 4 of the California Civil Code (commencing with Section 3045.1).

Subject to the foregoing, reimbursement of ASHP under this Section 12.01 shall be the first priority claim against any third party. This means that ASHP shall be reimbursed from any recovery from a third party before payment of any other existing claims, including any claim by the Member for general damages. ASHP may collect from the proceeds of any final judgment, compromise, or settlement agreement recovered by the Member or his or her legal representative.

ASHP may require the Member to cooperate in protecting ASHP's interests under this Section 12.01 and to execute and deliver to ASHP or its nominee any and all liens, assignments or other documents which may be necessary or proper to fully and completely effectuate and protect ASHP's rights, or its nominee, including, but not limited to, the granting of a lien right in any claim or action made or filed on Member's behalf and the signing of documents evidencing the same.

The Member shall not be entitled to settle any claim, or release any person from liability, without ASHP's prior written consent, if such release or settlement will extinguish or act as a bar to ASHP's right of reimbursement.

In the event ASHP employs an attorney for the purpose of enforcing any part of this section against a Member based on the Member's failure to cooperate with ASHP, the prevailing party in any legal action or proceeding shall be entitled to reasonable attorney's fees.

In lieu of payment as indicated above, ASHP, at it's option, may choose subrogation to the Member's rights to the extent of the benefits received under this Agreement. ASHP's subrogation right shall include the right to bring suit in the Member's name. ASHP may require the Member to cooperate with ASHP when ASHP exercises its right of subrogation, and the Member shall not be entitled to take any action or refuse to take any action which should prejudice the rights of ASHP under this Section 12.01.

13. **NON-DUPLICATION OF BENEFITS/COORDINATION OF BENEFITS.**

13.01 **Worker's Compensation.** ASHP shall not furnish benefits under this Agreement to any Member which duplicate the benefits to which the Member is entitled under any applicable workers' compensation law. The Member shall be responsible for taking whatever action is necessary to obtain payment under workers' compensation laws where payment under that system can be reasonably expected. Failure to take proper and timely action under such circumstances will preclude ASHP's responsibility for furnishing such benefits on behalf of the Member to the extent that payment of such benefits could have been reasonably expected under workers' compensation laws had action been taken.

If ASHP for any reason provides benefits which duplicate the benefits to which a Member is entitled under workers' compensation law, ASHP may require the Member to reimburse ASHP, or its nominee, for the cost of all such services and benefits provide by ASHP, at Prevailing Rates, immediately upon obtaining a monetary recovery, whether due to settlement or judgment. The Member shall hold any sum collected as the result of a workers' compensation action in trust for ASHP. Such sum shall not exceed the lesser of the amount of the recovery obtained by the Member or the reasonable value of all services and benefits furnished to the Member or on the Member's behalf by ASHP on account of each incident.

ASHP may require the Member to cooperate in protecting ASHP's interests under this Section 13.01 and to execute and deliver to ASHP or its nominee any and all liens, assignments, or other documents which may be necessary or proper to fully and completely effectuate and protect ASHP's rights, or its nominee, including, but not limited to, the granting of a lien right in any claim or action made or filed on Member's behalf and the signing of any documents evidencing such lien. The Member's failure to cooperate reasonably with ASHP as provided in this Section 13.01 may result in termination of the Member's membership under this Agreement.

13.02 **Automobile Accident or Liability Coverage.** ASHP shall not furnish benefits under this Agreement which duplicates the benefits to which a Member is entitled under any other automobile accident or liability coverage. The Member shall be responsible for taking whatever action is necessary to obtain the benefits of such coverage and shall notify ASHP of such coverage. If payment of services are provided by ASHP in duplication of the benefits available to Member under other automobile, accident or liability coverage, ASHP may seek reimbursement to the extent of the reasonable value of the benefits provided by ASHP from the insurance carrier, provider and Member.

If the cost of Covered Services exceeds any other applicable coverage pursuant to this Section 13.04, ASHP benefits shall be provided over and above such coverage.

13.03 **Coordination of Benefits.** All of the benefits provided under this Agreement are subject to coordination of benefits. Coordination of benefits rules shall be applied by ASHP in accordance with the coordination of benefits regulations, and interpretive instructions, promulgated by the California Department of Managed Health Care, as amended from time to time, which are incorporated into this Agreement.

13.04 **Dual Membership**. If an individual is a Subscriber and his or her wife or husband also is a Subscriber, then, to the extent this Agreement allows a Dependent of a Subscriber to become a Member, each may become a Member. Each then may enroll the other and their Dependents as Members. If this happens, the individual and his or her wife or husband each may claim the combined maximum benefits to which such an individual is entitled under this Agreement. No one may claim benefits that exceed 100% of the charges for Covered Services.

14. MISCELLANEOUS PROVISIONS.

14.01 **Governing Law.** This Agreement is subject to the laws of the State of California, specifically, the Knox-Keene Health Care Service Plan Act of 1975, as amended, and the regulations promulgated thereunder by the California Department of Managed Health Care. Any provision required to be in this contract by any of the above shall bind ASHP and Group whether or not expressly provided in this Agreement.

14.02 **Use of Name in Promotional/Marketing Materials.** ASHP reserves the right to control all use of its name, symbols, trademarks, or service marks currently existing or later established. However, either party may use the other party's name, symbols, trademarks or service marks with the prior written or verbal approval of the other party in advertising or other promotional materials relating to this Agreement.

14.03 **Assignment.** This Agreement 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 ASHP assigns, sells, or otherwise transfers substantially all of its assets and business to another corporation, firm, or person, with or without recourse, this Agreement will continue in full force and effect as if such corporation, firm or person were a party to this Agreement provided such corporation, firm, or person continues to provide Covered Services.

14.04 **Validity.** The unenforceability or invalidity of any paragraph of this Agreement shall not affect the enforceability and validity of the balance of this Agreement.

14.05 **Confidentiality.** ASHP agrees to maintain and preserve the confidentiality of Members' medical records in accordance with state and federal laws. However, a Member authorizes the release of information and access to Member's medical records for purposes of utilization review, quality assurance, processing of any claim, financial audit, coordination of benefits, or for any other purpose reasonably related to the provision of benefits under this Agreement to ASHP, its agents and employees, a Member's Participating Provider, and appropriate governmental agencies. When required by law, ASHP shall obtain Member's specific written authorization for the release of Member's medical records.

14.06 **Amendments.** Amendments to this Agreement shall be valid only if made in writing and signed by both ASHP and Group, except that any amendment which is necessary to comply with California and/or federal regulations or law, shall not require Group's signature and shall be automatically incorporated into this Agreement upon receipt by Group.

14.07 **Attachments.** The Cover Sheet and Attachment A attached hereto are incorporated by reference and made an integral part of this Agreement.

14.08 **Waiver of Default.** The waiver by ASHP of any one or more defaults by Group or 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.

14.09 **Notice.** Any notice required to be given to Group or ASHP hereunder shall be in writing and either delivered personally or sent by registered or certified mail, return receipt requested, to either Group or ASHP at the addresses listed below, or at such other addresses as either Group or ASHP may hereafter designate to the other:

To ASHP: American Specialty Health Plans of California, Inc.
P.O. Box 509002
San Diego, Ca 92150-9002
Attn.: President

To Group: See Address on Signature Page.

All notices shall be deemed given on the date of delivery if delivered personally or three (3) business days after such notice is deposited in the United States mails, addressed and sent as provided above.

14.10 **No Refusal Based on Impairment.** ASHP will not refuse to cover, refuse to continue to cover, or limit the amount, extent, or kind of coverage available to a Member, or charge a different premium, solely because of a physical or mental impairment unless based on sound actuarial principles applied to actual experience or sound underwriting practices.

14.11 **No Exception for Medi-Cal Coverage.** This Agreement does not provide any exception for other coverage where the other coverage is entitlement to: (a) Medi-Cal benefits under Chapter 7 or Chapter 8 of Part 3 of Division 9 of the California Welfare and Institutions Code; or (b) Medicaid benefits under Subchapter XIX (beginning with Section 1396) of Chapter 7 of Title 42 of the United States Code. This Agreement also does not provide an exemption for enrollment because a Member is entitled to such Medi-Cal or Medicaid benefits.

15. **EXECUTION.**

15.01 **Execution of Agreement.** Group and ASHP accept the terms, conditions and provisions of this Agreement upon execution of this Agreement. Each Member shall be bound by this Agreement and the terms, conditions and provisions of any enrollment form or similar form signed by the Member or by a Subscriber, if the Member is a Dependent of the Subscriber.

16. **DISPUTE RESOLUTION.**

16.01 **Informal Discussions.** ASHP and Group will attempt to resolve disputes under this Agreement by informal discussions. This Article 16 also will apply to any dispute submitted by a Member under this Agreement through the Grievance Procedures.

16.02 **Arbitration.**

16.02.01 If a dispute involving a Member cannot be resolved using informal discussions or through the Grievance Procedures, it will be resolved by binding arbitration.

16.02.02 If a Member wants to settle any dispute under this Agreement, the Member must submit it to binding arbitration after he or she completes ASHP's grievance process. The requirement that a Member submit a dispute to arbitration applies broadly, including to settle any claim of malpractice against ASHP. A Member's claims against a Participating Provider are not subject to this Agreement, except to the extent the Member and the Participating Provider agree to follow and/or be bound by ASHP's Grievance Procedures in accordance with the provisions of Section 7.04, and a Member may seek any appropriate legal action against a Participating Provider deemed necessary.

a. The Member and ASHP will follow applicable law with regard to arbitration and ASHP's arbitration policies. California law may require, for a dispute involving $200,000 or less, that the Member and ASHP select a single, neutral arbitrator. In that situation, the arbitrator will not have the power to award more than $200,000.

b. At the request of a Member, ASHP will send the Member a copy of ASHP's arbitration policies. Those policies, as ASHP may amend them from time to time, will bind the Member and ASHP.

If a Member seeks to arbitrate a dispute under or with regard to this Agreement, the Member must give notice to ASHP, and, if ASHP seeks to arbitrate a dispute, ASHP must give notice to the Member. The notice must contain a demand for arbitration and must describe the dispute, the issues involved, the amount of any claim, and the remedy sought.

Any arbitration under this Agreement will be held in accordance with the Commercial Arbitration Rules of the American Arbitration Association (the "AAA") and must be submitted to the AAA in accordance with those procedures. Any arbitration under this Agreement will be held in California at a location mutually acceptable to the parties, provided that, if the parties cannot agree on a location for the arbitration, the AAA shall specify the location. In cases of extreme hardship, ASHP will pay all or a part of a Member's fees and expenses for a neutral arbitrator.

16.02.03 If a dispute involving ASHP and Group cannot be resolved through informal discussions and Group or ASHP wants to settle the dispute, Group or ASHP must submit it to binding arbitration. Any such arbitration shall be subject to the same policies, require the same type of notice, and be initiated and held in the same manner as set froth in Section 16.02.02, above.

16.02.04 Group and ASHP each hereby agrees and acknowledges that California Health and Safety Code Section 1363.1 requires ASHP to include various statements set forth above in this Agreement as well as the following statement, which is substantially the wording provided by Section 1295(a) of the California Code of Civil Procedure:

> *It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this Agreement were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, and any dispute as to the delivery of services under this Agreement will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this Agreement, by entering into it, are giving up any constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.*

IN WITNESS WHEREOF, the parties hereto have executed this Agreement in San Diego, California, on _____, _____.

American Specialty Health Plans of California, Inc.

By:_____
George DeVries, President
P.O. Box 509002
San Diego, CA 92150-9002

Group

By: _____
Signature
Name:_____

Title: _____

Group Name:_____

Address:_____

Mailstop/Suite:_____

City:_____

Zip:_____ State:_____

Name for Notices per Section 14:

_____

ATTACHMENT L

TO THE

PACIFICARE OF CALIFORNIA

MEDICAL AND HOSPITAL

GROUP SUBSCRIBER AGREEMENT

PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA, INC.
BEHAVIORAL HEALTH SERVICES BENEFIT PLAN

Including Treatment for Severe Mental Illnesses and Serious Emotional Disturbances

Parity Compliant
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01/01/04 Edition
Doc. #7946

PACIFICARE BEHAVIORAL HEALTH OF CALIFORNIA, INC.
BEHAVIORAL HEALTH SERVICES BENEFIT PLAN

PacifiCare of California's Benefit Plan for the treatment of Chemical Dependency and Mental Disorders (the "Benefit Plan") is offered through an arrangement with PacifiCare Behavioral Health of California, Inc. ("PBHC"), a specialized health care service plan licensed under the Knox-Keene Health Care Service Plan Act of 1975. This coverage includes treatment for the Severe Mental Illness ("SMI") of adults and children and treatment for the Serious Emotional Disturbances ("SED") of a child.

I. DEFINITIONS

The definitions below apply only to this PBHC Benefit Plan. Except as provided below, the definitions, terms and conditions for PBHC coverage are the same as for other PacifiCare of California medical services.

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

Appeals Process - The procedure for reviewing Member's complaints and appeals.

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

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 the PBHC Clinician for review as part of the concurrent review monitoring process.

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

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

Parity Compliant
Parity + Supp Att L
1/01/04 Edition
Doc. #7946

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

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

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

Contracted Rate - The rate, or percentage of rate, that the Participating Provider agrees to accept from PBHC as payment in full for covered services, excluding any applicable Copayments payable by the Member.

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

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

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

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

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

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

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

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

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

(1) immediate harm to self or others;
(2) placing the Member's health in serious jeopardy;
(3) serious impairment of the Member's functioning; or
(4) serious dysfunction of any bodily organ or part of the Member.

If a Member is temporarily outside of California, experiences a situation which requires Behavioral Health Services and a delay in treatment from a PBHC Participating Provider in California would result in a serious deterioration to the Member's health, the situation will be considered an Emergency.

Emergency Treatment – Medically Necessary ambulance and ambulance transport services provided through the "911" (or alternative emergency response system) and medical screening, examination and evaluation by a Practitioner, to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if an Emergency for a Behavioral Health Service 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 - Refer to the "Experimental and Investigational Therapies" Section of this Agreement.

Facility - A health care facility which is duly licensed by the state in which it operates to provide inpatient, residential, day treatment, partial hospitalization or outpatient care for the diagnosis and/or treatment of Chemical Dependency or Mental Disorders.

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

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

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

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

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

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

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

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

(a) Rendered for the treatment or diagnosis of a Behavioral Health condition as defined by the DSM-IV;

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

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

(d) If more than one service, supply or level of care meets the requirements, of (a) through (c) above, furnished in the most cost-effective manner which

may be provided safely and effectively to the Member.

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

Mental Disorder - A mental or nervous condition diagnosed by a licensed Practitioner according to the criteria in the DSM-IV and limited to the impairment of a Member's mental, emotional or behavioral functioning on a daily basis. Mental Disorders include Severe Mental Illnesses of a person of any age and Serious Emotional Disturbances of a child.

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

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

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

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

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

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

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

Practitioner - A psychiatrist, psychologist, or other allied behavioral health 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 a written agreement with PBHC to provide Behavioral Health Services to Members.

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

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

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

Schedule of Benefits - The schedule of Behavioral Health Services, which is provided to a Member under this Benefit Plan. The Schedule of Benefits is attached to this Benefit Plan description and is incorporated in full herein. Also see the Schedule of Benefits under the PacifiCare of California Medical Plan.

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

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; and
2) Is under the age of eighteen (18) years old.
3) Furthermore, the child must meet one or more of the following criteria:
    a. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
        (i) the child is at risk of removal from home or has already been removed from the home,
        (ii) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or

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

c. The child meets special education eligibility requirements under Chapter 26.5 commencing with Section 7570 of Division 7 of Title 1 of the California Government Code.

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

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

Service Area - 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.

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

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

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

II. TERMS AND CONDITIONS OF PBHC COVERAGE

2.01 Pre-Authorization for Behavioral Health Services.

Except for Emergency Treatment, all Behavioral Health Services received by a Member must be pre-authorized by a PBHC Clinician in order to qualify for coverage under this Benefit Plan. Members requiring Behavioral Health Services other than in an Emergency must call the PBHC twenty-four (24)

hour Customer Service telephone number 1-800-999-9585. In order to evaluate the nature and severity of the Member's problem, the PBHC Clinician will complete an initial assessment. During this assessment, the Member will be asked a number of questions about the circumstances that are contributing to his/her lack of psychological well being.

If the Member's problem is determined to require Medically Necessary Behavioral Health Services, the PBHC Clinician will recommend the most appropriate treatment for the Member and will contact the Participating Facility or Participating Provider regarding the initially authorized Behavioral Health Services or Behavioral Health Treatment Program. No benefits are provided for services without the prior authorization of PBHC, unless such services are Emergency Treatment and the procedures set forth in Section 2.03, below, are followed.

2.02 Concurrent Review of Behavioral Health Services.

Member shall cooperate with PBHC's concurrent review of Behavioral Health Services, which shall be conducted on a regular basis. The purpose of concurrent reviews is to ensure the effectiveness and appropriateness of the level of care, and to determine the Medical Necessity of a continuous stay and/or treatment.

The PBHC Clinician must authorize all extended lengths-of-stay and transfers to different levels of care as well as any related additional services.

2.03 Emergency Treatment.

Emergency Treatment shall be covered by PBHC if the procedures below are followed.

Step 1: In an Emergency, the Member should get help or treatment immediately. This means the Member should call "911" or alternative emergency response system, or go directly to the nearest health care facility for treatment if they have to.

In a situation which the Member considers Urgent, but not a life-threatening Emergency, the Member or designee should call the Customer Service Department for assistance in finding a Participating Provider near their location. If a Participating Provider cannot be located, they may be sent to a practitioner outside of our PBHC network.

Step 2: Within 48 hours of the Emergency, or as soon as is reasonably possible after the Member's condition has stabilized, the Member, or someone acting on their behalf,

needs to call the PBHC toll-free number. If they do not call PBHC, the Member may have to pay for the treatment.

Step 3: PBHC will arrange follow up Behavioral Health Services after the Member's condition is stable or they have returned to their Service Area. PBHC, in discussion with their physician, may move them to one of its Participating Providers, as long as the move would not harm their health.

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

Definition of Emergency

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

(1) immediate harm to self or others;
(2) placing the Member's health in serious jeopardy;
(3) serious impairment of the Member's functioning; or
(4) serious dysfunction of any bodily organ or part of the Member.

2.04 Continuing Treatment for New Members.

Continuing Treatment is for Members who:

(1) were not offered an out-of-network option or did not have the option to continue with their previous health plan at the time of enrollment under this Plan;
(2) have been eligible and enrolled in this Plan for less than thirty (30) days;
(3) had no other health plan choice other than through PacifiCare's arrangement with PBHC;
(4) are under treatment by a non-participating provider at the time of enrollment for a condition listed in the DSM-IV;
(5) the treatment is a covered Behavioral Health Service or benefit under this Plan; and
(6) have a condition where an immediate change in Practitioner could present a risk of harm to self or others.

Such Behavioral Health Services may be covered by PBHC for the purpose of safely transitioning the Member to a Participating Provider. If the Behavioral Health Services are approved by PBHC, PBHC may cover such services to the extent they would be covered by a Participating Provider under the PBHC Plan.

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

For inpatient treatment, PBHC will conduct a full inpatient assessment by a licensed PBHC Case Manager. If the services received meet the Emergency Services criteria, the PBHC Case Manager will continue to authorize services at the current non-participating facility and/or Practitioner until such time that the Member is determined to be medically stable and able to safely transfer to a Participating Facility. If the services do not meet the Emergency services criteria, as set forth by PBHC, for the level of care being administered, PBHC will authorize the appropriate number of days necessary to treat the condition at the current non-participating facility and arrange for the Member to be safely transferred to a PBHC Participating Facility.

2.05 Continuing Treatment if Participating Provider is Terminated from the PBHC Network.

In the event a Member's Participating Provider is terminated from the PBHC network for reasons other than a medical disciplinary cause, fraud or other criminal activity, the Member may be eligible to continue receiving care from that provider following the termination, provided the terminated provider agrees to the terms and conditions of the terminated provider contract. Continued care from the terminated provider may be for up to ninety (90) days or longer if Medically Necessary for chronic, serious or acute conditions, if they are receiving mental health counseling and are in a crisis period, or until their care can be safely transferred to a PBHC Participating Provider.

In order to exercise this option, the Member, or the Member's designee, must call the PBHC Customer Service Department. If the Member would like to find out more about this option or would like a copy of the PBHC Continuity of Care Policy, they may call the Customer Service Department.

2.06 Appeals Procedure and Dispute Resolution.

PBHC and Member agree to the voluntary resolution of claims relating to the performance of this Agreement by PBHC and Member. The PBHC Appeals Process and Quality Review procedure are designed to ensure that all appeals are handled promptly, investigated thoroughly and resolved in a timely manner.

Appeals not related to quality of care (such as those related to claims payment or coverage) are reviewed in accordance with the Appeals Procedures outlined in Section 2.07 below. Complaints relating to quality of care provided by a PBHC Participating Provider are reviewed in accordance with the Quality Review process described in Section 2.12 below.

If a single appeal involves both quality of care and non-quality of care issues, the entire case will be reviewed through the Quality Review procedure described in Section 2.12, then upon completion of the Quality Review, the Member will be sent an initial determination relating to the non-quality of care issue.

Members may initiate a formal Appeal or Quality Review by calling PBHC at 1-800-999-9585 or by writing to the PBHC Appeals Department. PBHC will not discriminate against a Member on the grounds that the Member initiated an appeal or a quality review inquiry.

2.07 PBHC Appeals Process.

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

2.07.02 A Member or the Member's authorized representative, may initiate this Appeal Process either verbally, by calling the PBHC Customer Service Department toll-free number, or in writing to the address indicated below.

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

Acknowledgment letters are sent to the individual initiating the appeal within five (5) days of receipt of written appeals.

2.07.03 The appeal is reviewed with the PBHC Medical Director, Director of Clinical Services, or designee. The Member is notified in writing of the appeal resolution determination within thirty (30) business days of receipt of the appeal and provided with instructions for initiating an Independent Medical Review ("IMR"), as described later in this Agreement. All determinations and rationale for determinations are documented, in writing, to the Participating Provider and the Member. If PBHC is unable to review the appeal within thirty (30) business days of receipt of the appeal, the individual who initiated the appeal will be notified of the delay, the specific reason for the delay, and the expected date of review.

2.07.04 If the Member is dissatisfied with the determination, the Member or the Member's representative may request an Independent Medical Review within six (6) months of the receipt of the appeal resolution determination. The IMR is available at no charge for PBHC Members who meet certain criteria. Additional information related to the Independent Medical Review Process is included under the Section 2.09 "Independent Medical Review of a Disputed Health Care Service".

2.07.05 If the Member is dissatisfied with the Independent Medical Review determination, the Member may, within sixty (60) days of the determination, submit or request that PBHC submit the appeal to binding arbitration or voluntary mediation before Judicial Automated Management System ("JAMS"), an independent and neutral arbitrator.

However, Members who have legitimate health or other reasons which would prevent them from electing binding arbitration within sixty (60) days will have as long as is necessary to accommodate their special needs in order to elect binding arbitration.

2.07.06 Upon submission of a dispute to JAMS, the Member and PBHC agree to be bound by the rules of procedure and the decision of JAMS. Full discovery shall be permitted in preparation for arbitration pursuant to California Code of Civil Procedure, Section 1283.05. PBHC and the Member understand that by entering into this Agreement, they waive

their constitutional right to have any such dispute decided in a court of law before a jury and instead are accepting the use of arbitration.

2.07.07 Voluntary Mediation. In order to initiate voluntary 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 Commercial Mediation Rules, unless otherwise agreed by the parties. Expenses for mediation shall be borne equally by both parties. The Department of Managed Health Care ("DMHC") shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process.

2.07.08 Binding Arbitration. Any claim, controversy, dispute or disagreement between PBHC and Member which arises out of or is related to this Agreement that is not resolved by the above Appeals Process shall be resolved by binding arbitration by a single arbitrator. If the amount of the claim is less than $200,000, then the arbitrator shall have no jurisdiction to award more than $200,000. JAMS or such other neutral administrator as PBHC shall designate shall administer the arbitration.

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

Arbitration hearings shall be held at the neutral administrator's offices in Los Angeles, California or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration as provided by California law and civil procedure.

2.07.09 The arbitrator(s) selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of California including, but not limited to, the imposition of sanctions. The arbitrator(s) shall have the power to grant all

remedies provided by California law. The arbitrator(s) shall prepare in writing an award that includes the legal and factual reasons for the decision.

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

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

2.07.11 Further, if the Member seeks review by the DMHC at any time after the initial thirty (30) days following the Member's submission of the appeal to PBHC, the Member will have an additional sixty (60) days from the date of the final resolution of the matter by the DMHC to elect binding arbitration.

2.08 Expedited Review Process.

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

2.09 Independent Medical Review Involving a Disputed Health Care Service.

2.09.01 A Member may request an independent medical review, or IMR, of disputed health care services from the DMHC if the

Member believes that health care services have been improperly denied, modified, or delayed by PBHC. A "disputed health care service" is any health care service eligible for coverage under this contract that has been denied, modified, or delayed by PBHC, in whole or in part because the service is not Medically Necessary. The Member must meet the criteria described in the IMR Eligibility Section below to see if his or her grievance qualifies for an IMR.

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

2.09.03 IMR Eligibility. The Member's application for an IMR will be reviewed by the DMHC to confirm that:

1. The Member's provider has recommended a health care service as Medically Necessary; or
2. The Member has received Urgent care or Emergency Services that a provider determined was Medically Necessary; or
3. The Member has been seen by a PBHC Participating Provider for the diagnosis and treatment of the medical condition for which the Member sought independent review; and
4. The disputed health care service has been denied, modified, or delayed by PBHC, based in whole or in part on a decision that the health care service is not Medically Necessary; and
5. 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.

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

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

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

2.10 Authorization and Denial of Behavioral Health Care Services.

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

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

1. 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.

2. If the Member's condition poses an imminent and serious threat to their health, including but not limited to, severe pain, potential loss of life, limb, or other major bodily function, or lack of timeliness would be

detrimental in regaining maximum function, the decision will be rendered in a timely fashion appropriate for the nature of the Member's condition, not to exceed seventy-two (72) hours after PBHC's receipt of the information reasonably necessary and requested by PBHC to make the determination.

If the decision cannot be made within these timeframes because (1) PBHC is not in receipt of all the information reasonably necessary and requested, or (2) PBHC requires consultation by an expert reviewer, or (3) 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 PBHC Participating Provider and the Member, in writing, that a decision cannot be made within the required timeframe.

The notification will specify the information requested but not received or the additional examinations or tests required, and the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by PBHC, PBHC shall approve, deny or modify the request for authorization within the timeframes specified above, as applicable.

PBHC notifies requesting Participating Providers of decisions to approve, deny or delay requests for authorization of Behavioral Health Services for Members within twenty-four (24) hours of the decision.

Members are notified of the decision to deny, delay or modify requested Behavioral Health Services, in writing, within two (2) business days of the decision, including a description of the reasons for the decision, the criteria or guidelines used, the clinical reasons for decisions regarding medical necessity, and information about how to file an appeal of the decision with PBHC.

2.11 Experimental and Investigational Therapies.

Coverage decisions regarding experimental or investigational therapies are eligible for an Independent Medical Review for PBHC Members who meet all of the following criteria:

1. The Member has a Life-Threatening or Seriously Debilitating condition, as defined below and which meet the criteria listed in items #2, #3, #4 and #5, below:

   - "Life-Threatening" means either or both of the following: (1) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; (2) diseases

or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

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

2. The Member's PBHC Participating Provider certifies that the Member has a Life-Threatening or Seriously Debilitating condition, as defined above, for which standard therapies have not been effective in improving the Member's condition, for which standard therapies would not be medically appropriate for the Member, 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) the Member's 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 the Member 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) the Member, or the Member's non-participating physician who is a licensed, board-certified or board-eligible physician or provider qualified to practice in the area of practice appropriate to treat the Member's condition, has requested a therapy that, based on two documents from medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for the Member than any available standard therapy.

   Such certification must include a statement of the evidence relied upon by the provider in certifying his or her recommendation. PBHC is not responsible for 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 physician designee has denied the Member's 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 would be a covered service, except for PBHC's determination that the treatment, drug, device, procedure or other therapy is experimental or investigational.

IMR for coverage decisions regarding Experimental or Investigational therapies shall be processed in accordance with the protocols outlined under

Section 2.09 "Independent Medical Review Involving a Disputed Health Care Service".

2.12 PBHC Quality Review Process.

The Quality Review Process is an internal review process that addresses Member concerns regarding the quality or appropriateness of services provided by PBHC Participating Providers that has the potential for adverse effect on the Member and is referred to the Quality Improvement Department for investigation. If the Member's complaint is not resolved to the Member's satisfaction, the Member may pursue the Appeal Process, however, outcomes of the quality review process are confidential and not communicated to the Member.

2.12.01 Quality of care complaints that affect a Member's current treatment shall be immediately evaluated. If necessary, other appropriate PBHC personnel and the PBHC Participating Provider will be consulted.

2.12.02 The Quality Improvement Specialist will be responsible for responding to questions the Member may have about his or her complaint and about the Quality Review process.

In appropriate instances, the Quality Improvement Specialist may arrange a meeting between the Member and the PBHC Participating Provider.

2.12.03 The relevant medical records are obtained from the appropriate providers and are reviewed by the PBHC Quality Improvement Specialist or his or her designee.

If necessary, a letter is sent to the Participating Provider, as appropriate, requesting further information. Additional information is received and reviewed by the Quality Improvement Specialist or his or her designee.

2.12.04 After reviewing the medical records, the case is referred to the PBHC Peer Review Committee for review and recommendation of corrective action against the Participating Provider involved, if appropriate. If the Member has submitted a written complaint, the Member shall be notified of the completion in writing within thirty (30) days. The oral and written communications involving the Quality Improvement Specialist and the results of the review shall remain confidential and cannot be shared with the Member.

The Quality Improvement Specialist shall follow-up to ensure that any corrective actions against a Participating Provider are carried out.

2.12.05 The outcome of the Quality Review Process may not be submitted to voluntary mediation or binding arbitration as described above in Section 2.07 of this Agreement.

2.13 Review by the Department of Managed Health Care.

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll free number **(1-800-HMO-2219)** to receive complaints regarding health plans. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers **(1-800-735-2929 (TTY) or 1-888-877-5378 (TTY))** to contact the Department. The Department's Internet web site **(http://www.hmohelp.ca.gov.)** has complaint forms and instructions online. If a Member has a grievance against PBHC, the Member should first telephone PBHC at 1-800-999-9585 and use PBHC's Appeal Process outlined in this Agreement.

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

COVERED SERVICES.

Behavioral Health Services are covered only when they are:

- **Incurred while Member is eligible for coverage under this Behavioral Health Plan;**
- **Pre-Authorized by PBHC as Medically Necessary; and**
- **Rendered by a PBHC Participating Provider, except in the case of an Emergency.**

PBHC will pay for the following Behavioral Health Services furnished in connection with the treatment of Mental Disorders and/or Chemical Dependency as outlined in the Schedule of Benefits, provided the above criteria above been satisfied. You should refer to your Schedule of Benefits for further information about your participating Behavioral Health Plan.

I. Mental Health Services (Including Services For The Diagnosis And Treatment Of Smi And Sed Conditions:

A. Inpatient

1. Inpatient Mental Health Services provided at an Inpatient Treatment Center or Day Treatment Center are covered when Medically Necessary, pre-authorized 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 pre-authorized by PBHC.

B. Outpatient

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

II. Chemical Dependency Services.

A. Inpatient

1. Inpatient Chemical Dependency Services, including Medical Detoxification provided at an Inpatient Treatment Center – Medically Necessary Chemical Dependency Services, including Medical Detoxification, which have been pre-authorized by PBHC and are provided by a Participating Practitioner while the Member is confined in a Participating Inpatient Treatment Center, or at a Participating Residential Treatment Center.

2. Inpatient Physician Care – Medically Necessary Chemical Dependency Services, including Medical Detoxification, provided by a Participating Practitioner while the Member is confined at an Inpatient Treatment Center or at a Residential Treatment Center, or is receiving services at a Participating Day Treatment Center and which have been pre-authorized by PBHC.

3. Chemical Dependency Services Rendered at a Residential Treatment Center – Medically Necessary Chemical Dependency Services provided by a Participating Practitioner, provided to a Member during a confinement at a Residential Treatment Center are covered, if provided or prescribed by a Participating Practitioner and pre-authorized by PBHC.

4. Medical Detoxification – Medical Detoxification services are covered when provided by a Participating Practitioner at a Participating Inpatient Treatment Center or at a Residential Treatment Center when pre-authorized by PBHC.

B. Outpatient.

1. Outpatient Physician Care – Medically Necessary Chemical Dependency Services provided by a Participating Practitioner and pre-authorized by PBHC. Such services must be provided at the office of the Participating Practitioner or at a Participating Outpatient Treatment Center.

III. Other Behavioral Health Services.

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

2. Laboratory Services – Diagnostic and therapeutic laboratory services are covered when ordered by a Participating Practitioner in connection with the Medically Necessary diagnosis and treatment of Mental Disorder and/or Chemical Dependency when pre-authorized by PBHC.

3. Inpatient Prescription Drugs – Inpatient prescription drugs are covered only when prescribed by a PBHC Participating Practitioner for treatment of a Mental Disorder or Chemical Dependency while the Member is confined to an Inpatient Treatment Center or, in the case of treatment of Chemical Dependency a Residential Treatment Center.

4. Injectable Psychotropic Medications – Injectable psychotropic medications are covered if prescribed by a PBHC Participating Practitioner for treatment of a Mental Disorder when pre-authorized by PBHC.

5. Psychological Testing – Medically Necessary psychological testing is covered when pre-authorized by PBHC and provided by a Participating Practitioner who has the appropriate training and experience to administer such tests.

EXCLUSIONS.

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 *Group Subscriber Agreement.*

1. Any confinement, treatment, service or supply not authorized by PBHC, except in the event of an Emergency.

2. All services not specifically included in this PBHC Schedule of Benefits included with this *Group Subscriber Agreement.*

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 the Member which duplicate the benefits to which the Member is entitled under any applicable Workers' Compensation law are not covered, as described in the Section of this *Group Subscriber Agreement* titled "Non-Duplication of Benefits with Workers' Compensation".

6. Any services that are provided by a local, state or federal governmental agency are not covered except when coverage under this Behavioral Health Plan is expressly required by federal or state law.

7. Speech therapy, physical therapy and occupational therapy services provided in connection with the treatment of psychosocial speech delay, learning disorders, including mental retardation and motor skill disorders, and educational speech delay including delayed language development.

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

9. Routine, custodial and convalescent care, long term therapy and/or rehabilitation. (Individuals should be referred to appropriate community resources such as school district or regional center for such services).

10. Any services provided by non-licensed providers.

11. Pastoral or spiritual counseling.

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

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

14. Genetic counseling services.

15. Community Care Facilities that provide 24-hour 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 injectible psychotropic medication as set forth in Section 4, all non-prescription 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. (Non-prescription and prescription drugs prescribed by a PBHC Participating Practitioner while the Member is confined at an Inpatient Treatment Center and non-prescription 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 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, MRI's, 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 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 *Group Subscriber Agreement* 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 *Group Subscriber Agreement,* 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 II) 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".

30. Expenses incurred due to liable third parties are not covered, as described in the Section of this *Group Subscriber Agreement* title "Reimbursement of Third Party Expenses".

31. Mental Health Services rendered at a Residential Treatment Center or other facilities or institutions that are not Inpatient Treatment Centers.

32. Methadone treatment in connection with Medical Detoxification.

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CALIFORNIA

Supplement to the Combined Evidence of Coverage and Disclosure Form

Plan U

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Plan U
PBH Behavioral Health Care

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.

Mental Health Services

Inpatient, Residential and Day Treatment *Unlimited days*	Same as medical plan hospitalization Copayment[1]
Outpatient Treatment *Unlimited visits*	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

Chemical Dependency Services

Inpatient, Residential and Day Treatment *Maximum Annual Benefit for detoxification and all levels of care limited to $25,000 per Calendar Year; $35,000 Lifetime Maximum Benefit*	Paid in full
Emergency and Urgently Needed Services[2]	Same as medical plan Emergency and Urgently Needed Services[2] Copayment waived if admitted as an inpatient

Severe Mental Illness Benefit[3]

Inpatient, Residential and Day Treatment *Unlimited days*	Same as medical plan hospitalization Copayment[1]
Outpatient Treatment *Unlimited visits*	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 will be applied to Medical Plan Lifetime Dollar Maximum Benefit, if applicable.

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

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

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

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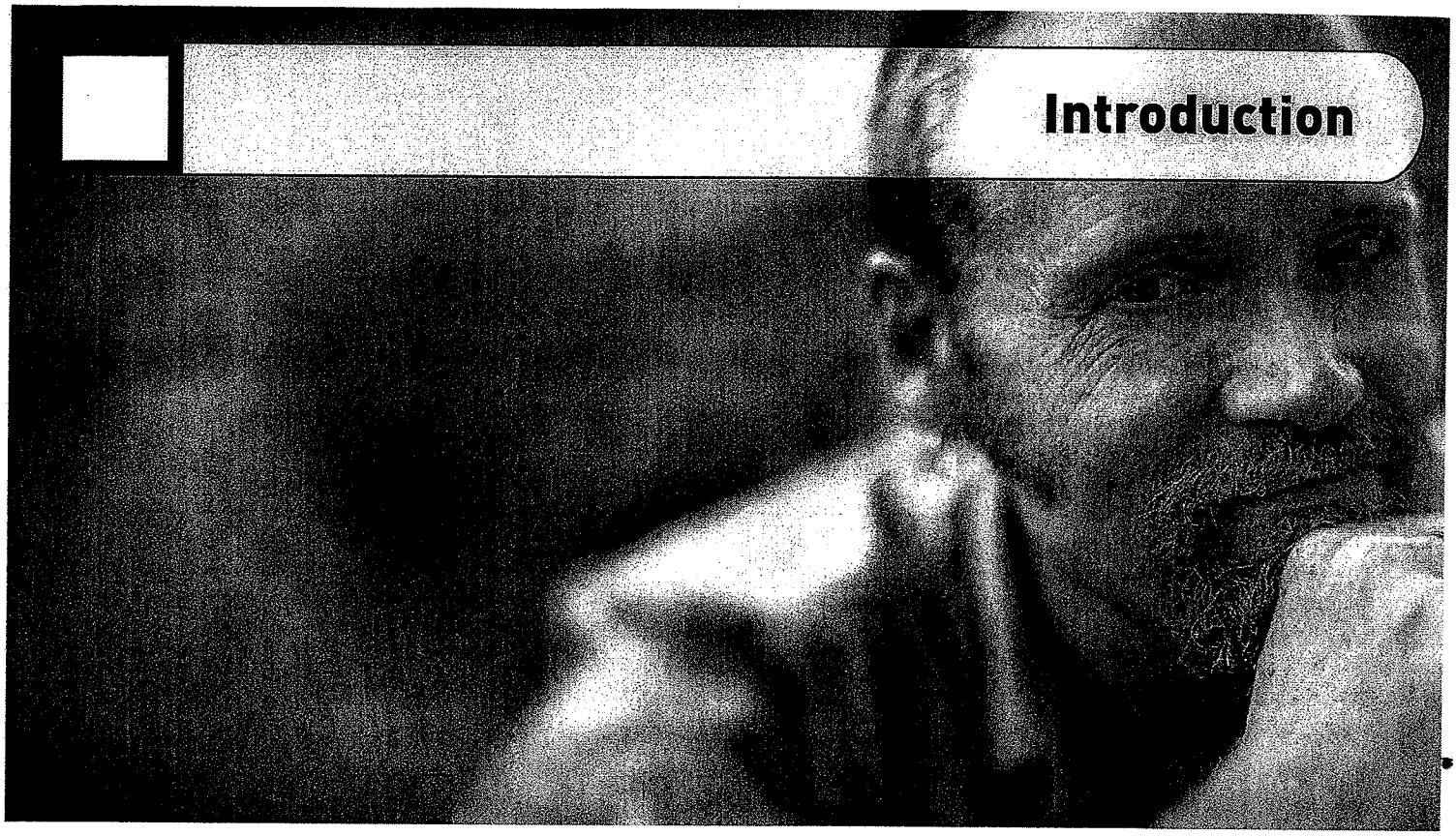

Introduction

PacifiCare Behavioral Health of California's Behavioral Health Care Plan

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 health and chemical dependency 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 Disturbances (SED). As a PacifiCare of California Behavioral Health Member, you and your eligible Dependents 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, and all services are completely confidential.

This *Combined Evidence of Coverage and Disclosure Form* (EOC) contains a summary of the terms and conditions of your coverage with PacifiCare Behavioral Health of California, and all applicants have a right to view this document prior to enrollment. This EOC should be used in conjunction with your *PacifiCare of California Combined Evidence of Coverage and Disclosure Form*, and it should be read completely and carefully. Individuals with special behavioral health needs should carefully read those sections that apply to them.

Please refer to the *PacifiCare Behavioral Health of California Schedule of Benefits* in this EOC and your *PacifiCare of California Medical Schedule of Benefits* for a summary of benefits, Copayments, exclusions and limitations. It is important that you carefully read the following information so you will know how to access your behavioral health care benefits.

Introduction

This is only a summary of your Behavioral Health Managed Care Plan. The PacifiCare of California and PBHC Group Subscriber Agreements ("Group Agreements") must be consulted to determine the exact terms and conditions of your coverage. Copies of the Group Agreements are available from your Group, from PacifiCare of California or from PacifiCare Behavioral Health of California upon request.

PacifiCare Behavioral Health of California, Inc.
23046 Avenida de la Carlota, Suite 700
Laguna Hills, California 92653
1-800-999-9585

How Your PacifiCare Behavioral Health Benefits Work

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

- We offer you direct 24-hour access to our services.
- We coordinate and pay for all behavioral health care as provided under your Plan, provided you use our Participating Providers.
- You may have some Copayments or Coinsurance amounts.

What Does PacifiCare Behavioral Health of California Do?

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

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

What Is Behavioral Health?

Behavioral health is the name for the treatment of:

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

What Is Severe Mental Illness?

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

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

What Is the Serious Emotional Disturbance of a Child?

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

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; and
2. Is under the age of eighteen (18) years old.
3. Furthermore, the child must meet one or more of the following criteria:
   a. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either of the following occur:
      i. the child is at risk of removal from home or has already been removed from the home;
      ii. the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or

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

c. The child meets the special education eligibility requirements under Chapter 26.5, commencing with Section 7570 of Division 7 of Title 1 of the Government Code of the State of California.

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

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

How Do I Get Behavioral Health Services?

Step 1

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

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

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

Step 2

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

Step 3

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

Utilization Review criteria or guidelines for specific mental health and chemical dependency conditions are used to authorize treatment. Specific care and treatment may vary depending on individual needs and benefit plan. The criteria are available upon request by calling PBHC's Customer Service department.

What if I Want to Change My Participating Provider?

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

If I See a Provider Who Is Not Part of PBHC's Provider Network, Will It Cost Me More?

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

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

Can I Call PBHC in the Evening or on Weekends?

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

Emergency Treatment

What Is an Emergency?

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

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

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

What Happens in an Emergency?

Step 1

In an Emergency, get help or treatment immediately.

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

Step 2

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

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

Step 3

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

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

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

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

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

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

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

Provider Information

About Our Participating Providers

Call the PBHC Customer Service department for:

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

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

Who Are PacifiCare Behavioral Health's Participating Providers?

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

How Are Participating Providers Compensated by PBHC?

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

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

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

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

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

Continuing Treatment for New Members

Continuing Treatment is for Members who:

1. Were not offered an out-of-network option or did not have the option to continue with their previous health plan at the time of enrollment under this Plan;
2. Have been eligible and enrolled in this Plan for less than thirty (30) days;
3. Had no other health plan choice other than through PacifiCare's arrangement with PBHC;
4. Are under treatment by a non-participating provider at the time of enrollment for a condition listed in the DSM-IV;
5. Are under treatment for a covered Behavioral Health Service or benefit under this Plan; and
6. Have a condition where an immediate change in Practitioner could present a risk of harm to self or others.

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

Outpatient Treatment

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

Inpatient Treatment

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

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

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

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

Public Policy Participation

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

What About New Treatments?

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

Concurrent Reviews

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

What if I Get a Bill?

You should not get a bill from your PBHC Participating Provider because PBHC's Participating Providers have been instructed to send all their bills to us for payment. You may however, have to pay a Copayment to the Participating Provider each time you receive services. You could also get a bill from an emergency room provider if

you use Emergency care. If this happens, send PBHC the original bill or claim as soon as possible and keep a copy for yourself. You are responsible only for the amount of your Copayment, as described in the *Schedule of Benefits* in this EOC.

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

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

Non-Emergency Treatment provided by non-Participating Providers and facilities is not covered by PBHC.

Termination of Benefits – Conditions for Termination

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

Your Financial Responsibilities

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

Confidentiality of Information

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

Authorization and Denial of Behavioral Health Care Services

PBHC uses criteria or guidelines to determine whether to approve, deny, delay or modify, based on Medical Necessity, Behavioral Health Services to its Members. The 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 guidelines, based on a particular diagnosis upon request.

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

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, PBHC shall approve or deny the request for authorization within the time frames specified above as applicable.

Member agrees that their Provider will be their "authorized representative" (pursuant to ERISA) regarding receipt of approvals of requests for behavioral health care services for purposes of medical management.

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

If the Member requests an extension of a previously authorized and currently ongoing course of treatment, and the request is an Urgent Request as defined previously, PBHC will approve, 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 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 the 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.

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 which meet the criteria listed in items 2, 3, 4 and 5 below:
   - "Life-threatening" means either or both of the following: (i) diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted; (ii) diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.
   - "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity.
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 the California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. Such certification must include a statement of the evidence relied upon by the physician in certifying his or her recommendation. PBHC is not responsible for the payment of services rendered by non-contracting providers that are not otherwise covered under the Member's PBHC benefits; and
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.

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

General Information

Second Opinions

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

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

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

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

Responding to Your Concerns – The PBHC Appeals Process

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

If you feel the situation has not been addressed to your satisfaction, you may submit a formal complaint within 180 days of your receipt of an initial determination over the telephone by calling the PBHC toll-free number. You can also file a complaint in writing:

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

Appeals Process

All Members have the right to appeal any claim denial or denial of treatment authorization. Members, or their authorized representatives including their treating providers, may initiate the Appeal Process either verbally or in writing; however, it may be necessary for PBHC to request written clinical or other information in order for the appeal to be reviewed.

PBHC Appeals Process

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. 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.

The PBHC Director of Clinical Services (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) business days after PBHC's receipt of all information necessary for review by PBHC, except in the case of "expedited reviews" discussed below. For appeals involving the delay, denial or modification of health care 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 care services based on a finding that the services are not Covered Services, the response will specify the provisions in the plan contract that exclude that coverage. If the complaint is related to quality of care, the complaint will be reviewed through the procedure described in the section of this *Combined Evidence of Coverage and Disclosure Form* captioned "PBH Quality Review Process."

If the Member is dissatisfied with the appeal, the Member may, within sixty (60) days, submit or request that PBHC submit the appeal to voluntary mediation or binding arbitration before Judicial Arbitration and Mediation Services, Inc. (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). The Member may file a grievance with the Department of Managed Health Care after they have participated in the PBH's appeals process, voluntary mediation or binding arbitration for thirty (30) days.

(i) Voluntary Mediation – In order to initiate mediation, the Member or the agent acting on behalf of the Member shall submit a written request for voluntary mediation. If the parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with its JAMS 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.

(ii) Binding Arbitration – Any and all disputes of any kind whatsoever, including, but not limited to, claims for medical malpractice (that is as to whether any medical services rendered under the health plan were unnecessary or unauthorized or were improperly, negligent or incompetently rendered) between Member (including any heirs or assigns) and PBHC, except for claims subject to ERISA, shall be submitted to binding arbitration. 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. Member and PacifiCare 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 Rules 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 to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Rules will be utilized.

Arbitration hearings shall be held in Orange County, California, or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration as provided by California law and the Code of Civil Procedure. 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 California law. The parties shall divide equally the expenses of JAMS and the arbitrator. In cases of extreme hardship, PBHC may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS. 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.

Expedited Review Process

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

Independent Medical Review of a Disputed Health Care Service

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

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

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

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

Responding to Your Concerns – The PBHC Appeals Process

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

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

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

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

Binding Arbitration and Voluntary Mediation

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

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

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

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

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

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

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

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

Responding to Your Concerns – The PBHC Appeals Process

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

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

The PBHC Quality Review Process

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

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

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

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

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

Review by the Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll-free telephone number **(1-888-HMO-2219)** to receive complaints regarding health plans. The hearing and speech impaired may call the Department's direct toll-free number **(1-877-688-9891 (TDD))** or the California Relay Service's toll-free numbers **(1-800-735-2929 or 1-888-877-5378 (TTY))**. The Department's facsimile number is (916) 229-4328. The Department's Internet Web site **(http://www.hmohelp.ca.gov)** has complaint forms and instructions online. If you have a grievance against PBHC, you should first telephone PBHC at **(1-800-999-9585, TDHI: 1-888-877-5378)** and use PBH's grievance process before contacting the Department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than thirty (30) days, you may call the Department for assistance.

PBHC's grievance process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Covered Services

Behavioral Health Services must be:

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

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

1. Inpatient Hospital Benefits/Acute Care and Partial Hospital Benefits – Inpatient hospital services provided at a PBHC Participating Facility, except in an Emergency.
2. Inpatient Physician Care – Services of physicians while the Member is hospitalized on an inpatient basis.
3. Physician Care – Diagnostic and treatment services including consultation and treatment.
4. Ambulance – Use of an ambulance (land or air) for emergencies, including, but not limited to, ambulance or ambulance transport services provided through the 911 emergency response system is covered without prior authorization when the Member reasonably believes that the behavioral health condition requires Emergency Services that require ambulance transport services. Use of an ambulance for a non-Emergency is covered when specifically authorized by PBHC.
5. Laboratory services – Diagnostic and therapeutic laboratory services are covered when related to the approved Behavioral Health Treatment Plan.
6. Inpatient Prescription Drugs – Inpatient Prescription Drugs are covered only when prescribed by a PBHC Participating Provider for Behavioral Health Services.
7. Outpatient Prescription Drugs – Outpatient Prescription Drugs are covered only if an Outpatient Prescription Drug Supplemental Benefit Rider is attached to the *PacifiCare of California Agreement* and the prescription drugs were prescribed by a PBHC Participating Provider for a Behavioral Health diagnosis.
8. Injectable Psychotropic Medications – Injectable psychotropic medications are covered if prescribed by a PBHC Participating Provider for a Behavioral Health diagnosis.
9. Psychological Testing – When Preauthorized by a PBHC Clinician and provided by a licensed psychologist under contract with PBHC.

Exclusions and Limitations

1. All exclusions and limitations listed in the *PacifiCare of California Group Subscriber Agreement and EOC* under the "Exclusions and Limitations" section.
2. Treatment for any learning or reading disorder, mental retardation, motor skills disorder, and communication disorder.
3. Treatments which do not meet national standards for mental health professional practice.
4. Non-organic therapies, including, but not limited to, the following: bioenergetics therapy, confrontation therapy, crystal healing therapy, educational remediation, EMDR, guided imagery, marathon therapy, primal therapy, rolfing, sensitivity training, transcendental meditation, Lovaas' Discrete Trial Training, Facilitated Communication, and EEG biofeedback (neurofeedback).
5. Organic therapies, including, but not limited to, the following: aversion therapy, carbon dioxide therapy, environmental ecological treatment or remedies, herbal therapies, hemodialysis for schizophrenia, vitamin or orthomolecular therapy, and rapid anesthesia opiate detoxification.
6. Treatments designed to regress the Member emotionally or behaviorally.
7. Personal enhancement or self-actualization therapy and other treatments.
8. Routine, custodial, convalescent care, long term therapy and/or rehabilitation. Individuals should be referred to appropriate community resources, such as school districts and/or regional centers for these services.
9. Services provided by non-licensed providers for the treatment of any illness or injury.
10. Pastoral or spiritual counseling.
11. Dance, poetry, music or art therapy except as part of a Behavioral Health Treatment Program.
12. Thought field therapy.
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.
15. Community care facilities that provide 24-hour nonmedical residential care.
16. 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.)

Understanding Behavioral Health Care Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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:

Understanding Behavioral Health Care Terms

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

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

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

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

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

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

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

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

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

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

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

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

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

a. Rendered for the treatment or diagnosis of a Behavioral Health condition as defined by the DSM-IV;

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

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

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

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

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

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

Understanding Behavioral Health Care Terms

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

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

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

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

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

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

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

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

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

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

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; and
2. Is under the age of eighteen (18) years old.
3. Furthermore, the child must meet one or more of the following criteria:
   a. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
      i. the child is at risk of removal from home or has already been removed from the home;
      ii. the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment; or
   b. The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; or
   c. The child meets special education eligibility requirements under Chapter 26.5 commencing with Section 7570 of Division 7 of Title 1 of the California Government Code.

Understanding Behavioral Health Care Terms

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

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

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

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

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

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.

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23046 Avenida de la Carlota, Suite 700
Laguna Hills, CA 92653

Customer Service:
800-999-9585
888-877-5378 (TDHI)

Visit our Web site @ www.pacificare.com

CM-303-42473.2
PC4269-002 Rev. 3/03
MPU

PacifiCare®

Hearing Aid Benefits

Hearing Aids Are Paid in Full

Hearing aid benefits include, but are not limited to, the following:

Benefits

- An audiometric examination by an audiologist when authorized through the Member's Participating Medical Group.
- Hearing aids or ear molds – one appliance for each ear every thirty-six (36) months when Medically Necessary to provide functional improvement and when authorized through the Member's Participating Medical Group and obtained from a participating PacifiCare provider.

Limitation

Coverage expenses relating to hearing aids are limited to the Usual and Customary Charge of a basic hearing aid to provide functional improvement.

Exclusions

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

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

Questions? Call the Customer Service Department at 1-800-624-8822 (HMO) 1-800-913-9133 (POS) or 1-800-442-8833 (TDHI)

5701 Katella Avenue
Cypress, CA 90630

Customer Service:
800-624-8822 (HMO)
800-913-9133 (POS)
800-442-8833 (TDHI)
www.pacificare.com

CM-703-48043.10
PC3503-002 Rev. 7/03

CALIFORNIA

PacifiCare
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HMO Pharmacy Schedule of Benefits

Summary of Benefits	Generic Formulary	Brand Formulary	Non-Formulary
Retail Pharmacy Copayment (per Prescription Unit or up to 30 days)	**$5**	**$15**	**$25**
Mail-Service Pharmacy Copayment (up to 3 Prescription Units or up to 90 days)	**$10**	**$30**	**$50**

What Is My Schedule of Benefits?

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

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

How Do I Use My Prescription Drug Benefit?

Your prescription drug benefit helps to cover the cost for some of the medications prescribed by a PacifiCare 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 $5.
- When you fill or refill a prescription for a Formulary brand-name medication, your Copayment is $15.
- When you fill or refill a prescription for a non-Formulary generic or non-Formulary brand-name medication, your Copayment is $25.

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 $5. 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 2 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 and not excluded from coverage will be subject to the higher non-Formulary Copayment except as described in the following paragraph. For more on our Formulary, please refer to your *Supplement to the Combined Evidence of Coverage and Disclosure Form* or visit **www.pacificare.com**.
- Occasionally a non-Formulary drug is Medically Necessary. You may choose to pay your non-Formulary Copayment or you may request preauthorization review. Preauthorization requests may only be initiated by your PacifiCare Participating Physician and PacifiCare will provide a determination

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

of the request to your Participating Physician within 2 business days.
If the preauthorization request is approved by PacifiCare, you will pay the applicable Formulary brand-name or generic Copayment.

ADDITIONAL INFORMATION

Medications Covered By Your Benefit

The following medications are included in the PacifiCare managed Formulary and are available to your Participating Physician. Your benefit also includes non-Formulary drugs for the non-Formulary Copayment listed above when ordered by a Participating Physician and filled at a 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 unless they are on PacifiCare's Selected Brands List. A copy of the Selected Brands List is available upon request from PacifiCare's Customer Service department.
- 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.

Preauthorization for Selected Drugs

Selected drugs must 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 medications that require PacifiCare's preauthorization, please contact PacifiCare's Customer Service department.

Exclusions and Limitations

While the prescription drug benefit covers most medications, there are some that are not covered:

- Drugs or medicines purchased and received prior to the Member's effective date or subsequent to the Member's termination.
- Therapeutic devices or appliances, including hypodermic needles, syringes (except insulin syringes), support garments and other 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-Food-and-Drug-Administration-approved indications, see the following exclusion.
- Off-Label Drug Use. Off-Label Drug Use means that the Provider has prescribed a drug approved by the Food and Drug Administration (FDA) for a use that is different from 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 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. (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.

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.

P.O. Box 6006
Cypress, CA 90630

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

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Outpatient Prescription Drug Benefit

Supplement to the Combined Evidence of Coverage and Disclosure

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 your medical *Combined Evidence of Coverage and Disclosure Form* [Section Eight] 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 become 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
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