

PacifiCare[®]

HMO Plan

**Individual Health Plan
HMO Subscriber Agreement/
Combined Evidence of Coverage
and Disclosure Form**

INSIDE FRONT COVER

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

INTRODUCTION

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.

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

PacifiCare arranges for services through a network of contracting hospitals, physicians and other health care providers which serve PacifiCare Members in an organized and cost-effective manner. PacifiCare will cover the cost of all Medically Necessary Covered Services authorized by your Primary Care Physician, and all Emergency Services required by you and your covered dependents. Specialty care under this Health Plan will be covered only if you receive a referral in advance from your Primary Care Physician.

While PacifiCare arranges for the provision of a full range of Medical and Hospital Services, you are required to take an active part in ensuring the success of your Health Plan. Read this Agreement carefully as it will explain your responsibilities and benefits as a Subscriber. If after reading this Agreement you have any questions regarding this Health Plan, please contact PacifiCare's Customer Service department.

The words and terms that are capitalized in this Agreement have a specific meaning as defined in the "Definitions" Section I below. Because this meaning may differ from the usual meaning of these words or phrases, please refer to the "Definitions" section to be sure you understand what these words and phrases mean.

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

SECTION I. DEFINITIONS

Act The Knox-Keene Health Care Service Plan Act of 1975, as amended, as set forth at Chapter 2.2 of Division 2 of the California Health and Safety Code and the related regulations promulgated by the California Department of Managed Health Care.

Agreement This PacifiCare Health Plan Individual HMO Subscriber Agreement, including but not limited to all applications, health questionnaires and information submitted by the Subscriber and his or her Dependents

applying for coverage, the *Schedule of Benefits*, other appropriate attachments and addenda, and any amendments hereto.

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

Catastrophic Medical Condition A severe injury or illness which may require ongoing treatment, expensive treatment, or treatment which requires a high intensity of service integration.

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

Clinical Improvement Committee A committee established and maintained by PacifiCare, consisting of physician members from Participating Medical Groups and chaired by the PacifiCare Medical Director, which performs Quality Reviews and establishes PacifiCare's standards of care, service, policies and procedures.

Copayment A Member's share of costs for Medical Services and Hospital Services, usually paid to the Primary Care Physician or other Participating Provider at the time care is rendered. The specific Copayment amounts that apply to the various Medical Services and Hospital Services for the plan type selected are listed in the *Schedule of Benefits*, which is made part of this Agreement. When a Copayment is expressed as a percentage, the Copayment shall be based on a percentage of the applicable charge for such health service, which charge shall be negotiated between the Participating Provider and PacifiCare.

Covered Services The Medical and Hospital Services arranged or reimbursed by PacifiCare as set forth in this Agreement subject to the exclusions and limitations provided herein.

Custodial Care Care that PacifiCare determines to be provided primarily for the maintenance of a Member or which is designed essentially to assist a Member in meeting his or her activities of daily living and which is not primarily provided for its therapeutic value in the treatment of a sickness or bodily injury. Activities of daily living include, but are not limited to, bathing, feeding, dressing, walking and taking oral medicine. Custodial Care does not require the continuing attention of trained medical or paramedical personnel.

Customer Service Department The person or persons designated by PacifiCare to whom oral and written Member complaints may be addressed. The Customer Service department may be contacted by telephone at 1-800-207-2077 or by writing to the Customer Service department, PacifiCare of California, 5701 Katella Avenue, Cypress, California 90630.

Dependent The Spouse or unmarried child (including a step-child, child placed for the purpose of adoption, or adopted child) of a Subscriber who meets the eligibility requirements set forth in this Agreement, who is enrolled in this Health Plan, and for whom PacifiCare has received Health Plan Premiums.

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; or
- Active labor, meaning labor at a time that either of the following would occur:
 - (1) there is inadequate time to effect safe transfer to another hospital prior to delivery; or
 - (2) a transfer poses a threat to the health and safety of the Member or unborn child.

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

Enrollment The signing of the PacifiCare Enrollment Application Form by the Subscriber on behalf of the Subscriber and his or her Dependents, and its approval by PacifiCare.

Experimental or Investigational Treatment Defined in the "Exclusions and Limitations of Benefits" section of the Agreement.

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

Health Plan The health plan described in this Agreement.

Health Plan Premiums The amounts established by PacifiCare to be paid to PacifiCare by Subscriber on behalf of the Subscriber and his or her Dependents in consideration of the benefits provided under this Health Plan.

Home Care A coordinated program of Medically Necessary skilled services ordered by Member's Participating Medical Group and provided to a Member

in his or her home. Services appropriate to the needs of the individual patients are planned, coordinated and made available through a multidisciplinary health team.

Hospice Care Services provided when the goal of treatment is to provide supportive care and counseling during the terminal phase of an illness. These services are provided at the Member's request if the Member's Participating Medical Group determines that the Member has six months of life expectancy or less and no longer elects to pursue aggressive medical treatment for the terminal illness.

Hospital A general acute care hospital licensed by the State of California, designated and utilized by Member's Primary Care Physician for the provision of Hospital Services to Members.

Hospital Services Medically Necessary services and supplies performed or supplied by a Hospital on an inpatient or outpatient basis which are directed or authorized by Member's Primary Care Physician.

Inpatient Rehabilitation Facility A freestanding inpatient rehabilitation facility or rehabilitation unit of a licensed hospital certified under Titles XVIII and XIX of the Social Security Act which is under contract with PacifiCare.

Lifetime Benefit Maximum means the lifetime maximum dollar amount paid for covered charges. Covered charges mean the rates for services negotiated by the Plan or its contracting providers for Covered Services provided to you or a Dependent while enrolled in this PacifiCare Health Plan, less the amount of the Member's Copayment. The Lifetime Benefit Maximum is shown on the *Schedule of Benefits* and is calculated for you and each Dependent on an individual basis.

Medical Services Medically Necessary professional services and supplies of Physicians, surgeons and paramedical personnel, including medical, surgical, diagnostic, and therapeutic services and preventative services which are performed, directed or authorized by a Member's Primary Care Physician.

Medically Necessary (or Medical Necessity) Medical or Hospital Services which are determined by a medical director of PacifiCare or the Participating Medical Group to be:

- (a) Rendered for the treatment or diagnosis of an injury or illness;
- (b) Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with professionally recognized standards, which shall include the consideration of scientific evidence;
- (c) Not furnished primarily for the convenience of the Member, the attending Physician, or other provider of service; and

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

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

Medicare (Original Medicare) The Hospital Insurance Plan (Part A) and the supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act as amended.

Member Any Subscriber or Dependent.

Monetary Recovery Payment from a third party including any insurer as a result of payment of benefits, settlement, verdict or judgment, or recovery by any other means in money or in kind from or on behalf of a party held responsible for an injury or illness to a Member.

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

PacifiCare Enrollment Packet This packet contains information supplied by PacifiCare to prospective Subscribers which summarizes this Agreement and contains the PacifiCare Enrollment Application.

PacifiCare’s Case Management Program is a program in which PacifiCare of California 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, which 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.

Participating Medical Group An individual practice association, individual primary care physician or group of licensed doctors of medicine or osteopathy which has entered into a written agreement with PacifiCare to provide Medical Services to Member and which Member has selected from a list supplied by PacifiCare to provide or coordinate the provision of Member’s Medical and Hospital Services.

Participating Providers Providers who contract with PacifiCare to provide Covered Services to Members.

Physician Any allopathic physician or osteopathic physician duly licensed to practice in the State of California.

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

Primary Care Physician Primary Care Physicians are the following:

- (i) Physicians who have a written agreement with PacifiCare to provide Medical Services to its Members;
- (ii) Physicians who are affiliated with an independent practice association which is under contract with PacifiCare; or
- (iii) A Participating Medical Group which has been selected by a Subscriber to provide and coordinate all Covered Services for the Subscriber and his or her enrolled Dependents under this Agreement.

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

Primary Residence Means the home or address at which the Member actually lives most of the time. A residence will no longer be considered a Primary Residence if:

- (i) Member moves without intent to return;
- (ii) Member is absent from the residence for ninety (90) consecutive days; or
- (iii) Member is absent from the residence for more than one-hundred (100) days in any six (6) month period.

Member shall notify PacifiCare of a change in Primary Residence as soon as possible. A change in Primary Residence shall result in disenrollment of the Member, if Member’s Primary Residence is not within the Service Area.

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

Providers Duly-licensed physician groups, Physicians, Hospitals, Skilled Nursing Facilities, extended care facilities, home health agencies, alcoholism and drug abuse centers, mental health professionals and any other health facilities or health care providers.

Reasonable and Customary Charges The usual charges for Medical and Hospital Services for cases of comparable nature and severity in the Service Area.

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

Service Area The geographic area in which PacifiCare is licensed to arrange for Medical and Hospital Services in the State of California by the California Department of Managed Health Care.

Skilled Nursing Care Skilled nursing services or physical therapy which is Medically Necessary, ordered by a Member's Participating Medical Group, required to be provided by a licensed nurse or a licensed physical therapist and above the level of Custodial Care.

Skilled Nursing Facility A skilled nursing facility or skilled nursing unit of a legally operated hospital certified under Titles XVIII and XIX of the Social Security Act.

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

Student Dependent A Dependent over the age of nineteen (19) and under the age of twenty-four (24) who is enrolled on a full-time basis at a certified educational institution such as an accredited college or university.

Subscriber An individual who is enrolled in the Health Plan and who meets all eligibility requirements stated in this Agreement and for whom the appropriate Health Plan Premium has been received by PacifiCare.

Technology Assessment Committee Consists of a minimum of nine (9) physicians from PacifiCare's Participating Medical Groups and qualified members of PacifiCare's staff, which reviews medical devices, treatments and procedures for the purpose of evaluating which may be Experimental or Investigational and for determining appropriate patient selection criteria for their use.

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

Utilization Review Committee A Committee utilized by PacifiCare or a Participating Medical Group or Primary Care Physician to promote the efficient use of resources and maintain quality of health care. Duties of the Utilization Review Committee include the prospective, current and retrospective review of Medical Services. The Utilization Review Committee

shall review elective specialist referrals and hospital admissions on a prospective basis and Emergency Service specialist referrals and hospital admissions on a retrospective basis.

SECTION II. ELIGIBILITY PROVISIONS

PacifiCare establishes conditions of eligibility which must be met in order to be eligible for coverage under this Health Plan. In order to participate in this Health Plan, you, the Subscriber and your enrolled Dependents, must be under age sixty-five (65), your application must be approved by PacifiCare, and you must meet all of the eligibility requirements set forth below. An exception exists only for Student Dependents.

Subscriber Eligibility

In order to enroll in this Health Plan, a prospective Subscriber must meet each of the following requirements:

- a. The Subscriber must continually and permanently reside within PacifiCare's Service Area.
- b. The Subscriber must designate a Participating Medical Group for each enrolled Member within a thirty (30)-mile radius of the Subscriber's Primary Residence or Primary Workplace.
- c. The Subscriber must pay Health Plan Premiums to PacifiCare as described in this Agreement.
- d. The Subscriber must notify PacifiCare of any changes to the information requested or provided on the PacifiCare Enrollment Application within thirty (30) days of the change. This information includes the Members' addresses, marital status, or dependent status.

Limitation on Subscriber Eligibility

Individuals age sixty-five (65) years old and older are not eligible to enroll in this Health Plan. Also individuals who are for any reason eligible for Medicare benefits (Part A and/or Part B) are not eligible to enroll in this Health Plan. Upon request, a Member shall provide PacifiCare with any information necessary to determine the Member's eligibility for Medicare. Member shall also provide PacifiCare with information regarding coverage under any other governmental or private health care program. Medicare-eligible persons may be eligible for enrollment in PacifiCare's Secure Horizons Health Plan.

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. (See Section XXVI for the definition of "Eligible Individual.")

Dependent Eligibility

The Subscriber's Spouse and the unmarried dependent children of the Subscriber or of the Subscriber's Spouse who are under the age of twenty-four (24) may enroll as Dependents of the Subscriber if the Dependent meets each of the eligibility requirements set forth below. For purposes of eligibility, children of the Subscriber include:

- (1) The natural born children, or children placed for the purpose of adoption by, or legally adopted children of the Subscriber or of the Subscriber's Spouse (i.e. stepchildren);
- (2) Children for whom the Subscriber or the Subscriber's Spouse has been appointed a legal guardian by a court; and
- (3) Children for whom the Subscriber or the Subscriber's Spouse is required to provide health coverage pursuant to a qualified medical support order.

The following requirements must be met to ensure eligibility:

- a. The Subscriber through whom the Dependent is eligible must be enrolled in the Health Plan; and
- b. The Dependent must select a Participating Medical Group located within a thirty (30)-mile radius of the Dependent's Primary Residence or Primary Workplace, if located within the PacifiCare Service Area, or within a thirty (30) mile radius of the enrolled parent's Primary Residence or Workplace.

Dependent enrollment and eligibility shall not be denied because the Dependent:

- (1) Was born to a single person or unmarried couple;
- (2) Is not claimed as a Dependent on the Subscriber's federal income tax return; or
- (3) Does not reside with the Subscriber or within the PacifiCare Service Area.

Coverage for Students

A Dependent unmarried child who is registered on a full-time basis (at least twelve (12) semester units or the equivalent as determined by PacifiCare) at a certified educational institution may continue as an eligible Dependent through the age of twenty-three (23) for full time students, provided proof of such status is submitted to PacifiCare on a periodic basis, as requested by PacifiCare. If the Dependent student resides outside of the Service Area, the student must maintain a permanent address inside the Service Area with the Subscriber and the student must select a Participating Medical Group within thirty (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.

Commencement of Coverage for Newborns or Newly-Adopted Dependents

Coverage for newborn children of Subscriber begins at birth. Coverage for children for whom the Subscriber or the Subscriber's Spouse has been appointed legal guardian by a court begins on the date physical custody of the child is obtained by the legal guardian. PacifiCare may require the legal guardian to present evidence that physical custody has been obtained. Coverage for adopted children or children placed for adoption by the Subscriber begins from and after the date on which the adoptive child's birth parents or other appropriate legal authority signs a written document, including but not limited to a health facility minor release form, a medical authorization form, or a relinquishment form, granting the Subscriber or Subscriber's Spouse the right to control the health care of the adoptive child, or in the absence of a written document, on the date there exists evidence of the Subscriber's or Subscriber Spouse's right to control the health care of the child placed for adoption. In order for coverage for a newborn child to continue for more than thirty-one (31) days after birth or, in the case of an adopted child, thirty-one (31) days after the date physical custody is obtained, a PacifiCare Change Form for the Dependent must be submitted and approved by PacifiCare prior to the expiration of the thirty-one (31) days, or proof of good health will be required. Eligibility for an adopted child ends if the placement is interrupted before legal adoption or the child is removed from the Subscriber's custody. Eligibility for a child for whom Subscriber has been appointed legal guardian ends when the guardianship ends or the child reaches the limiting age.

Coverage for Dependents As a Result of Court or Administrative Order

A person having custody of the Dependent or a custodial parent who is not a Member may inquire about Dependent coverage, if the Subscriber is required to provide coverage for the Dependent pursuant to a court or administrative order, including a Qualified Medical Child Support Order (QMCSO), by calling PacifiCare's Customer Service department. Evidence of such order must be submitted with the Individual Plan Enrollment Application. Information, including but not limited to the identification card, the *Combined Disclosure/Evidence of Coverage* or other available information including notice of termination will be provided to the custodial parent, legal custodian and/or District Attorney. Coverage will begin on the first of the month following receipt and acceptance by PacifiCare of an enrollment application with the court or

administrative order attached. Nothing in this section shall prohibit PacifiCare from requiring a health statement form for a new Dependent other than a newborn, or a child placed for adoption or newly adopted as described above.

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

Coverage for Disabled Dependents

Dependent unmarried children, who reside within the Service Area with either the Subscriber or the Subscriber's separated or divorced spouse, who are incapable of self-sustaining employment by reason of mental retardation, debilitating Chronic Condition, or physical handicap and who are dependent upon Subscriber for support and maintenance, and who would otherwise be eligible to enroll as Dependents except for the fact that they are older than the age of twenty-four (24), may enroll or continue enrollment in this Health Plan beyond the limiting age, provided proof of such incapacity and dependency is provided to PacifiCare within thirty-one (31) days of the onset of the disability, attainment of the limiting age, or upon request. PacifiCare may require ongoing proof of Dependent's incapacity and dependency, but not more frequently than annually following the first two years following the attainment of the limiting age or the onset of the disability. Such proof shall include a written statement by a licensed psychologist, psychiatrist, or other physician to the effect that such Dependent is incapable of self-sustaining employment by reason of mental retardation, Chronic Condition or physical handicap.

Commencement of Coverage

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

Member's Eligibility Not Affected By Health Status

A Member otherwise eligible and duly enrolled hereunder shall not be terminated from this Health Plan due to the Member's health status or need for health services.

SECTION III. SELECTING AND USING A PRIMARY CARE PHYSICIAN

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY RECEIVE COVERED SERVICES.

Each Member has a Primary Care Physician, who is responsible for the direction and coordination of the Member's medical care. The Primary Care Physician will arrange for referrals to other Participating Providers, for laboratory tests, X-rays, specialty care, Hospital Services or any other health care service that may be Medically Necessary.

EXCEPT FOR EMERGENCY SERVICES AND URGENTLY NEEDED SERVICES, OR AS OTHERWISE NOTED IN THIS AGREEMENT, SERVICES AND SUPPLIES OBTAINED WITHOUT ADVANCE REFERRAL FROM THE MEMBER'S PRIMARY CARE PHYSICIAN WILL NOT BE COVERED UNDER THIS HEALTH PLAN.

Choosing Your Primary Care Physician

The Subscriber has the responsibility of designating the Primary Care Physician for each Member from among the available Primary Care Physicians. The selected Primary Care Physician must practice within a thirty (30)-mile radius of the Member's Primary Residence or Primary Workplace. PacifiCare provides a Provider Directory listing Primary Care Physicians in the Subscriber's area. However, the Provider Directory is subject to change and the current participation status of any Provider can only be obtained by calling PacifiCare's Customer Service department. Because not all Primary Care Physicians listed in the Provider Directory are available for newly assigned Members, the Subscriber should contact the Primary Care Physician to ensure that the practice is accepting new patients.

The selected Primary Care Physician must be written on the Enrollment Application. If the Subscriber does not notify PacifiCare of the Subscriber's selection, PacifiCare may either reject the application for enrollment, or assign a Primary Care Physician for the Subscriber and each Dependent.

Representatives of PacifiCare's Customer Service department can provide assistance in the selection of a Primary Care Physician.

Reproductive Health Disclosure

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency

contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the PacifiCare Health Plan Customer Service department at 1-800-207-2077 or 1-800-442-8833 (TDHI) to ensure that you can obtain the health care services that you need. If you have chosen a Participating Medical Group that does not provide family planning benefits and these benefits have been purchased by your employer, please call Customer Service for assistance.

Change of Primary Care Physician

If a Subscriber elects to change Primary Care Physicians for the Subscriber or any Dependent, the Subscriber must contact the Customer Service department by telephone or obtain a Change Request Form from the Customer Service department. Upon notification, PacifiCare will record the change, and send the Subscriber a new Member identification card. If PacifiCare receives the change before the 15th day of the month, PacifiCare will change the Primary Care Physician effective the first day of the next month. If PacifiCare receives the requested change after the 15th day of the month, the change will be effective the first day of the subsequent month. However, if a Member is hospitalized, confined in a Skilled Nursing Facility, or otherwise receiving acute institutional care at the time of the request, PacifiCare will not change the Primary Care Physician during the period of institutional or acute care nor for one full calendar month following completion of this care.

Required Change of Primary Care Physician

PacifiCare will provide notice to its Members if for any reason the Member's Primary Care Physician is no longer able or eligible to continue providing care to a PacifiCare Member within thirty (30) days of such event. The Member will have thirty (30) days within which to select another Primary Care Physician. If the Member fails to designate a new Primary Care Physician, PacifiCare will assign one. PacifiCare shall send the Member written notice of the identity and location of the Primary Care Physician and the effective date of change. After the Subscriber selects a new Primary Care Physician, the Member must obtain authorization for all Covered Services from the new Primary Care Physician.

Refusal of Medical Treatment

A Member may at any time refuse to accept a Primary Care Physician's recommended treatment or counsel. However, if the Primary Care Physician believes no professionally acceptable alternatives exist, the Primary Care Physician may conclude that such refusal is incompatible with the physician-patient relationship and obstructive to the provision of proper medical care. The Member will be fully advised of the Primary Care Physician's position. If the physician-patient relationship is materially damaged, the Primary Care Physician may request that PacifiCare authorize the Member to designate a different Primary Care Physician. PacifiCare will evaluate such request in light of the best interest of the Member and the geographic accessibility of other Primary Care Physicians. If PacifiCare authorizes a change of Primary Care Physician, the Member must select one within thirty-one (31) days. If the Member fails to select a new one, PacifiCare will assign one on the Member's behalf. If the Member refuses to accept the new Primary Care Physician's recommended treatment or counsel and no professionally acceptable alternative exist, then neither PacifiCare nor the involved Primary Care Physicians will be responsible to provide for or arrange further medical care or further cover the cost of services for the condition being treated. Notwithstanding the above, the Primary Care Physician shall continue to provide or arrange all Medically Necessary Covered Services for all conditions other than the condition for which the Member has refused to accept the recommended treatment.

SECTION IV. REFERRALS TO SPECIALISTS

Referrals must be coordinated by a Primary Care Physician. Generally, Primary Care Physicians refer exclusively to specialists who are Participating Providers within their common Participating Medical Group. If a Member self-refers to the Member's choice of Provider, PacifiCare will not provide coverage for the cost of these services.

Standing Referrals To Specialists

You may receive a standing referral to a specialist if your Primary Care Physician determines, in consultation with the specialist and your Participating Medical Group's Medical Director or a PacifiCare Medical Director, that you need continuing care from a specialist. A "standing referral" means a referral by your Primary Care Physician for more than one visit to a participating specialist as indicated in the treatment plan, if any. The standing referral will be made according to a treatment plan approved by your Participating Medical Group or PacifiCare, in consultation with your Primary Care Physician, the specialist, and you, if a treatment plan is considered necessary. The treatment plan may limit the

number of visits to the specialist, may limit the period of time the visits are authorized, or may require the specialist to provide your Primary Care Physician with regular reports on the health care provided to you. You may request a standing referral by asking your Primary Care Physician or specialist.

Extended Referral for Coordination of Care By Specialist

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

Direct Access To Ob/Gyn Physician Services

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

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

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

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

SECTION V. AUTHORIZATION, MODIFICATION AND DENIAL OF HEALTH CARE SERVICES

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

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

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

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

- Decisions to approve, modify, or deny, requests for authorization of health care services, based on Medical Necessity, will be made in a timely fashion appropriate for the nature of the Member’s condition, not to exceed five (5) business days from PacifiCare’s or the Participating Medical Group’s receipt of the information reasonably necessary to make the decision.
- If the Member’s condition poses an imminent and serious threat to their health including, but not limited to, potential loss of life, limb, or other major bodily function, or lack of timeliness would be detrimental in regaining maximum function, the decision will be rendered in a timely fashion appropriate for the nature of the Member’s condition, not to exceed seventy-two (72) hours after PacifiCare’s receipt of the information reasonably necessary and requested by PacifiCare to make the determination.

SECTION VI. EMERGENCY SERVICES AND CATASTROPHIC CASE MANAGEMENT

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

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

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

If you would like a copy of PacifiCare's policies and procedures, a description of the processes utilized for authorization, modification or denial of health care services, or PacifiCare's criteria or guidelines, you may contact the PacifiCare Customer Service department at 1-800-207-2077.

Emergency and Urgently Needed Services

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

The costs of Emergency or Urgently Needed Services, minus applicable Copayments, shall be covered by PacifiCare if the procedures discussed below are followed. Notwithstanding the above, if the need for any Covered Services arises while the Member is within the Service Area, such services must be provided or arranged by Member's Participating Medical Group unless it is an Emergency or Urgently Needed Service.

Procedures for Receiving Emergency Services

- a. An Emergency Medical Condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected by the Member to result in any of the following:
 - (i) placing the Member's health in serious jeopardy;
 - (ii) serious impairment to your bodily functions;
 - (iii) serious dysfunction of any bodily organ or part; or
 - (iv) 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.
- b. If the Member believes that he or she needs Emergency Services the Member should:

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

It is appropriate for the Member to use the 911 emergency response system or alternative emergency system in his or her area, for assistance in an emergency situation as described above when

ambulance services are required and the Member reasonably believes that his or her condition is immediate and serious and requires emergency ambulance transport services to transport the Member to an appropriate facility.

- c. The Member must notify PacifiCare or the Member's Participating Medical Group within twenty-four (24) hours, or as soon as possible, after the initial receipt of Emergency Services to inform them of the location, duration and nature of the service provided.

Procedures for Receiving Urgently Needed Services

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

Urgent situations refer to less serious medical conditions than emergency situations. Examples include:

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

What to Do When You Require Urgently Needed Services

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

- If possible, call, or have someone on your behalf call, your Primary Care Physician or Participating Medical Group. The telephone numbers for your Primary Care Physician and Participating Medical Group are on the front of your PacifiCare ID card. Assistance is available 24 hours a day, seven days a week.
- Identify yourself as a PacifiCare Member and ask to speak to a physician. If you are calling during non-business hours and a physician is not immediately available, ask to have the physician-on-call paged. A physician should call you back shortly.
- Explain your situation and follow the instructions provided.

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

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

Non-Qualifying Services

Emergency room visits for non-Emergency or non-Urgently Needed Services which have not been authorized by Member's Primary Care Physician in Member's Participating Medical Group and visits to Outside Providers for non-Emergency or non-Urgently Needed Services which have not been authorized by Member's Primary Care Physician in Member's Participating Medical Group are not covered under this Agreement.

Post-Stabilization and Follow-up Treatment

If the Member requires additional services following stabilization of an emergency or urgently needed condition, the Member should obtain these services from or with the authorization of his or her Primary Care Physician in his or her Participating Medical Group or the PacifiCare Out-of-Area Unit. The PacifiCare Out-of-Area Unit can be reached at 1-800-762-8456. Follow-up care provided in an emergency room is not a covered benefit unless the Member obtains prior authorization from his or her Primary Care Physician or PacifiCare. Out-of-Area follow-up care includes, but is not limited to: Routine follow-up care to Emergency or Urgently Needed Services, such as treatments, procedures, X-rays, lab work and doctor's visits, as well as Rehabilitation Services, Skilled Nursing Care or home health care. Prior authorization must be obtained from the Member's Participating Medical Group or PacifiCare for follow-up care to be covered. If an Outside Provider is utilized, PacifiCare may elect to transfer the Member to the Member's Participating Medical Group or to an alternative provider designated by the Participating Medical Group, provided the transfer would not create an unreasonable risk to the Member's health.

PacifiCare's Case Management Program

PacifiCare's Case Management Program is a program in which PacifiCare of California 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, which 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. For further assistance please contact PacifiCare's Customer Service department.

SECTION VII. IDENTIFICATION CARDS

Each Member will receive an identification card. Possession of the identification card does not entitle a Member to services or other benefits under this Health Plan. The holder of an identification card must be a Member on whose behalf all applicable Health Plan Premiums, Copayments and other charges have been received by PacifiCare. The Member should show his or her identification card each time the Member visits a Primary Care Physician or other Participating Provider to whom the Member has been referred. If any Member permits the use of his or her identification card by any other person, PacifiCare may immediately terminate that Member's membership as provided in the "Termination Provisions" Section XII of this Agreement.

SECTION VIII. CUSTOMER SERVICE DEPARTMENT

The Customer Service department is staffed by representatives who are sensitive to the health care needs of Members. This department is available to help Members understand this Health Plan, to help them select a Primary Care Physician, and to assist them with any concerns about using this Health Plan. To reach a Customer Service Associate, call:

Toll Free Number: 1-800-207-2077
Monday - Friday 8:00 a.m. to 8:00 p.m.

This and other useful numbers are printed on the back of the Member identification card.

SECTION IX. COPAYMENTS AND HEALTH PLAN PREMIUMS

Copayments

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

It is the Member's responsibility to inform PacifiCare when the Member has satisfied the annual Copayment maximum. This maximum is set forth in the *Schedule of Benefits*. Accordingly, it is important to keep all receipts for Copayments which the Member has actually paid. Copayments paid for certain Covered Services are not applicable to a Member's annual Copayment maximum; these exceptions are specified in the *Schedule of Benefits*.

Health Plan Premiums

Subscriber shall pay the Health Plan Premiums directly to PacifiCare when due. Health Plan Premiums must be received by PacifiCare on or before the first business day of the month for which coverage is being provided. All payments are to be made payable to PacifiCare of California and mailed to:

PacifiCare of California
Mailstop CY24-597
5701 Katella Avenue
Cypress, California 90630

A Subscriber may pay his or her monthly Health Plan Premiums by automatic deduction from a personal checking account. Contact PacifiCare's Customer Service department at 1-800-207-2077 for further information and an authorization form.

Modification of Rates and Benefits

The Health Plan Premium rate, the benefits set forth in this Agreement and its Attachments, including but not limited to the *Schedule of Benefits*, may be modified by PacifiCare in its sole discretion if PacifiCare provides thirty (30) days written notice mailed postage prepaid to the Subscriber. All modifications shall take effect on the first day of the first full month following the expiration of the 30-day notice period.

Payments Made In Error

If PacifiCare pays any fees for services which were not authorized by Member's Primary Care Physician, and which were not Emergency Services, Member shall reimburse PacifiCare for such payment. Failure to reimburse PacifiCare, or reach reasonable accommodations with PacifiCare concerning repayment, within fifteen (15) days after receiving PacifiCare's request for reimbursement, shall be grounds for termination of Member's membership in this Health Plan. The exercise of PacifiCare's termination rights shall not affect PacifiCare's right to collect reimbursement from the Member.

Effect of Payment

Except as otherwise provided in this Agreement, PacifiCare will only provide Covered Services to Members who timely pay their Health Plan Premiums, and then only for the period for which payment is received.

Lifetime Benefit Maximum

Your health care coverage may be subject to a Lifetime Benefit Maximum for the duration of your coverage under the PacifiCare Health Plan. Please refer to your *Schedule of Benefits* for the amount of your Lifetime Benefit Maximum, if any. If your *Schedule of Benefits* indicates that your PacifiCare Health Plan has a Lifetime Benefit Maximum, the Lifetime Benefit Maximum will be calculated for you and any Dependents on an individual basis. The Lifetime Benefit Maximum will be reached when total covered charges for Covered Services received by you or any of your Dependents reaches the amount set forth in your *Schedule of Benefits*. Covered charges mean the rates for services negotiated by the Plan or its contracting providers for Covered Services, less the amount of the Member's Copayment. Once you reached the Lifetime Benefit Maximum amount no further coverage for the services described in your *Combined Evidence of Coverage and Disclosure Form* will be available under this PacifiCare Health Plan.

This Lifetime Benefit Maximum does not apply to any PacifiCare of California supplemental benefits offered by your employer. Some supplemental benefits may be subject to a separate maximum benefit. Please refer to the *Supplement to the Combined Evidence of Coverage and Disclosure Form* for more information. If you or one of your enrolled family members is experiencing a major illness or recurring hospitalizations, PacifiCare's Case Management Program can assist in coordinating resources. Please refer to PacifiCare's Case Management Program in the "Emergency Services and Catastrophic Case Management," Section VI, of this brochure for further information about this program.

The Lifetime Benefit Maximum is individually cumulative for you and any of your Dependents if you are enrolled in a PacifiCare Health Plan with a Lifetime Benefit Maximum. If you and any of your Dependents end your coverage under a PacifiCare Health Plan with a Lifetime Benefit Maximum, then re-enroll later in another PacifiCare Health Plan with a Lifetime Benefit Maximum, any covered charges calculated under your previous PacifiCare Health Plan will carry over to your new PacifiCare Health Plan.

SECTION X. THIRD PARTY LIABILITY

Third Party Liability

To the extent permitted under applicable federal and state law and as provided for in this Agreement, in the case of injuries caused by an act or omission of a third party, and any complications incident thereto, the benefits of this Agreement shall be furnished by PacifiCare to Member. Member agrees, however to reimburse PacifiCare, or its nominee, for the cost of all such services and benefits provided, to the extent allowed under state and federal law, immediately upon obtaining a monetary recovery, whether due to judgment, arbitration award, or settlement agreement on account of such injury. PacifiCare or its nominee shall have a lien on any such monetary recovery by Member, and Member shall hold any sum due to PacifiCare or its nominee pursuant to this Section X in trust. The amount of PacifiCare's or its nominee's lien shall be determined in accordance with California Civil Code Section 3040, or any other applicable law in effect at the time the lien arises.

Member agrees that PacifiCare's rights to reimbursement under this Section X are the first priority claim against any third party. This means that PacifiCare shall be reimbursed from any recovery before payment of any other existing claims, including any claim by the Member for general damages. To the extent permitted by state and/or federal law, and as set forth in this Section X, PacifiCare may collect from the proceeds of any settlement or judgment recovered by Member or his or her legal representative regardless of whether the Member has been fully compensated.

Member agrees to cooperate in protecting the interests of PacifiCare under this provision. Member must execute and deliver to PacifiCare or its nominee any and all liens, assignments or other documents which may be necessary or proper to fully and completely effectuate and protect the rights of PacifiCare, or its nominee, including but not limited to, the granting of a lien right in any claim or action made or filed on behalf of Member and the signing of documents evidencing same. Member's failure to cooperate with PacifiCare in a reasonable manner as provided in this Section X may result in such Member's termination from this Health Plan.

Member shall not settle any claim, or release any person from liability, without the written consent of PacifiCare, wherein such release or settlement will extinguish or act as a bar to PacifiCare's rights of reimbursement.

In the event PacifiCare employs an attorney for the purpose of enforcing any part of this section against a Member based on Member's failure to cooperate with PacifiCare, the prevailing party in any legal action or proceeding shall be entitled to reasonable attorney's fees.

Workers' Compensation

PacifiCare shall not furnish benefits under this Agreement to any Member which duplicate the benefits to which such Member is entitled under any applicable workers' compensation law. The Member is responsible for taking whatever action is necessary to obtain payment under workers' compensation laws where payment under the workers' compensation system can be reasonably expected. Failure of the Member to take proper and timely action will preclude PacifiCare's responsibility to furnish benefits to the extent that payment could have been reasonably expected under workers' compensation laws. If a dispute arises between the Member and the Workers' Compensation carrier, as to the Member's ability to collect under workers' compensation laws, PacifiCare will provide the benefits described in this Agreement until resolution of the dispute.

If PacifiCare for any reason provides benefits which duplicate the benefits to which Member is entitled under workers' compensation law, Member agrees to reimburse PacifiCare, or its nominee, for the cost of all such services and benefits provided by PacifiCare, at Prevailing Rates, immediately upon obtaining a Monetary Recovery. Member shall hold any sum collected as the result of a worker's compensation action in trust for PacifiCare. Such sum shall not exceed the lesser of the amount of the recovery obtained by the Member or the value at Prevailing Rates of all services and benefits furnished to Member or on Member's behalf by PacifiCare as a result of each incident.

Automobile, Accident or Liability Coverage

PacifiCare, or its nominee, shall not furnish benefits under this Agreement which duplicate the benefits to which a Member is entitled under any other automobile, accident or liability coverage. Member is responsible for taking whatever action is necessary to obtain the benefits of such coverage when it is available and shall notify PacifiCare of such coverage when available. If payment or services are provided by PacifiCare and/or its nominee in duplication of the benefits available to the Member under other automobile, accident or liability coverage, PacifiCare and/or its nominee may seek reimbursement to the extent of the reasonable value of the benefits provided by PacifiCare from the insurance carrier, Provider, and/or Member, to the extent permitted under state and/or federal law.

Should the cost of Medical or Hospital Services exceed the coverage of any applicable other coverage pursuant to this Section X, PacifiCare benefits shall be provided over and above such coverage.

Health Insurance or Other HMO Coverage

PacifiCare shall not duplicate the coverage available to a Member under any other group or individual health care insurance contract or health care service plan contract. A Member is responsible for taking whatever action is necessary to obtain the benefits of such coverage and shall notify PacifiCare of such coverage when it is available. If PacifiCare provides benefits which duplicate the benefits to which Member receives under such other coverage, Member will reimburse PacifiCare for services and benefits provided by PacifiCare at Prevailing Rates immediately upon obtaining a Monetary Recovery from the insurance carrier or health care service plan. Notwithstanding this provision, PacifiCare will not reduce the benefits payable under this Agreement to the extent that the Member is entitled to benefits under Medi-Cal.

Services In Excess of Other Reimbursement

Should the cost of Medical or Hospital Services exceed the coverage or reimbursement available under this Section X, PacifiCare shall provide benefits over and above such coverage.

Required Cooperation

Member agrees to cooperate in protecting the interests of PacifiCare under this Section X. The Member's failure to cooperate with PacifiCare in a reasonable manner in its efforts to secure payment from any third party, or a workers' compensation, automobile, accident, or liability carrier may result in such Member's termination from this Health Plan for good cause.

Member shall not settle any claim, or release any person from liability, without the written consent of PacifiCare, if such release or settlement will extinguish or act as a bar to PacifiCare's rights of reimbursement.

Attorneys' Fees

In the event PacifiCare employs an attorney for the purpose of enforcing any part of this Section X against a Member based on Member's failure to cooperate with PacifiCare, the prevailing party in any legal action or proceeding shall be entitled to reasonable attorneys' fees. This attorneys' fees provision applies only to legal action which must be taken to enforce PacifiCare's rights to reimbursement for money paid or payable to Member by third parties or other insurers. Except as provided in this Section X, there is no prevailing party attorneys' fee provision in this Agreement.

SECTION XI. TERM OF AGREEMENT

The term of this Agreement shall be one (1) year commencing on the date of execution of this Agreement, 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 unless terminated as provided herein.

SECTION XII. TERMINATION PROVISIONS

IF A SUBSCRIBER'S COVERAGE TERMINATES, THE COVERAGE FOR ALL OF HIS OR HER ENROLLED DEPENDENTS WILL ALSO TERMINATE EXCEPT AS PROVIDED IN SECTION XIII.

Termination for Cause

Coverage under this Agreement shall terminate upon the occurrence of any of the following:

- a. Non-payment of Health Plan Premiums, Copayments or Fees for Non-Covered Services. If the applicable Health Plan Premium payments or Copayments are not timely paid by a Subscriber on behalf of the Subscriber and his or her Dependents, PacifiCare will send a fifteen (15)-day written notice of termination to the Subscriber. The notice of termination will state that unless the Health Plan Premium or Copayment is paid within fifteen (15) days after mailing of the written notice, the Subscriber's membership in the Health Plan will terminate effective the last day for which Health Plan Premiums have been received. If within fifteen (15) days after mailing written notice of termination, Subscriber pays the Health Plan Premium or Copayment, PacifiCare's notice of termination shall be revoked and membership in this Health Plan shall continue without interruption.

The failure of any Subscriber to reimburse PacifiCare for payments made in error by PacifiCare within fifteen (15) days after the mailing of written notice of termination for nonpayment by PacifiCare or to reach reasonable accommodations with PacifiCare regarding repayment shall result in the termination of the membership of the Subscriber and his or her Dependents in this Health Plan. To obtain coverage after termination, Subscriber must submit a new application for membership and comply with all applicable eligibility requirements.

- b. Subscriber Permanently Moves Out of Service Area. If a Subscriber permanently moves outside of the Service Area, the membership of Subscriber and his or her Dependents shall terminate. For purposes of this Agreement, a permanent move outside the

Service Area shall be deemed to occur if either (a) the Subscriber is absent from the Service Area for ninety (90) consecutive days, or (b) the Subscriber moves his or her residence from the Service Area without the intent to return. The Subscriber shall notify PacifiCare of his or her permanent move from the Service Area as soon as possible. Termination shall be effective the last day of the month in which the Subscriber receives notice of termination from PacifiCare. Notice to the Subscriber's last-known address shall be deemed effective notice for purposes of this Section XII.

- c. Member Never Eligible for Membership. If a person who has never been eligible for membership in this Health Plan has received the benefits of membership in this Health Plan for reasons other than the fraud or deception of the person or another person through which the person is enrolled as a Dependent, such person's benefits shall be terminated effective fifteen (15) days after PacifiCare mails a written notice of termination to the Subscriber. Notice to the Subscriber's last-known address shall be deemed effective notice for purposes of this Section XII.
- d. Member Fraud or Deception. A Subscriber and the Subscriber's enrolled Dependents' membership in this Health Plan shall immediately terminate if the Subscriber knowingly furnishes PacifiCare with incorrect, incomplete or misleading information concerning the Subscriber or any Dependents upon which PacifiCare relies, or otherwise commits fraud or uses deception which affects the Subscriber's and Subscriber's Dependents' eligibility for enrollment or benefits under this Health Plan. In such instance, PacifiCare shall send a written notice of termination to the Subscriber which shall be effective on the date notice of termination is sent from PacifiCare to the Subscriber. Notice to the Subscriber's last-known address shall be deemed effective notice for purposes of this Section XII.
- e. Member Permits Misuse of Identification Card. A Member's membership in this Health Plan shall immediately terminate if such Member permits the use of his or her PacifiCare Identification Card by any other person. In such instance, PacifiCare shall mail a written notice of termination to the Subscriber which shall be effective on the date notice of termination is sent from PacifiCare to the Subscriber. Notice to the Subscriber's last-known address shall be deemed effective notice for purposes of this Section XII.
- f. Abusive Behavior. PacifiCare may disenroll a Member if the Member's behavior is threatening, violent, or abusive such that it seriously threatens or jeopardizes the safety of the employees of PacifiCare or its Contracting Medical Groups. Member's enrollment in PacifiCare shall be terminated effective fifteen

(15) days after PacifiCare mails a written notice of termination to the Subscriber. Notice to the Subscriber's last-known address shall be deemed effective notice for purposes of this Section XII. However, if a Member is unable to establish a Member-Physician relationship with his or her Primary Care Physician or other Provider, the Member will be given the opportunity to select another Primary Care Physician or other Provider.

- g. Failure to Cooperate with PacifiCare Third Party Lien Rights. PacifiCare may terminate a Member if the Member fails to reasonably cooperate with PacifiCare in the enforcement of PacifiCare's lien rights as required by Section X. Termination shall be effective fifteen (15) days after PacifiCare mails a written notice of termination to the Subscriber. Notice to the Subscriber's last-known address shall be deemed effective notice for purposes of this Section XII.
- h. Voluntary Disenrollment By the Subscriber. A Subscriber may voluntarily disenroll the Subscriber or a Dependent by submitting written notice of disenrollment to PacifiCare. The Subscriber shall be responsible for any Health Plan premiums through the last day of the first full month after notice of disenrollment is received by PacifiCare. Member's enrollment in PacifiCare will be terminated effective the last day for which Health Plan Premiums have been received. Notice to the Subscriber's last-known address shall be deemed effective notice for purposes of this Section XII.

Automatic Termination

(See Section XIII for availability of continuous coverage for Dependents.) Member's enrollment in PacifiCare shall be terminated effective fifteen (15) days after PacifiCare mails a written notice of termination to the Subscriber.

- a. Dependent's Loss of Eligibility. If an eligible Dependent is enrolled as a Dependent, the Dependent's enrollment shall terminate on the last day of the month in which the Dependent ceases to be eligible as set forth in Section II. (See Section XIII for availability of continuous coverage.)
- b. Death. If the Subscriber dies, all Dependents shall automatically become disenrolled at midnight at the end of the month in which the death occurred. (See Section XIII for availability of continuous coverage.)
- c. Dissolution of Marriage. Upon dissolution of the marriage between Subscriber and Spouse, the enrollment of the Spouse shall automatically terminate along with the enrollment of all of the Spouse's Dependents who are not also Dependents of the Subscriber on the first day of the month following the month in which a court enters a final

judgment or decree of dissolution of marriage. (See Section XIII for availability of continuous coverage for Dependents.)

Written Notice of Termination

When a written notice of termination is sent to the Subscriber pursuant to Section XII, it shall be dated, sent to the last-known address of the Subscriber 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; and
- d. That notwithstanding the Member Appeals (Grievance) procedure set forth in this Agreement, if Member believes that his or her Health Plan membership has been terminated because of his or her health status or requirements for health care services, Member may request a review before the Director of the Department of Managed Health Care for the State of California.

Proration of Health Plan Premiums

Any portion of the Health Plan Premium received by PacifiCare or payable to PacifiCare which corresponds to any unexpired full month for which payment is received or is payable, shall be prorated and returned by the owing party together with any other amounts due, less any offsets, within thirty (30) days of termination of the Subscriber or a Dependent or both.

Non-Liability After Termination

Upon termination of this Agreement, PacifiCare shall have no further liability to provide benefits to any former Member, including, without limitation, former Members hospitalized or undergoing treatment for an ongoing condition. An individual's rights to receive benefits under this Health Plan shall cease upon the effective date of termination.

Subscriber's Termination Rights and Responsibility

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

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

If PacifiCare terminates a Member's enrollment in this Health Plan, and the Member has reason to believe that the termination was based upon his or her health status or requirements for health care services, the terminated Member may request a review of the termination by the California Director of the Department of Managed Health Care.

SECTION XIII. CONTINUOUS COVERAGE FOR DEPENDENTS

Should a Dependent(s) lose coverage under this Health Plan due to a Subscriber's loss of eligibility for any reason set forth in Section XII, the Dependent(s) shall be eligible to enroll in this Health Plan without regard to health status, provided the Dependent(s) notifies PacifiCare within thirty (30) days of the Subscriber's loss of eligibility. If a Dependent loses eligibility because he or she reaches the age of nineteen (19) or no longer meets the definition of a Student Dependent, the Dependent shall be eligible to enroll in this Health Plan without regard to health status, provided the Dependent notifies PacifiCare within thirty (30) days of the Dependent's loss of eligibility.

SECTION XIV. APPEALS PROCEDURE AND DISPUTE RESOLUTION

XIV.01 Appeals and Quality Reviews

PacifiCare and Member agree to the voluntary resolution of claims relating to the performance of this Agreement by PacifiCare and Member. The PacifiCare Appeals Procedure and Quality Review Procedure are designed to ensure that all complaints are handled promptly, investigated thoroughly and resolved in a timely manner. Complaints not related to quality of care (such as claims payment or coverage) are reviewed in accordance with the Appeal procedures outlined in Section XIV.01.01. Complaints relating to quality of care are reviewed in accordance with the Quality Review procedures outlined in Section XIV.01.02. If a single complaint 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 XIV.01.02, then upon completion of the Quality Review, the Member will be sent an initial determination relating to the non-quality of care issue. If Member is dissatisfied with the initial determination relating to the non-quality of care issue, Member may seek further review of this determination through the PacifiCare Appeals procedure, beginning with Paragraph XIV.01.01(b).

Members can initiate a formal Appeal or Quality Review by calling the Customer Service department at 1-800-207-2077 or writing to the Appeals department. PacifiCare will not discriminate against a Member on

the grounds that the Member initiated an Appeal or a Quality Review. Member complaints are received either by telephone or in writing through the Customer Service department or Appeals department. Complaints which cannot be resolved by the Customer Service department are forwarded to the Appeals department for evaluation. If the complaint is made by telephone and the person taking the call is unable to resolve the problem to the satisfaction of the Member, the Member may be asked to submit the complaint in writing to initiate an appeal review. An Appeals Coordinator will assist the Member in filing a written complaint if the Member so desires. The Member will be sent a written acknowledgment of his or her complaint and an explanation of the review procedure within ten (10) days.

All unresolved complaints are directed to the PacifiCare Clinical Improvement Director or his or her designee. The Clinical Improvement Director or his or her designee conducts an initial review within one (1) business day and refers all complaints that do not involve a quality of care issue to the Medical Service Benefits Review department for review pursuant to the appeals procedure described in Paragraph XIV.01.01 below.

XIV.01.01 PacifiCare Appeals Process

Member complaints involving claims payment or coverage decisions or other complaints not related to quality of care will be handled using the procedures set forth below. Each level of review will be conducted independently and at no time will a person who has been involved in a determination made at one level of review be involved as a decision-maker in a review of that determination. At the conclusion of each level of review, the reviewers shall file a report in the appeals file indicating the information which has been reviewed and the findings and conclusions of the reviewers.

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

- a. PacifiCare's Health Services department will conduct a review, and an initial determination, including an explanation of the reasons for the determination, will be sent to the Member within thirty (30) days of PacifiCare's receipt of the Member's appeal. For appeals involving the delay, denial or modification of health care services, PacifiCare's written response will describe the criteria or guidelines used and the clinical reasons for its decision, including all criteria and clinical reasons related to Medical Necessity. For determinations delaying, denying, or modifying health care services based on a finding that the services are not Covered Services, the response will specify the

provisions in the plan contract that exclude 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 HMO Evidence of Coverage and Disclosure Form* captioned "Quality Management Review."

- b. If the Member is dissatisfied after the determination by the Health Services department, the Member may request a review by the Appeals and Grievance Committee by submitting a request within thirty (30) days of the receipt of the Health Services department's determination. A hearing before the Appeals and Grievance Committee shall be scheduled within thirty (30) days of the Member's request for a hearing. The Member's participation at the Appeals and Grievance Committee hearing is encouraged.
- c. If the Member is dissatisfied with the redetermination, the Member may, within sixty (60) days, submit or request that PacifiCare submit the Appeal to binding arbitration before Judicial Arbitration and Mediation Services, Inc. (JAMS).
 - (i) **Voluntary Mediation.** In order to initiate mediation, the Member or the agent acting on behalf of the Member shall submit a written request for voluntary mediation. If the parties mutually agree to mediation, the mediation will be administered by JAMS in accordance with its JAMS Comprehensive Arbitration Rules and Procedures, unless otherwise agreed to by the parties. Expenses for mediation shall be borne equally by the parties. The Department of Managed Health Care shall have no administrative or enforcement responsibilities in connection with the voluntary mediation process.
 - (ii) **Binding Arbitration.** With the exception of claims brought pursuant to the Plan's Quality Review Process, any claim, controversy dispute or disagreement between PacifiCare and Member which arises out of or is related to this Agreement that is not resolved by the above appeals and dispute resolution processes shall be resolved by binding arbitration by a single arbitrator. If the amount of the claim is less than \$200,000, then the arbitrator shall have no jurisdiction to award more than \$200,000. JAMS or such other neutral administrator as PacifiCare shall designate shall administer the arbitration. The JAMS Comprehensive Arbitration Rules and Procedures ("Rules") in effect at the time demand for arbitration is made will be applied to the arbitration. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following

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

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

XIV.01.02. Quality Management Review

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

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

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

XIV.01.03 Expedited Review Process

Complaints involving an imminent and serious threat to the health of the Member, including, but not limited to, potential loss of life, limb, or major bodily function, will be immediately referred to the PacifiCare medical director for expedited review, regardless of whether such complaints are received orally or in writing. If a complaint has been sent to the PacifiCare medical director for immediate expedited review, PacifiCare will immediately inform the Member in writing of his or her right to notify the Department of Managed Health Care of the grievance. PacifiCare will provide the Member and the Department of Managed Health Care with a written statement of the disposition or pending status of the expedited review no later than three days from receipt of the complaint.

XIV.02 Experimental or Investigational Treatment

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

XIV.02.01 Independent Review of Denied Experimental or Investigational Eligibility Criteria

PacifiCare provides the opportunity to seek an independent review under California's Independent Medical Review System pursuant to Health & Safety Code Section 1370.4 of its coverage decisions regarding experimental or investigational therapies for PacifiCare Members who meet all of the following criteria:

1. The Member has a life-threatening or seriously debilitating condition, defined as:

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

"Seriously debilitating" means diseases or conditions that cause major irreversible morbidity.

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

A PacifiCare Medical Director has denied the Member's request for a treatment or therapy recommended or requested pursuant to paragraph (3); and

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

XIV.02.02 How To Request an Independent Review

Within five (5) business days of a decision to deny coverage for an experimental or investigational therapy for a Member who has a life-threatening or seriously debilitating condition, PacifiCare will send the Member written notice of the denial and of the right to request an independent review if the physician certification and evidence requirements listed in Items 2 and 3 above are met. The denial notice from PacifiCare will include an application form, along with a pre-addressed envelope, to be used to request an independent review from the Department of Managed Health Care (DMHC). PacifiCare also will include a physician certification form that must be completed by the Member's physician for the Member to be eligible for an independent review.

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

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

XIV.02.03 Independent Review Procedures

If the Member requests an independent review, the review will be performed by an independent medical review organization (IRO) that has a contract with the DMHC. The IRO will select an independent panel which may include up to three (3) physicians or other medical professionals who are experts in the treatment of the Member's medical condition and knowledgeable about the recommended treatment. Neither PacifiCare nor the Member will choose or control the choice of physicians or other medical professional experts. The costs of the independent review will be borne by PacifiCare. The Member pays no application or processing fees of any kind for an independent review.

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

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

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

If the Member's physician determines that the proposed course of treatment or therapy would be significantly less effective if not promptly initiated, the analysis and recommendations will be rendered within seven (7) days of the request for expedited review.

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

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

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

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

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

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

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

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

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

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

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

XIV.03 Independent Medical Review of Grievances Involving a Disputed Health Care Service

You may request an independent medical review (IMR) of disputed health care services from the Department of Managed Health Care (DMHC) if you believe that health care services have been improperly denied, modified, or delayed by PacifiCare or one of its contracting providers. A "disputed health care service" is any health care service eligible for coverage and payment under your Subscriber Agreement that has been denied, modified, or delayed by PacifiCare or one of its contracting providers, in whole or in part due to

a finding that the service is not medically necessary. Disputed health care services do not encompass coverage decisions. A “coverage decision” means the approval or denial of health care services by PacifiCare or one of its contracting providers, substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of the health care service plan contract.

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

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

- (a) Your provider has recommended a health care service as medically necessary; or
- (b) You have received urgently needed services or emergency services that a provider determined were medically necessary; or
- (c) You have been seen by an contracting provider for the diagnosis or treatment of the medical condition for which you seek independent review; and

The disputed health care service has been denied, modified, or delayed by PacifiCare or one of its contracting providers, based in whole or in part on a decision that the health care service is not medically necessary; and

You have filed a grievance with PacifiCare regarding the decision to deny, delay or modify health care services and the disputed decision is upheld or the grievance remains unresolved after thirty (30) days or three (3) days in the case of an urgent grievance requiring expedited review. If your grievance requires expedited review you may bring it immediately to the Department’s attention. The DMHC may waive the requirement that you follow PacifiCare’s grievance process in extraordinary and compelling cases.

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

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

For more information regarding the IMR process, or to request an application, please call PacifiCare’s Customer Service department at 1-800-207-2077.

XIV.04 Review By Director of 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 telephone 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 **1-916-229-4328**. The Department’s Internet Web site (**<http://www.hmohelp.ca.gov>**) has complaint forms and instructions online. If you have a grievance against your health plan, you should first telephone your plan at **(1-800-207-2077** or **TDHI: 1-800-442-8833)** and use the plan’s grievance process before contacting the Department. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your plan, or a grievance that has remained unresolved for more than thirty (30) days, you may call the Department for assistance. The plan’s grievance process and the Department’s complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

XIV.05 Member Claims Against Participating Medical Groups, Providers, Physicians and Hospitals

Member claims for benefits under this Agreement shall be reviewed under the procedures described in Section XIV.01. Member’s claims against a Participating Medical Group, its member physicians, or Providers, Physicians or Hospitals, other than claims for benefits under this Agreement, are not governed by this Agreement. Member may seek any appropriate legal action against such persons and entities deemed necessary.

In the event of dispute between Member and a Participating Medical Group or its member physicians for claims other than claims for benefits and upon mutual agreement between Member and the Participating Medical Group or its member physician, PacifiCare agrees to make available the Member Appeals process described in Section XIV.01 of this Agreement for resolution of such dispute. In such instance, the decision of the Health Services department, review by the Physician Review Committee and redetermination by a PacifiCare executive officer and/or two PacifiCare medical directors shall not be binding upon the parties except upon agreement between the parties. Such grievance shall not be subject to binding arbitration except upon agreement between the parties. Should Member and a Participating Medical Group or its member physicians fail to resolve the grievance, Member and Participating Medical Group or its member physicians may seek any appropriate legal action deemed necessary.

Member claims against PacifiCare shall be handled as discussed in Section XIV.01.

SECTION XV. ACTS BEYOND PACIFICARE'S CONTROL

If circumstances beyond the reasonable control of PacifiCare, including any major disaster, epidemic, complete or partial destruction of facility, war, riot, or civil insurrection, result in the unavailability of the facilities, personnel, the Primary Care Physicians, or the Hospitals, then PacifiCare, the Primary Care Physician and the Hospital shall provide or attempt to arrange for Medical Services and Hospital Services insofar as practical, according to their best judgment, within the limitation of such facilities and personnel. Neither PacifiCare nor any Primary Care Physician or Hospital shall have any liability or obligation for delay or failure to provide or arrange for Medical and Hospital Services if such delay or failure is the result of any of the circumstances described above.

SECTION XVI. HEALTH PLAN AMENDMENTS

The terms and provisions of this Agreement, and the benefits and rates set forth in this Agreement may be amended or modified without the consent of Member if such amendments or modifications are required by law. Written notice of such amendments or modifications must be given to Member at least thirty (30) days prior to the effective date of the amendment or modification.

SECTION XVII. RELATIONSHIPS BETWEEN PARTIES

Member Non-Liability

In the event PacifiCare fails to pay a Primary Care Physician or a contracting Hospital for Covered Services provided to a Member under this Agreement, the Member shall not be liable to the Primary Care Physician or the Hospital for any sums owed by PacifiCare.

Physician-Patient Relationship

Except as provided in "Selecting and Using a Primary Care Physician," Section III, a Subscriber is responsible for selecting a Primary Care Physician for each Member. The physician-patient relationship between the Primary Care Physician and Member shall be maintained by the Primary Care Physician. The Primary Care Physician is responsible to Member for the provision of all Medical Services rendered to Member by that Primary Care Physician. Hospitals are responsible for the provision of all Hospital Services rendered to Members. The Subscriber and his or her enrolled Dependents acknowledge that PacifiCare is a health maintenance organization and not a health care provider.

SECTION XVIII. CONFIDENTIALITY

PacifiCare agrees to maintain and preserve the confidentiality of any and all medical records of Member. However, the Subscriber and his or her enrolled Dependents authorize the release of information and access to any and all of the Members' medical records for purposes of Utilization Review, Quality Assurance, processing of any claim, financial audit, or for any other purpose reasonably related to the provision of benefits under this Agreement to PacifiCare, its agents and employees, the Members' Primary Care Physicians, and appropriate governmental agencies.

SECTION XIX. GOVERNING LAW

This Agreement is subject to the laws of the State of California, including the Act, and the regulations promulgated thereunder by the California Department of Managed Health Care. Any provisions required to be in this Agreement by the above Act and regulations shall bind PacifiCare and Member whether or not expressly provided in this Agreement.

SECTION XX. NON-ASSIGNABILITY OF BENEFITS AND AGREEMENT

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.

SECTION XXI. NOTICES

Any notice required to be given under this Agreement shall be in writing and either delivered personally or by United States mail at the addresses set forth below or at such other addresses as the parties may hereafter designate:

If to PacifiCare:

PacifiCare of California
Vice President of Sales and Marketing
P.O. Box 6006
Cypress, California 90630-0006

If to a Subscriber, at the Subscriber's last address known to PacifiCare.

SECTION XXII. SECOND MEDICAL OPINION POLICY

A Member, or his or her treating participating health professional, may submit a request a second medical opinion to the Participating Medical Group (or in some cases PacifiCare, therefore Member should consult his or her Primary Care Physician). Second medical opinions will be provided or authorized when medically appropriate, including but not limited to the following:

- (i) the Member questions the reasonableness or necessity of recommended surgical procedures;
- (ii) the Member questions a diagnosis or plan for care for a condition that threatens loss of life, loss of limb, loss of bodily functions, or substantial impairment, including, but not limited to a chronic condition;

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

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

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

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

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

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

PacifiCare Customer Service Department
5701 Katella Avenue/P.O. Box 6006
Cypress, CA 90630
1-800-207-2077

SECTION XXIII. HOW PACIFICARE PROVIDERS ARE COMPENSATED

PacifiCare typically contracts with medical groups and Independent Practice Associations (IPAs) to provide medical services to Members and with hospitals to provide hospital services. The contracting medical groups and IPAs, in turn, employ or contract with individual physicians.

Most of PacifiCare's contracting medical groups and IPAs receive an agreed upon monthly payment from PacifiCare to provide services to Members. The monthly payment may either be a fixed dollar amount for each Member or a percentage of the monthly premium received by PacifiCare. The monthly payment typically covers professional services directly provided by the medical group or IPA, and may also cover certain referral services. Some of PacifiCare's contracting hospitals receive similar monthly payments in return for arranging hospital services for Members. Other hospitals are paid on a discounted fee-for-service or fixed charge per day of hospitalization.

At the beginning of each year, PacifiCare and each medical group or IPA agree on a budget for the cost of services covered under the program for all PacifiCare Members treated by the medical group or IPA. 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 medical group or IPA shares in the savings. The hospital and medical group or IPA typically participate in programs for hospital services similar to that described above.

Stop-loss insurance protects medical groups, IPAs and hospitals from large financial expenses. PacifiCare provides stop-loss protection to our contracting medical groups, IPAs and hospitals that receive monthly payments. If any providers do not obtain stop-loss protection from PacifiCare, they must obtain stop-loss insurance from an insurance carrier acceptable to PacifiCare. You may obtain additional information on PacifiCare's compensation arrangements by contacting PacifiCare or your Participating Medical Group.

SECTION XXIV. CONTINUITY OF CARE FOR TERMINATING PHYSICIANS

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

If you are receiving treatment for:

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

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

SECTION XXV. COMPLIANCE WITH NEWBORNS' AND MOTHERS' HEALTH ACT OF 1997

The California Newborns' and Mothers' Health Act of 1997 prohibits Health Care Service Plans from restricting maternity stay benefits for inpatient hospital care to a time period less than forty-eight (48) hours following a normal vaginal delivery and less than ninety-six (96) hours following a caesarean section. A decision to discharge the mother and newborn before the 48- or 96-hour time period can only be made by the treating physician in consultation with the mother. In addition, if the mother and newborn are discharged prior to the 48- or 96-hour time period, a post-discharge follow-up visit for the mother and the newborn must be provided within forty-eight (48) hours of discharge, when prescribed by the treating physician.

This notice serves to inform PacifiCare Members that PacifiCare provides maternity benefits consistent with the California Newborns' and Mother's Health Act of 1997.

SECTION XXVI. COVERAGE UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA")

An individual will be eligible for this Health Plan, regardless of health status, if he or she meets the Subscriber Eligibility requirements set forth in Section II and the definition of an Eligible Individual below:

Eligible Individual. An individual who meets the following conditions:

- (i) the individual has had at least 18 months of prior coverage, the most recent of which was under a group health plan, governmental plan or church plan;
- (ii) the individual is not currently eligible for coverage under a group health plan, Medicare or Medicaid;
- (iii) the individual does not currently have other insurance;
- (iv) the individual's most recent coverage was not terminated because of nonpayment of premiums or fraud; and
- (v) if eligible, the individual elected and exhausted COBRA continuation coverage.

SECTION XXVII. IMPORTANT INFORMATION ABOUT ORGAN AND TISSUE DONATIONS

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

Almost Anyone Can Be a Donor

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

Be Sure To Share Your Decision

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

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

How To Learn More

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

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

SECTION XXVIII. VALIDITY

The unenforceability or invalidity of any Section or Subsection of this Agreement shall not affect the enforceability and validity of the balance of this Agreement.

SECTION XXIX. WAIVER OF DEFAULT

The waiver by PacifiCare of any one or more defaults by a Subscriber or his or her enrolled Dependents 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.

SECTION XXX. ENTIRE AGREEMENT

This Agreement contains the entire understanding of the Subscriber and his or her enrolled Dependents 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, or communications, whether written or oral, between the Subscriber and PacifiCare with respect to the subject matter of this Agreement.

SECTION XXXI. EXECUTION OF AGREEMENT

PacifiCare accepts the terms, conditions and provisions of this Agreement upon execution of this Agreement. The Subscriber accepts the terms, conditions and provisions of this Agreement, on behalf of him or herself and his or her Dependents, upon completion and execution of the Enrollment Application.

PACIFICARE OF CALIFORNIA

d/b/a PACIFICARE HEALTH PLAN



Rich Roge
Vice President of Sales and Marketing

Medical and Hospital Benefits

I. BENEFITS WHILE HOSPITALIZED AS AN INPATIENT

When admitted by or authorized by Member's Primary Care Physician in Member's Participating Medical Group.

Please refer to your *Schedule of Benefits* for detailed Copayments and Deductibles.

Alcohol, Drug or other Substance Abuse

Detoxification – Detoxification is covered when authorized by Member's Primary Care Physician in Member's Participating Medical Group. Rehabilitation for alcohol, drug or other substance abuse or addiction is not covered. Medical problems associated with acute alcohol, drug or other substance abuse are covered by PacifiCare.

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

Costs for computerized national and international searches for bone marrow donors conducted through a registry are covered when Member is the intended recipient up to a maximum of \$10,000.00 or 50 potential donors, whichever occurs first, per lifetime. Computerized searches must be conducted by a PacifiCare Center of Excellence. These limitations apply to searches only. There is no dollar limitation for transplant services once a donor is identified.

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

Hospice Care – Hospice services authorized by Member's Primary Care Physician in Member's Participating Medical Group are covered in a facility or on an outpatient basis when Member:

- a) has been judged to have six months of life expectancy or less; and
- b) has determined to no longer pursue aggressive medical treatment and when the goal of treatment is to provide supportive nursing care and counseling to the Member during the terminal phase of an illness.

Inpatient Hospital Benefits/Acute Care – Medically Necessary inpatient Hospital Services authorized by Member's Primary Care Physician in Member's Participating Medical Group are covered, including semiprivate room, intensive care, definitive observation,

isolation, operating room, recovery room, laboratory, diagnostic and therapeutic radiology, nuclear medicine, pharmacy, inhalation therapy, dialysis, EKG, EEG, EMG, blood and blood plasma, anesthesia supplies, private nursing, and professional charges by the hospital pathologist or radiologist, coordinated discharge planning and other miscellaneous hospital charges for Medically Necessary care and treatment.

Autologous (self-donated) blood processing costs are covered up to a maximum dollar amount of \$120.00 per blood unit for blood collected for Member's scheduled surgery. Member is financially responsible for blood processing costs that exceed the \$120.00 per blood unit.

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

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

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

With the exception of Emergency or Urgently Needed Services, a Member will only be admitted to those hospitals, acute care, subacute care, transitional inpatient care and skilled nursing care facilities that are authorized by the Member's Participating Medical Group and under contract with PacifiCare. Members may call PacifiCare's Customer Service department to obtain a list of contracting subacute or transitional inpatient care facilities. Members may also call the Customer Service department to request a copy of PacifiCare's utilization review and prior authorization processes that apply to care provided in subacute care, transitional inpatient care and skilled nursing facilities.

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

Maternity Care – Complete inpatient Hospital Services for maternity care are covered including labor and delivery room, recovery room, delivery by cesarean section, miscarriage, involuntary abortion and any complications of pregnancy or childbirth.

Educational courses on lactation, child care and/or child bearing (Lamaze) are not covered.

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

Newborn Care – Coverage for newborn children of the Subscriber and enrolled Spouse begins at birth. Complete prenatal and postnatal Hospital Services including circumcision (if desired) and special care nursery are covered. In order for coverage to continue beyond thirty-one (31) calendar days after the date of birth, a PacifiCare Change Form for the Dependent must be submitted to PacifiCare within thirty-one (31) calendar days from the date of birth.

Reconstructive Surgery – Inpatient Reconstructive Surgery is covered when performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease to do either of the following:

- To improve function; or
- To create a normal appearance, to the extent possible.

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

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

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

Voluntary Interruption of Pregnancy – Please refer to your *Schedule of Benefits* for coverage information.

II. BENEFITS AVAILABLE ON AN OUTPATIENT BASIS

Unless otherwise noted, the following benefits are available on an outpatient basis authorized by Member’s Primary Care Physician in Member’s Participating Medical Group.

Alcohol, Drug, or other Substance Abuse Detoxification – Medical evaluation, detoxification and treatment for withdrawal are covered for substance abuse when authorized by Member’s Primary Care Physician in Member’s Participating Medical Group. Rehabilitation for substance abuse or addiction is not covered. Medical problems associated with acute alcohol, drug or other substance abuse are covered by PacifiCare.

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

Allergy Treatment – Services necessary for the treatment of allergies pursuant to an established treatment plan are covered. Serum is not covered.

Ambulance – Use of an ambulance or ambulance transport services (land or air), including but not limited to those provided through the 911 emergency response system, is covered without prior authorization, when the Member reasonably believes that the medical condition requires Emergency Services

requiring ambulance transport services. Use of an ambulance for a non-emergency is covered when specifically authorized by Member's Primary Care Physician in Member's Participating Medical Group.

Ambulance transportation is limited to the nearest available facility having the expertise to treat the Member's Emergency Condition.

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

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

Cochlear Implant Device – Implantable cochlear devices are covered for bilateral, profoundly hearing-impaired individuals who cannot benefit from conventional amplification (hearing aids). Coverage is for Members at least 18 months of age who have either profound bilateral sensory hearing loss or for prelingual Members with minimal speech perception under the best hearing aided condition.

Cochlear Implant Medical and Surgical Services – Medical and surgical services to implant cochlear devices are covered for bilateral, profoundly hearing-impaired individuals who cannot benefit from conventional amplification (hearing aids). Benefit includes short-term hearing rehabilitation 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 Rehabilitation.")

Corrective Appliances and Prosthetics – Prosthetics (except for bionic or myoelectric as explained below) are covered when Medically Necessary as determined by 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 post cataract extraction contact lens in a surgically affected eye; and removable, non-dental prosthetic devices such as a false eye or limb which do 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. Corrective Appliances are devices that are designed to support a weakened body part. These appliances are manufactured or custom fitted to an individual Member.

- Bionic and Myoelectric prosthetics are not covered. Bionic prosthetics are prosthetics that require surgical connection to nerves, muscles or other tissues. Myoelectric prosthetics are prosthetics, which have electric motors to enhance motion.
- Refer to specialized footwear and foot orthotics in exclusion and limitation section of this document.

Initial placement of corrective appliances and prosthetics are covered (purchase or rental). 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. All corrective appliances and prosthetics placements, repairs and adjustments must be authorized by the Member's Participating Medical Group or PacifiCare.

Crisis Intervention – Coverage for Crisis Intervention may be available as an additional benefit. Please refer to the *Schedule of Benefits* for coverage, if any.

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

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

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

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

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

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

- blood glucose monitors;
- glucose monitors designed to assist the visually impaired;
- strips;
- lancets and lancet puncture devices;
- pen delivery systems (or the administration of insulin);
- insulin pumps and all related necessary supplies;
- ketone urine testing strips;
- insulin syringes;
- and podiatry services and devices to prevent or treat diabetes related complications.

Equipment and supplies do not count against Member's Durable Medical Equipment limitation if applicable.

Visual aids are covered for Members determined to have a visual impairment that would prohibit proper dosing of insulin.

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

Durable Medical Equipment (Purchase or Repair) – Durable Medical Equipment is covered when it is designed and Medically Necessary to assist in the treatment of an injury or illness of the Member and is primarily for use in the home. Durable Medical Equipment is medical equipment which is able to exist for a reasonable period of time without significant deterioration. Examples of covered Durable Medical Equipment include wheelchairs, hospital beds and standard oxygen machines.

- Special optional attachments or modifications to Durable Medical Equipment are not covered.

Initial placement of Durable Medical Equipment are covered (purchase or rental). Replacements, repairs and adjustment to Durable Medical Equipment coverage are limited to normal wear and tear or because of a significant change in the Member's physical condition. All durable medical equipment placement, repairs and adjustments must be authorized by the Member's Participating Medical Group or PacifiCare.

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

Family Planning – Please refer to the *Schedule of Benefits* for coverage details.

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

Hearing Screening – Routine hearing screening by a participating health professional is covered to determine the need for hearing correction.

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

Home Care – Part-time or intermittent skilled home care for Medically Necessary skilled nursing care and skilled rehabilitation services by a licensed nurse and/or physical therapist are covered when authorized by the Member's Participating Medical Group or PacifiCare. Skilled care needs more extensive than part-time, or intermittent may require placement or transfer of a Member to a Skilled Nursing Facility. PacifiCare in consultation with the Member's Participating Medical Group will determine the appropriate setting for the Member's Skilled Care services.

Covered visits per calendar year is specified in the *Schedule of Benefits*. Visit defined as up to two (2) hours of skilled services by a licensed professional nurse or therapist.

Hospice Care – Hospice Care is covered when authorized by Member's Primary Care Physician in Member's Participating Medical Group when Member:

- a) has been judged to have six months of life expectancy or less; and
- b) has determined to no longer pursue aggressive medical treatment and when the goal of Hospice Care is to provide supportive nursing care and counseling to Member during the terminal phase of an illness.

Hospice Care benefits include: hospice nursing care, social services evaluation, counseling, and home health aide services. Hospice Care can be provided in a Facility or on an outpatient basis.

Immunizations – Immunizations for children are covered consistent with the most current version of both of the following:

- a) the Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics in September of 1987; and
- b) the most current version of the Recommended Childhood Immunization Schedule/United States, adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians.

The following immunizations may be covered: DPT, DP, Tetanus Toxoid, Oral Polio, Measles, Mumps, Rubella, Hepatitis B, Haemophilus influenza type b, and Varicella. For children under 2 years of age, immunizations are covered under Well-Baby Care.

Infusion Therapy – Services are covered when authorized by the Member's Participating Medical Group. Infusion therapy means therapeutic use of drugs or other substances, prepared or compounded, and administered by a qualified provider and given to a Member through a needle or catheter.

Services must be provided in the Member's residence, home or an institution that is not a hospital or is not primarily engaged in providing skilled nursing or rehabilitation services.

The infusion services must be furnished under a plan of treatment that is established, reviewed at least every 30 days, and ordered and authorized by the Member's Participating Medical Group.

Infusion therapy has a separate Copayment in addition to a home health or facility Copayment.

Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications) – What is covered: Outpatient injectable medications administered in the physician's office (except insulin) that are Medically Necessary and are a routine part of the medical office visit. Self-injectable medications (except insulin) that are Medically Necessary, and prescribed by a Participating Physician at the Member's Participating Medical Group are covered.

- Outpatient injectable medications, including self injectables, must be obtained through a PacifiCare participating provider or through the Member's Participating Medical Group and may require prior authorization.

- Injectable Drug Copayment is not applicable to Allergy Serum, Birth Control, Infertility, Immunizations and Insulin. For coverage regarding these benefits, if any, please refer to the *Schedule of Benefits* and the *Supplement to the Combined Evidence of Coverage and Disclosure Form*.

Laboratory Services – Diagnostic and therapeutic laboratory services are covered when available through and authorized by the Member's Participating Medical Group or PacifiCare.

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

Medical Social Services – Referrals to licensed community agencies or social services are covered.

Mental Health Services (Severe Mental Illness (SMI) and Serious Emotional Disturbances (SED)) – Coverage includes treatment for Severe Mental Illnesses (SMI) of adults and children and for children the treatment of Serious Emotional Disturbances of Children (SED) as required by state law. Please refer to your *Supplement to the PacifiCare Combined Evidence of Coverage and Disclosure* for a description of this coverage.

Coverage for Mental Health Services beyond Severe Mental Illness (SMI) and Serious Emotional Disturbances of Children (SED) may be available as an additional benefit. Please refer to the *Schedule of Benefits* for coverage, if any.

Oral Surgery Services – Dental Care as defined under the "Exclusions and Limitations of Benefits" section of this Agreement are not covered except as expressly provided below.

Oral surgical procedures are covered when approved by Member's Participating Medical Group in connection with the following: stabilization and emergency treatment within forty-eight (48) hours of an acute accidental injury to sound natural teeth, jaw bone, or surrounding tissues; correction of pathological conditions of a non-dental origin such as cleft lip and cleft palate, which have resulted in severe functional impairment. (Severe functional impairment is the inability to maintain nutritional status due to pain with limitation of the jaw system.)

Anesthesia and outpatient facility charges for Dental Care (as Dental Care is defined in the "Exclusions and Limitations of Benefits" section of this Agreement) when necessary to assure proper medical management, control, or treatment of a non-dental illness or injury. For example, coverage will be provided for anesthesia incident to a dental procedure which is required due to the Member's hemophilia, severe cardiac condition or severe respiratory condition.

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

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

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

Outpatient Surgery – Short-stay, day care or other similar outpatient surgery facility are covered when provided as a substitute for inpatient care. Professional Services are covered and included as part of inpatient physician care benefit.

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

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

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

Food products naturally low in protein are not covered.

Physician Care – Medically Necessary services of the physicians within the Member's Participating Medical Group and other licensed health professionals are covered with the prior authorization and referral of the Member's Participating Medical Group for preventive services, surgical procedures, consultation and treatment.

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

Physician Specialist Care – Care of a Specialist or other designated licensed health care professional with advanced training in an area of medicine is covered upon referral by the Member's Participating Medical Group or PacifiCare.

Radiation Therapy –

- Radiation Therapy (Standard): Standard photon beam radiation therapy is covered.
- Radiation Therapy (Complex): Complex radiation therapy is covered. This therapy requires specialized equipment, as well as specially trained or certified personnel to perform the therapy. Examples include, but are not limited to, brachytherapy, radioactive implants, conformal photon beam.
- Gamma knife procedures and stereotactic procedures are covered as outpatient surgery. Please refer to your *Schedule of Benefits*.

Radiological Services – 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, Barium studies, and bone density studies. Also see "Maternity and Periodic Health Evaluations."

Specialized Scanning and Imaging Procedures: CT, SPECT, PET, MRAs and MRI (with or without contrast media) are covered.

Refractions – Routine screening for refractive error every twelve (12) months following Member's initial date of Eligibility (frames and lenses are excluded).

Vision Screening – Routine eye health assessment and screening by a participating health professional to determine the need for vision correction.

Well-Baby Care – Preventive health service, including immunizations, provided by the Member's Participating Medical Group up to age two (2).

Services may include, but are not limited to, height, weight, head circumference measurements, physical exam, eye/ear exam, review of motor language and social skills, laboratory tests and routine immunizations. Refer to immunization description.

Well-Woman Care – including pap smear by a Participating Medical Group OB/GYN or Family Practice Physician (designated by the Member's Participating Medical Group as providing OB/GYN services) affiliated with your Participating Medical Group, and referral by the Participating Medical Group for screening mammography as recommended by the U.S. Preventive Services Task Force.

III. COVERAGE OF EMERGENCY OR URGENTLY NEEDED SERVICES

Emergency and Urgently Needed Services received in a physician office, hospital emergency room or other facility providing Medical or Hospital Services.

An Emergency Service is a Medically Necessary Medical or Hospital Service required as the result of a medical condition manifesting itself by the sudden onset of symptoms of sufficient severity, which may include severe pain, such that a reasonable person would expect the absence of immediate medical attention to result in:

- (1) placing the health of the individual in serious jeopardy;
- (2) serious impairment to bodily functions; or
- (3) serious dysfunction of any bodily organ or part.

Emergency Services include ambulance and ambulance transport services as described in the subsection of this Agreement captioned "Ambulance" under "Benefits Available on an Outpatient Basis."

Examples of medical conditions requiring Emergency Services include, but are not limited to, heart attacks, strokes, poisonings, active labor, or sudden inability to breathe.

Urgently Needed Services are Medically Necessary services required outside of the Service Area to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that treatment cannot be delayed until the Member returns to the Service Area. Urgent situations refer to less serious medical conditions, such as broken bones, lacerations requiring stitches and acute illnesses when Member is outside the PacifiCare Service Area and the delay necessary to return to the Service Area or to contact Member's Participating Medical Group would result in a serious deterioration in Member's Health.

Medical or Hospital Services which do not qualify as Emergency or Urgently Needed Services received without prior authorization from Member's Primary Care Physician in Member's Participating Medical Group are not covered. Thus, for example, medical

care provided outside the PacifiCare Service Area will not be covered if the need for care is for a known or chronic condition that is not manifesting itself by acute symptoms as set forth above.

IV. ANNUAL COPAYMENT MAXIMUM

When a Member's Copayments during any calendar year exceed the Annual Copayment Maximum Per Individual of \$1,500 then no further Copayments will be required of the Member during the remainder of the calendar year. The Annual Copayment Maximum per Family is computed at three (3) times the Annual Copayment Maximum per Individual.

The Annual Copayment Maximums do not apply to any Copayments required for outpatient drugs and prescription medications benefits or the \$1,000 Copayment for maternity benefits.

Member must keep all of his or her receipts to submit proof of reaching the Annual Copayment Maximums.

V. EXCLUSIONS AND LIMITATIONS OF BENEFITS

All services and benefits described below shall be excluded from coverage under this plan.

General Exclusions

1. All services not specifically included as benefits in the Agreement and in the *Schedule of Benefits*.
2. Services rendered without authorization from Member's Primary Care Physician in Member's Participating Medical Group (except for Emergency or Urgently Needed Services, or obstetrical and gynecological physician services obtained directly from an OB/GYN, Family Practice Physician or Surgeon (designated by your Participating Medical Group as providing OB/GYN services) affiliated with your Participating Medical Group).
3. Any services rendered prior to Member's start date of coverage or subsequent to the date coverage ends.
4. Services rendered by Outside Providers when Member has refused treatment provided or authorized by Member's Primary Care Physician in Member's Participating Medical Group.
5. Services which, in the judgment of PacifiCare, are not Medically Necessary and that are not consistent with professional practice.
6. Services which are part of a plan of treatment for a non-Covered Service, which are the sole, direct and predictable consequence of such non-Covered Service as recognized by the organized medical community

in the State of California; provided, however, that PacifiCare shall not exclude coverage for Medically Necessary services required to treat an illness or injury that may be a consequence of non-Covered Services but are not predictable in advance, such as unexpected complications of surgery.

Other Exclusions and Limitations

(The paragraph headings are intended for reference purposes only.)

Acupuncture, Acupressure, Biofeedback

Acupuncture, acupressure and biofeedback are not covered.

Alcoholism, Drug Addiction, Other Substance Abuse

Rehabilitation for chronic alcoholism, drug addiction or other substance abuse is not covered.

Allergy Treatment Allergy Serum is not covered.

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

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

Chiropractic Care Care and treatment provided by a chiropractor is not covered.

Corrective Appliances and Prosthetics Replacement of lost corrective appliances or prosthetics is not covered. Prosthetics that require surgical connection to nerves, muscles or other tissues (bionic) are not covered. Prosthetics that have electric motors to enhance motion (myoelectronic) are not covered.

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

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

When services are determined to be cosmetic, all services to be provided as part of the cosmetic treatment plan are also excluded, including hospital, physician,

medical supplies, or medications (injectable, intravenous or taken by mouth).

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

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

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

Developmental Disorders Services that are primarily oriented towards treating a social, developmental or learning problem, rather than a medical problem, are not covered.

Disabilities Connected To Military Services

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

Durable Medical Equipment

Replacement of lost Durable Medical Equipment is not covered. Additional accessories to Durable Medical Equipment for the comfort or convenience of the Member for ambulation primarily in the community, including home and car remodeling or modification, are not covered.

Annual benefits limit may apply please refer to the *Schedule of Benefits*.

Emergency and Urgently Needed Services

Emergency and Urgently Needed Services are covered in a non-contracting facility only as long as the emergent or urgent condition exists and a transfer would be medically inappropriate. Routine follow-up care including treatments, procedures, X-rays, lab work, Physician visits, rehabilitation, and Skilled Nursing Care will not be covered without the authorization from Member's Primary Care Physician in Member's Participating Medical Group once it is medically

reasonable for the Member to obtain these services from the Participating Medical Group. The fact that the Member is outside the Service Area and that it is inconvenient for the Member to obtain the required services from the Participating Medical Group will not entitle the Member to coverage.

Experimental or Investigational Treatment

Experimental or investigational treatments are not covered unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. Unless otherwise dictated by federal or state law, decisions as to whether a particular treatment is experimental or investigational, and therefore not a covered benefit, are determined by PacifiCare's Medical Director or his or her designee based upon criteria established by PacifiCare's Technology Assessment Guidelines Committee pursuant to the following guidelines.

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

1. It cannot be lawfully marketed without the approval of the United States Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use;
2. It is the subject of a current investigational new-drug or new-device application on file with the FDA;
3. It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial, as these Phases are defined in regulations and other official actions and publications issued by the FDA and the Department of Health and Human Services (HHS);
4. It is being provided pursuant to a written protocol which describes among its objectives determinations of safety and/or efficacy as compared with standard means of treatment;
5. It is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations and other official actions and publications issued by the FDA and the HHS;
6. The predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings;
7. The predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness or effectiveness compared with conventional alternatives; or

8. It is not investigational or experimental in itself pursuant to the above, and would not be Medically Necessary, but for the provision of a drug, device, treatment, or procedure which is investigational or experimental.

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

1. The Member's medical records;
2. The protocol(s) pursuant to which the drug, device, treatment or procedure is to be delivered;
3. Any consent document the Member, or his or her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure;
4. The published authoritative medical or scientific literature regarding the drug, device, treatment, or procedure at issue as applied to the illness or injury at issue;
5. Opinions of other agency review organizations/ review organizations, e.g. ECRI Health Technology Assessment Information Service, HAYES New Technology Summaries or AHCPR (Agency for Health Care Policy and Research);
6. Expert medical opinion; and
7. Regulations and other official actions and publications issued by the FDA and HHS.

A Member with a life threatening or seriously debilitating condition may be entitled to an expedited hearing in cases in which a proposed treatment is denied as Experimental or Investigational as provided in the Subscriber Agreement or pursuant to California Health and Safety Code Section 1370.4. In addition, a Member may be entitled to an external, independent review of PacifiCare's coverage determination regarding experimental or investigational therapies pursuant to California Health and Safety Code 1370.4. See Section 7.02 of the Agreement for a description of how the Member may access the external, independent review process.

Family Planning Progesterone implants (Norplant) are limited to one device per 5 year period. Depo-Provera Medication is limited to one injection every ninety (90) days.

Foot Care Routine foot care, including but not limited to removal or reduction of corns and calluses, clipping of toenails, treatment for flat feet, fallen arches, and chronic foot strain, except when Medically Necessary. Also note exclusions for Specialized Footwear below.

Hearing Aids and Implantable Hearing Devices

Hearing aids and other implantable hearing devices are not covered. Audiology services (other than screening for acuity) are not covered. Hearing aid supplies are not covered. Implantable hearing devices are not covered except that cochlear devices for bilateral, profoundly hearing impaired individuals not benefited from conventional amplification (hearing aids) are covered.

Infertility Reversal Reversal of voluntary sterilization is not covered.

Infertility Services Services for infertility are not covered.

Institution Services and Supplies – Non-Eligible

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

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

Mental Disorders and Nervous Disorders Mental Health Services are not covered except for Severe Mental Illnesses (SMI) of adults and children and for children the treatment of Serious Emotional Disturbances (SED) as required by State Law. Please refer to the *Supplement to the PacifiCare Medical Combined Evidence of Coverage and Disclosure Form* for a description of this coverage for SMI/SED.

Academic, educational testing, counseling and remediation are not covered.

Non-Licensed Professionals Treatment for any illness or injury when not attended by a licensed physician or surgeon or health care professional.

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

Off-Label Drug Use Off-Label Drug Use means that the Provider has prescribed a drug approved by the Food and Drug Administration (FDA) for a use that is different than 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 herein and any applicable attachment. If a self injectable drug prescribed is for off-label drug use, the drug and its administration will be covered only if it satisfies the following criteria: (1) The drug is approved by the FDA. (2) The drug is prescribed by a participating licensed health care professional for the treatment of a

life-threatening condition or for a chronic and seriously debilitating condition. (3) The drug is Medically Necessary to treat the condition. (4) The drug has been recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following: The American Medical Association *Drug Evaluations*, The American Hospital Formulary Service *Drug Information*, The United States Pharmacopoeia *Dispensing Information* or in two articles from major peer reviewed medical journals that present data supporting the proposed Off-Label Drug use or uses as generally safe and effective. (5) The drug is administered as part of a core medical benefit as determined by PacifiCare. Nothing in this section shall prohibit PacifiCare from use of a formulary, copayment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is 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 otherwise outlined in this Agreement.

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

Organ Transplants Organ transplants not Medically Necessary and organ transplants considered Experimental or Investigational as defined herein are not covered, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. The following organ transplants are examples of organ transplants considered Experimental or Investigational at the time of printing this Agreement: Pancreas (alone) transplant or pancreas after kidney transplant.

Out-of-Area Services Medical and Hospital Services, except for Emergency and Urgently Needed Services, are not covered when received outside the Service Area. Out-of-Area follow-up care and maintenance therapy are not covered unless preapproved by the PacifiCare Out-of-Area Unit or by Member's Participating Medical Group. Member's Participating Medical Group provides twenty-four (24) hour access to Members to obtain authorization for Out-of-Area care. In addition, the PacifiCare Out-of-Area Unit can be reached during regular business hours at 1-800-207-2077. Out-of-Area follow-up care and maintenance therapy includes, but is not limited to:

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

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

Outpatient Drugs and Prescription Medications

Prescribed and non-prescribed medications are not covered, except when provided in an inpatient setting or as covered under the Supplemental Outpatient Prescription Drug Benefits Program attached to this Agreement.

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

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

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

Recreational, Educational or Hypnotic Therapy

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

Rehabilitation Maintenance or chronic level rehabilitation services including physical, occupational and speech therapy provided on an inpatient or outpatient basis is not covered except as medically necessary.

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

Skilled Nursing Facility Care Skilled Nursing Facility room and board charges incurred beyond one hundred (100) days per qualifying condition are not covered. A qualifying condition is a medical condition which requires skilled nursing services, which as a practical matter – in the determination of PacifiCare and the Member's Participating Medical Group – cannot be delivered in a setting other than a Hospital or a Skilled Nursing Facility, except that a medical condition will not be considered a qualifying condition if during the 60 days preceding the medical condition the Member has received Skilled Nursing Care.

Specialized Footwear for Foot Disfigurement

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

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

Weight Alteration Programs (Inpatient or Outpatient)

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

INSIDE BACK COVER

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