NEVADA

PacifiCare SignatureValue®
Offered by PacifiCare of Nevada, Inc.

Evidence of Coverage
2008

Reference Page:

Please fill this out for your reference.

Your PacifiCare Member identification number (located on your Membership card): _____

Your Effective Date of enrollment: _____

Questions? Problems? Need help?

Call or write PacifiCare Customer Service

1-800-347-8600/TDHI 1-800-360-1797, Monday through Friday, 7 a.m. to 8 p.m. (Pacific Standard Time)

700 East Warm Springs Road

Las Vegas, NV 89119

Web site: **www.pacificare.com**

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Welcome to PacifiCare of Nevada, Inc.
A UnitedHealthcare Company

Since 1992, we've been providing health care coverage in the state. This publication will help you become more familiar with your health care benefits. It will also introduce you to our health care community.

PacifiCare provides health care coverage to Members who have properly enrolled in our plan and meet our eligibility requirements. To learn more about these requirements, see ***Section 7. Member Eligibility****.*

What is this publication?

This publication is called an *Evidence of Coverage*. It is a legal document that explains your health care plan and should answer many important questions about your benefits. Many of the words and terms are capitalized because they have special meanings. To better understand these terms, please see ***Section 10. Definitions***.

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

What else should I read to understand my benefits?

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

What if I still need help?

After you become familiar with your benefits, you may still need assistance. Please don't hesitate to call our Customer Service department at **1-800-347-8600/TDHI 1-800-360-1797**, Monday through Friday, 7 a.m. to 8 p.m. (Pacific Standard Time). **Note:** Your *Evidence of Coverage* provides the terms and conditions of your coverage with PacifiCare and all applicants have a right to view this document prior to enrollment. The *Evidence of Coverage* should be read completely and carefully. Individuals with special health needs should pay special attention to those sections that apply to them.

You may correspond with PacifiCare at the following address:

PacifiCare of Nevada, Inc.
700 East Warm Springs Road
Las Vegas, NV 89119

PacifiCare's Web site is:
www.pacificare.com

SECTION 1. GETTING STARTED: YOUR PRIMARY CARE PHYSICIAN

- **What is a Primary Care Physician?**
- **What is a Subscriber?**
- **What is a Contracted IPA?**
- **Your *Provider Directory***
- **Choosing Your Primary Care Physician**
- **Continuity of Care**

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

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

Introduction

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

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

What is a Primary Care Physician?

When you become a Member of PacifiCare, one of the first things you do is choose a doctor to be your Primary Care Physician. This is a doctor who is contracted with PacifiCare and who is primarily responsible for the coordination of your health care services. A Primary Care Physician is trained in internal medicine, general practice, family practice or pediatrics. At times, others may participate in the coordination of your health care services, such as a Hospitalist. (Please refer to **Section 2. Seeing Your Doctor** for information on Hospitalist programs.)

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

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

While both are Members of PacifiCare, there's a difference between a Subscriber and an enrolled Family Member. A Subscriber is the Member who enrolls through his or her employment after meeting the eligibility requirements of the Employer Group and PacifiCare. A Subscriber may also contribute toward a portion of the Premiums paid to PacifiCare for his or her health care coverage for him or herself and any enrolled Family Members. An enrolled Family Member is someone such as a Spouse or Child whose Dependent status with the Subscriber allows him or her to be a Member of PacifiCare.

Why point out the difference? Because Subscribers often have special responsibilities, including sharing benefit updates with any enrolled Family Members. Subscribers also have special responsibilities that are noted throughout this publication. If you're a Subscriber, please pay attention to any instructions given specifically for you.

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

Choosing a Primary Care Physician

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

- Your doctor is selected from the list of Primary Care Physicians in PacifiCare's *Provider Directory*.
- Your doctor is located within 25 miles of either your Primary Residence or Primary Workplace.

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

What is a Contracted Independent Physician Association (IPA)?

A Contracted Independent Physician Association (IPA) is an association of Physicians that are contracted with PacifiCare of Nevada, Inc. to provide all Covered Services to PacifiCare of Nevada, Inc. Members. A Contracted IPA may act as an administrator or may subcontract with an administrator when delegated to perform claims processing on behalf of PacifiCare of Nevada, Inc. A Contracted IPA may also be delegated to perform utilization management functions for PacifiCare Members. In either circumstance, PacifiCare of Nevada, Inc. works closely with such Contracted IPAs to make certain they perform in accordance with PacifiCare of Nevada, Inc. standards. Contracted IPAs are independent contractors and not employees of PacifiCare of Nevada, Inc.

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

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

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

Note: If you are seeing a Contracting Provider who is not a part of an IPA, your doctor will coordinate services directly with PacifiCare.

Choosing a Primary Care Physician for Each Enrolled Family Member

Every PacifiCare Member must have a Primary Care Physician; however, the Subscriber and any enrolled Family Members don't need to choose the same doctor. Each PacifiCare Member can choose his or her own Primary Care Physician, so long as the doctor is selected from PacifiCare's list of Primary Care Physicians and the doctor is located within 25 miles of either the Member's Primary Residence or Primary Workplace.

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

What is Continuity of Care?

Under certain circumstances, new Members of PacifiCare may be able to temporarily continue receiving services from a Non-Contracted Provider. This short-term transition assistance is intended for new Members who are

experiencing an acute episode of care while making the transition to PacifiCare. Typically, this condition requires prompt medical attention and is of limited duration. (Examples include: pregnancy in the second or third trimester; being in an acute Hospital or scheduled to be in the hospital immediately after your PacifiCare coverage becomes effective; undergoing an active course of chemotherapy, radiation therapy, or psychiatric counseling; or being on a transplant list.)

If you're a new Member and believe you qualify for continuity of care, please call the Customer Service department and request the form "Continuity of Care for New Enrollees Request." Complete and return this form to PacifiCare as soon as possible. Upon receiving the completed form, a medical review will be completed in three business days. If you qualify, you will be notified by telephone of the decision and provided with the plan of your care. If you don't qualify, attempts will be made to notify you by telephone of the decision. You will be notified by phone or in writing within three business days of the completed review, and alternatives will be offered.

Please note: It's not enough to simply prefer receiving treatment from a former Physician or other Non-Contracted Provider, even for a Chronic Condition. You should not continue care with a Non-Contracted Provider without our formal approval*. If you do not receive Preauthorization by PacifiCare and your Contracted IPA, payment for services performed by a Non-Contracted Provider will be your responsibility.*

If You Are Pregnant

Every Member of PacifiCare needs a Primary Care Physician, including your newborn. If you are pregnant, we encourage you to plan ahead and pick a Primary Care Physician for your baby. Newborns remain enrolled with mother's Primary Care Physician from birth until discharge from the hospital. You may enroll your newborn with a different Primary Care Physician following the newborn's discharge by calling PacifiCare Customer Service. If a Primary Care Physician isn't chosen for your Child, the newborn will remain with the mother's Primary Care Physician. You can learn more about changing Primary Care Physicians in **Section 4. Changing Your Doctor or Medical Group**. (For more information about adding a newborn to your coverage, see **Section 7. Member Eligibility**.)

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

You can learn more about your changing Primary Care Physician in **Section 4. Changing Your Doctor**. (For more about adding a newborn to your coverage, see **Section 7. Member Eligibility**.)

Does your group or hospital restrict any reproductive services?

Some hospitals and other Providers do not provide one or more of the following services that may be covered under your plan contract and that you or your Family Member might need: family planning, contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, clinic, or call the PacifiCare Customer Service department at **1-800-347-8600/TDHI 1-800-360-1797** to ensure that you can obtain the health care services that you need.

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

SECTION 2. SEEING THE DOCTOR

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

Now that you've chosen a Primary Care Physician, you have a doctor for your routine health care.

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

Seeing the Doctor: Scheduling Appointments

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

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

Referrals to Specialists

Your Primary Care Physician is responsible for determining when it's Medically Necessary for you to see a specialist. (There is an exception for visits to obstetrical and gynecological (OB/GYN) Physicians. This is explained below in "OB/GYN: Getting Care without a Referral.") If your Primary Care Physician determines you need a referral, he or she will submit a request to your Contracted IPA and PacifiCare; then a Utilization Review Committee will review the request. If approved by the Utilization Review Committee, the referral is authorized; if the request is not approved, the referral is denied. In the event of a denial, you can request an appeal of the decision. For more about Appeals, see **Section 8. Overseeing Your Health Care**.

PacifiCare Express Referrals®

PacifiCare offers a program called PacifiCare's Express Referrals. Express Referrals means if your Primary Care Physician decides you need a specialist, no further authorization is required. Without this program, any referral made by your Primary Care Physician will be reviewed and can be denied by your Contracted IPA or PacifiCare.

To locate the Contracted IPAs offering Express Referrals, see your *Provider Directory*. You can also contact our Customer Service department or find a list at **www.pacificare.com**.

Standing Referrals to Specialists

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

your Primary Care Physician or PacifiCare. **Please note:** A standing referral and treatment plan is only allowed if approved by both your Contracted IPA and PacifiCare.

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

Extended Referral for Care by a Specialist

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

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

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

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

OB/GYN: Getting Care without a Referral

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

Please remember: If you visit an OB/GYN or family practice Physician not contracted with PacifiCare without Preauthorization, you will be financially responsible for these services. Any OB/GYN inpatient or Hospital Services, except Emergency or Urgently Needed Services, need to be authorized in advance by your Contracted IPA or PacifiCare.

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

- Call the telephone number on the front of your ID card and request the names and telephone numbers of the OB/GYNs contracted with PacifiCare.
- Telephone and schedule an appointment with your selected Contracted OB/GYN.

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

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

Second Medical Opinions

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

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

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

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

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

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

If you are requesting a second medical opinion about care given by your Primary Care Physician, the second medical opinion will be provided by an appropriately qualified health care professional of your choice within the Contracted Provider Network.

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

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

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

For questions about or to submit a request for a second medical opinion, Members may call or write PacifiCare's Customer Service department at:

PacifiCare Customer Service Department
700 East Warm Springs Road
Las Vegas, NV 89119
1-800-347-8600/TDHI 1-800-360-1797

What is PacifiCare's Case Management Program?

PacifiCare has licensed registered nurses who, in collaboration with the Member, Member's designated family and the Member's Contracted IPA may help arrange care for PacifiCare Members experiencing a major illness or recurring hospitalizations. Case Management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates options to meet an individual's health care needs based on the health care benefits and available resources. Not every Member will be assigned a case manager.

Prearranging Hospital Stays

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

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

If Medically Necessary, your Primary Care Physician or Hospitalist may discharge you from the hospital to a Subacute/Skilled Nursing Facility. He or she can also arrange for Home Health Care Visits.

Please note: If a Hospitalist program applies, a Hospitalist may direct your inpatient hospital or facility care instead of your Primary Care Physician.

Hospitalist Program

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

SECTION 3. EMERGENCY AND URGENTLY NEEDED SERVICES

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

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

IMPORTANT!

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

What are Emergency Medical Services?

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

What is an Emergency Medical Condition?

The State of Nevada defines an Emergency Medical Condition as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by the Member, as a Prudent Layperson, to result in any of the following:

- *Placing the Member's health in serious jeopardy;*
- *Serious jeopardy to the health of an unborn Child;*
- *Serious impairment to his or her bodily functions; or*
- *A serious dysfunction of any bodily organ or part.*

An Emergency Medical Condition does not include services provided at a hospital emergency room that a Prudent Layperson could have obtained at their Primary Care Physician's office or where there is a pattern of the Member visiting multiple emergency rooms for the purpose of seeking prescriptions for pain medications.

What to Do When You Require Emergency Services

If you believe you are experiencing an Emergency Medical Condition, ***call 911 or go directly to the nearest hospital emergency room or other facility for treatment****.* **You do not need to obtain Preauthorization to seek treatment for an Emergency Medical Condition that could cause you harm.** Ambulance transport services provided through the 911 emergency response system are covered if you reasonably believe that your medical condition requires emergency ambulance transport services. PacifiCare covers all Medically Necessary Emergency Services provided to Members in order to stabilize an Emergency Medical Condition.

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

Post-Stabilization and Follow-up Care

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

Following your discharge from the hospital, any Medically Necessary follow-up medical or Hospital Services must be provided or authorized by your Primary Care Physician in order to be covered by PacifiCare. Regardless of where you are in the world, if you require additional follow-up medical or Hospital Services, please call your Primary Care Physician or PacifiCare Customer Service to request authorization. PacifiCare Customer Service can be reached during regular business hours 7 a.m. to 8 p.m., PST at 1-800-347-8600/TDHI 1-800-360-1797.

Out-of-Area Services

PacifiCare arranges for the provision of Covered Services through its Contracted IPAs and other Contracted Providers. With the exception of Emergency Services, Urgently Needed Services, authorized Post-Stabilization Care, or other specific services authorized by both your Contracted IPA and PacifiCare, when you are away from the Geographic Service Area served by your Contracted IPA, you are not covered for any other medical or Hospital Services. Your *Provider Directory* lists all Contracted Providers in your service area.

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

1. Routine follow-up care to Emergency or Urgently Needed Services, such as treatments, procedures, X-rays, lab work and doctor visits, Rehabilitation Services, Skilled Nursing Services or Home Health Care Visits.
2. Maintenance therapy and durable medical equipment, including, but not limited to, routine dialysis, routine oxygen, routine laboratory testing or a wheelchair to assist you while traveling outside the Geographic Service Area.
3. Medical care for a known or Chronic Condition without acute symptoms as defined under Emergency Services or Urgently Needed Services.
4. Ambulance services are limited to transportation to the nearest facility with the expertise for treating your condition.

You can also request authorization by calling PacifiCare Customer Service during regular business hours 7 a.m. to 8 p.m. PST at **1-800-347-8600/TDHI 1-800-360-1797**.

What to Do When You Require Urgently Needed Services

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

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

Out-of-Area Urgently Needed Services

Urgently Needed Services are Medically Necessary health care services required to prevent the serious deterioration of a Member's health resulting from an unforeseen illness or injury for which treatment cannot be delayed until the Member returns to the Geographic Service Area.

Urgently Needed Services are required in situations where a Member is temporarily outside the Geographic Service Area and the Member experiences a medical condition that, while less serious than an Emergency Medical Condition, could result in the serious deterioration of the Member's health if not treated before the Member returns to the Geographic Service Area or contacts his or her Primary Care Physician.

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

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

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

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

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

Always Remember

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

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

SECTION 4. CHANGING YOUR DOCTOR

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

Changing Your Primary Care Physician

If you want to change your Primary Care Physician, you should contact our Customer Service department. PacifiCare will approve your request if the Primary Care Physician you've selected is accepting new patients and meets the other criteria in **Section 1. Getting Started**. This includes being located within 25 miles of your Primary Residence or Primary Workplace.

In addition, you must meet the following criteria:

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

PacifiCare reviews these requests on a case-by-case basis. If you meet these requirements and call us by the last day of the month, your transfer will be effective on the first day of the following month. For example, if you meet the above requirements and you call PacifiCare on June 25th to request a new doctor, the transfer will be effective on July 1.

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

If your request to change to a different Primary Care Physician is denied by PacifiCare, you have a right to file a Grievance. Remember, if you change your Primary Care Physician, all Specialist Referrals become invalid. In order for continuing visits to your Specialist(s) to be covered, a new Referral must be obtained from your new Primary Care Physician.

When We Change Your Contracted Provider

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

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

Continuing Care with a Terminated Physician

You may be eligible to continue receiving care from a terminated Physician if the doctor didn't voluntarily end participation with PacifiCare or a Contracted IPA. The care must be Medically Necessary and the terminated Physician must agree to the previous terms and conditions of his or her contract with PacifiCare. The cause of termination by PacifiCare or your Contracted IPA also has to be for a reason other than a medical disciplinary cause, fraud or any criminal activity.

Continued care from the terminated Physician may be provided for an acute or serious Chronic Condition for up to 90 calendar days, or a longer period until you can be safely transferred to another Provider. Continued care from a terminated Physician may be provided if you have a high-risk pregnancy or a pregnancy in the second or third trimester. Care may be extended through completed treatment of pregnancy-related and postpartum conditions, or until your care can be safely provided by another Physician. If you are receiving treatment for any of these conditions, contact our Customer Service department. You can request permission to continue being treated by this Physician beyond the termination date.

PacifiCare must Preauthorize or coordinate services for continued care. If you have any questions or want to appeal a denial, or would like a copy of PacifiCare's Continuity of Care Policy, call our Customer Service department. (To learn more about appealing a denial, see **Section 8. Overseeing your Health Care**.)

Continuity of Care for New Members

Under certain circumstances, new Members of PacifiCare may be able to temporarily continue receiving services from a Non-Contracted Provider. This short-term coverage is intended for new Members who are experiencing an acute episode of care while making the transition to PacifiCare. For more detail, see **Section 1. Getting Started**.

SECTION 5. YOUR MEDICAL BENEFITS

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

This section explains your medical benefits, including what is and isn't covered by PacifiCare. You can find some helpful definitions in the back of this publication. Refer to your Summary of Benefits for further information including, but not limited to, Copayment/Coinsurance and Limitations. A copy of your Summary of Benefits is explained with this document. PacifiCare's Commercial HMO Benefit Interpretation Policy Manual and Medical Management Guidelines Manual are available at ***www.pacificare.com****.*

Your Medical Benefits

I. Inpatient Benefits

These benefits are provided when admitted or authorized by PacifiCare. All services must be Medically Necessary as defined in this Evidence of Coverage. The fact that a Physician has ordered a particular service, supply, or treatment will not make it covered under the Health Plan. A service, supply, or treatment must be both Medically Necessary and not excluded from coverage in order to be a Covered Service.

With the exception of Emergency or Urgently Needed Services, a Member will only be admitted to acute care and Skilled Nursing Care Facilities that are authorized by PacifiCare.

Please refer to your *Summary of Benefits* for further information, including, but not limited to, any applicable Copayments/Coinsurance and limitations for all provisions listed in Section 5.

1. **Alcohol, Drug, or Other Substance Abuse Detoxification** – Treatment of withdrawal from the physiological effects of alcohol or drugs is covered up to $1,500 per Benefit Plan Year. Admission to a PacifiCare Contracted Facility for the diagnosis and treatment of alcohol or substance abuse is covered when authorized by a PacifiCare Contracted Provider up to $9,000 per Benefit Plan Year. Member is responsible for all applicable Copayments. Maximum amounts are combined inpatient and outpatient. Detoxification is the medical treatment of withdrawal from alcohol, drug or other substance addiction. Treatment in an acute care setting is covered for the acute stage of alcohol, drug or other substance abuse withdrawal when medical complications occur or are highly probable. Detoxification is initially covered up to forty-eight (48) hours and extended when Medically Necessary. Methadone treatment for detoxification is not covered. Rehabilitation for substance abuse or addiction is not covered. Coverage for treatment of alcohol, drug or other substance abuse or addiction may be available if purchased by the Subscriber's employer as a supplemental benefit. If the Member's Health Plan includes a Behavioral Health supplemental benefit, a brochure describing it will be enclosed with these materials.
2. **Blood and Blood Products** – Blood and blood products are covered. Autologous (self-donated), donor-directed and donor-designated blood processing costs are limited to blood collected for a scheduled procedure.
3. **Bloodless Surgery** – Surgical procedures performed without blood transfusions or blood products, including Rho(D) Immune Globulin, for Members who object to such transfusion on religious grounds are covered only when available within the Member's Contracted Provider Network.

4. **Bone Marrow and Stem Cell Transplants** – Non-Experimental/Non-Investigational autologous and allogeneic bone marrow and stem cell transplants and transplant services are covered when the recipient is a Member and the bone marrow or stem cell services are performed at a Designated Facility. The testing of immediate blood relatives to determine the compatibility of bone marrow and stem cells is limited to immediate blood relatives who are sisters, brothers, parents and natural children. The testing for compatible unrelated donors and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors conducted through a registry are covered when the Member is the intended recipient. Costs for such searches are covered up to a maximum of $15,000 per procedure**.** A Designated Facility approved by PacifiCare must conduct the computerized searches. There is no dollar limitation for Medically Necessary donor-related clinical transplant services once a donor is identified.

5. **Cancer and Chronic Fatigue Syndrome Study or Clinical Trials** – All Routine Patient Care Costs related to an approved study or therapeutic clinical trial for cancer or chronic fatigue syndrome (Phases I, II, III and IV) are covered for a Member who is diagnosed with cancer or chronic fatigue syndrome and whose Contracted Treating Physician recommends the study or clinical trial has a meaningful potential to benefit the Member.

   For the purposes of this benefit, Contracted Treating Physician means a Physician who is treating a Member as a Contracted Provider pursuant to an authorization or Referral from the Member's Contracted IPA or PacifiCare.

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

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

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

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

   An approved study or clinical trial for cancer or chronic fatigue syndrome is one where the treatment either involves a drug that is exempt under federal regulations from a new drug application or is approved by the National Institutes of Health.

A study or clinical trial with endpoints defined exclusively to test toxicity is not an approved study or clinical trial.

All services must be Preauthorized by PacifiCare's Medical Director or designee. Additionally, services must be provided by a PacifiCare Contracted Provider in PacifiCare's Geographic Service Area. In the event a PacifiCare Contracted Provider does not offer a study or clinical trial with the same protocol as the one your Contracted Treating Physician recommended, you may select a Provider performing a study or clinical trial with that protocol within the State of Nevada.

An approved study or clinical trial for cancer or chronic fatigue syndrome will be Preauthorized by PacifiCare's Medical Director if:

- There is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study; and
- There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment.

PacifiCare is required to pay for the services covered under this benefit at the rate agreed upon by PacifiCare and a Contracted Provider, minus any applicable Copayment, Coinsurance or deductibles. Health care services that are specifically excluded from coverage as defined in this *Evidence of Coverage* are not covered regardless whether such services are provided under the clinical trial or study.

In the event you participate in a study or clinical trial provided by a Non-Contracted Provider that does not agree to perform these services at the rate PacifiCare negotiates with Contracted Providers, you will be responsible for payment of the difference between the Non-Contracted Provider's billed charges and the rate negotiated by PacifiCare with Contracted Providers, minus any applicable Copayment, Coinsurance or deductibles.

Any additional expenses you may have to pay beyond PacifiCare's negotiated rate as a result of using a Non-Contracted Provider do not apply to your Annual Copayment Maximum.

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

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

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

7. **Inpatient Hospital Benefits/Acute Care** – Medically Necessary inpatient Hospital Services authorized by the Member's Contracted IPA and PacifiCare are covered, including, but not limited to: semi-private room, nursing and other licensed health professionals, intensive care, operating room, recovery room, laboratory, and professional charges by the hospital pathologist or radiologist and other miscellaneous hospital charges for Medically Necessary care and treatment.
8. **Inpatient Physician and Specialist Care** – Services from Physicians, including specialists and other licensed health professionals within, or upon referral from, the Member's Contracted IPA are covered while the Member is hospitalized as an inpatient. A specialist is a licensed health care professional with advanced training in an area of medicine or surgery.
9. **Inpatient Rehabilitation Care** – Rehabilitation Services that must be provided in an inpatient rehabilitation facility are covered. Inpatient rehabilitation consists of the individual or combined and coordinated use of medical, physical, occupational and speech therapy for training or retraining individuals disabled by disease or injury. The goal of these services is for the disabled Member to obtain his or her highest level of functional ability. This benefit does not include drug, alcohol or other substance abuse rehabilitation.
10. **Mastectomy, Breast Reconstruction After Mastectomy and Complications From Mastectomy** – Medically Necessary mastectomy and lymph node dissection are covered, including prosthetic devices and/or reconstructive surgery to restore and achieve symmetry for the Member incident to the mastectomy. The length of a hospital stay is determined by the attending Physician and surgeon in consultation with the Member, consistent with sound clinical principles and processes. Coverage includes any initial and subsequent reconstructive surgeries or prosthetic devices for the diseased breast on which the mastectomy was performed. Coverage is provided for surgery and reconstruction of the other breast if, in the opinion of the attending surgeon, this surgery is necessary to achieve symmetrical appearance. Medical treatment for any complications from a mastectomy, including lymphedema, is covered.
11. **Maternity Care** – Prenatal and maternity care services are covered, including labor, delivery and recovery room charges, delivery by cesarean section, treatment of miscarriage, and complications of pregnancy or childbirth.
    - Educational courses on lactation, childcare and/or prepared childbirth classes are not covered.
    - Alternative birthing center services are covered when provided or arranged by a Contracted Hospital affiliated with the Member's Provider Network.
    - Licensed nurse midwife services are covered only when available within the Member's Contracted Provider Network.
    - A minimum 48-hour inpatient stay for normal vaginal delivery and a minimum 96-hour inpatient stay following delivery by cesarean section are covered. Coverage for inpatient hospital care may be for a time period less than the minimum hours if the decision for an earlier discharge of the mother and newborn is made by the treating Physician in consultation with the mother.
12. **Mental Health Services** – Services to treat severe mental illness for adults and Children are covered up to 40 days per Benefit Plan Year for inpatient hospitalization of the Severe Mental Illness in a PacifiCare Contracted Hospital. Services are covered on an individual, couple or family basis when all individuals treated are Members of PacifiCare. See your supplement to this *Evidence of Coverage* for a description of this coverage. Refer to the *Summary of Benefits* for additional coverage of Mental Health Services, if any. Severe Mental Illness means any of the following mental illnesses that are biologically based:
    - Schizophrenia
    - Schizoaffective disorder

- Bipolar disorder
- Major depressive disorders
- Panic disorder
- Obsessive-compulsive disorder

13. **Newborn Care** – Postnatal Hospital Services are covered, including circumcision and special care nursery. Circumcision is covered for male newborns prior to hospital discharge. See "Circumcision" under Outpatient Benefits for an explanation of coverage after hospital discharge.

14. **Organ Transplant and Transplant Services** – Non-Experimental and non-Investigational organ transplants and transplant services are covered when the recipient is a Member and, except in an emergency, the transplant is performed at a Designated Facility. (See "Emergency Medical Condition Transplant Services" below).

    Listing of the Member at a second Designated Facility is a covered benefit unless the Regional Organ Procurement Agency is the same for both facilities. Organ transplant listing is limited to two Designated Facilities. If the Member is listed at two facilities, PacifiCare will only cover costs associated with the transplant surgical procedure (includes donor surgical procedure and services) and post transplant services at the facility where the transplant is performed. The Member will be responsible for any duplicated diagnostic costs for a transplant evaluation incurred at the second facility. Covered Services for living donors are limited to Medically Necessary clinical services once a donor is identified. Transportation and other nonclinical expenses of the living donor are excluded, and are the responsibility of the Member who is the recipient of the transplant. (See the definition for "National Preferred Transplant Network Facility.")

    Emergency Medical Condition Transplant Services:

    - If the Member is out of the Geographic Service Area and experiences an Emergency Medical Condition that requires transplant services and the treating Physician determines the Member is not medically stable for transfer to a Designated Facility, PacifiCare will cover all Medically Necessary Emergency transplant services at the non-National Preferred Transplant Network Facility. The Member, or someone else on the Member's behalf, must notify PacifiCare within 48 hours, or as soon as reasonably possible, after admission to the non-Designated Facility.
    - Following the stabilization of the Emergency Medical Condition that required Emergency transplant services at a non-National Preferred Transplant Facility, PacifiCare reserves the right to transfer the Member to a National Preferred Transplant Network Facility in lieu of authorizing post-stabilization services at the treating facility.

15. **Reconstructive Surgery** – Reconstructive surgery to improve function is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. The purpose of reconstructive surgery is to correct abnormal structures of the body to improve function. Reconstructive procedures require Preauthorization by both the Member's Contracted IPA and PacifiCare.

16. **Skilled Nursing/Subacute and Transitional Care** – Medically Necessary Skilled Nursing Services and Skilled Rehabilitation Care are covered. Both the Member's Contracted IPA and PacifiCare will determine where the Skilled Nursing Services and Skilled Rehabilitation Care will be provided. Refer to your *Summary of Benefits* for the number of days covered under your Health Plan. Subacute and Transitional Care are levels of care provided by a Skilled Nursing Facility to a Member who does not require Hospital acute care, but who requires more intensive licensed Skilled Nursing Facility care than is provided to the majority of the patients in a Skilled Nursing Facility.

Skilled Nursing Facility Services will be provided when authorized by the Member's Primary Care Physician or authorized by the Member's Contracted IPA and PacifiCare, in place of a hospital stay, when Medically Necessary. Days spent out of a Skilled Nursing Facility when transferred to an acute hospital setting are not counted toward the limits as described in your *Summary of Benefits* when the Member is transferred back to a Skilled Nursing Facility. Such days spent in an acute hospital setting do not count toward renewing the limits as described in your *Summary of Benefits*. Skilled Nursing Facility Services will be provided when authorized by the Member's Primary Care Physician or authorized by the Member's Contracted IPA and PacifiCare, in place of a hospital stay, when Medically Necessary. Days spent out of a Skilled Nursing Facility when transferred to an acute hospital setting are not counted toward the limits as described in your *Summary of Benefits* when the Member is transferred back to a Skilled Nursing Facility. Such days spent in an acute hospital setting do not count toward renewing the limits as described in your *Summary of Benefits*.

Prescription drugs are covered when furnished by the Skilled Nursing Facility and used by the Member during a period of covered Skilled Nursing Facility care. Custodial Care and services or supplies not included in the written plan treatment are not covered.

17. **Voluntary Termination of Pregnancy** – Please refer to the *Summary of Benefits* for the terms of any coverage or specific coverage limitations.

II. Outpatient Benefits

The following benefits are available on an outpatient basis and must be provided by the Member's Primary Care Physician or authorized by the Member's Contracted IPA and PacifiCare. All services must be Medically Necessary as defined in this *Evidence of Coverage*. The fact that a Physician has ordered a particular service, supply, or treatment will not make it covered under the Health Plan. A service, supply, or treatment must be both Medically Necessary and not excluded from coverage in order to be a Covered Service.

Please refer to your *Summary of Benefits* for further information, including, but not limited to, any applicable Copayments/Coinsurance, and limitations for all provisions listed in Section 5.

1. **Alcohol, Drug or Other Substance Abuse Detoxification** – Treatment of withdrawal from the physiological effects of alcohol or drugs is covered up to $1,500 per Benefit Plan Year. Counseling on an individual, family or group bases is covered with no Primary Care Referral required. Benefit is up to $2,500 per Benefit Plan Year. Maximum amounts are combined inpatient and outpatient. Detoxification is the medical treatment of withdrawal from alcohol, drug or other substance addiction. Medically Necessary detoxification is covered. Methadone treatment for detoxification is not covered. In most cases of alcohol, drug or other substance abuse or toxicity, outpatient treatment is appropriate unless another medical condition requires close inpatient monitoring. Rehabilitation for substance abuse or addiction is not covered.
2. **Allergy Serum** – Allergy serum, as well as needles, syringes and other supplies for the administration of the serum are covered for the treatment of allergies. Allergy serum, needles and syringes must be obtained through a PacifiCare Contracting Physician.
3. **Allergy Testing and Treatment** – Services and supplies are covered, including provocative antigen testing, to determine appropriate allergy treatment. Services and supplies for the treatment of allergies, including allergen/antigen immunotherapy, are covered according to an established treatment plan.
4. **Ambulance** – The use of an ambulance (land or air) is covered without Preauthorization, when the Member, as a Prudent Layperson, reasonably believes that the medical or psychiatric condition requires Emergency Services and an ambulance transport is necessary to receive these services. Such coverage includes, but is not limited to, ambulance or ambulance transport services provided through the 911 emergency response system. Ambulance transportation is limited to the nearest available emergency

facility having the expertise to stabilize the Member's Emergency Medical Condition. Use of an ambulance for non-Emergency Services is covered only when specifically authorized by the Member's Contracted IPA or PacifiCare.

5. **Attention Deficit/Hyperactivity Disorder** – Diagnostic evaluation and laboratory monitoring of prescribed drugs for Attention Deficit/Hyperactivity Disorder (ADHD) are covered. Coverage for outpatient prescribed drugs is only available if the Subscriber's Employer Group has purchased the supplemental Outpatient Prescription Drug Benefit. This benefit does not include non-crisis Mental Health counseling, family counseling or behavior modification programs.
6. **Blood and Blood Products** – Blood and blood products are covered. Autologous (self-donated), donor-directed and donor-designated blood processing costs are limited to blood collected for a scheduled procedure. For directly donated blood, Member pays blood bank processing fees.
7. **Bloodless Surgery** – Please refer to the benefit described above under "Inpatient Benefits for Bloodless Surgery." Outpatient services Copayments/Coinsurance and/or deductibles apply for any services received on an outpatient basis.
8. **Cancer and Chronic Fatigue Syndrome Study and Clinical Trials** – Please refer to the benefit described above under "Inpatient Cancer and Chronic Fatigue Syndrome Study or Clinical Trials." Outpatient services Copayments/Coinsurance and/or deductibles apply for any services received on an outpatient basis.
9. **Circumcision** – Circumcision is covered for male newborns prior to hospital discharge. Circumcision is covered after hospital discharge only when:
   - Circumcision was delayed by the Contracted IPA during initial hospitalization. Unless the delay was for medical reasons, the circumcision is covered after discharge only through the 28-day neonatal period.
   - Circumcision was determined medically inappropriate during initial hospitalization due to medical reasons (for example, prematurity, congenital deformity, etc.). The circumcision is covered when the Contracted IPA determines it is medically safe and the circumcision is performed within 90 days of that determination.
   - All other requests for circumcision must be reviewed for Medical Necessity by a PacifiCare Medical Director or designee.
10. **Cochlear Implant Device** – An implantable unilateral cochlear device for bilateral, profoundly hearing-impaired individuals who are not benefited from conventional amplification (hearing aids) is covered. Coverage is for Members at least 18 months of age who have either profound bilateral sensory hearing loss or for prelingual Members with minimal speech perception under the best hearing aided condition. Please also refer to "Cochlear Implant Medical and Surgical Services."
11. **Cochlear Implant Medical and Surgical Services** – The implantation of a cochlear device for bilateral, profoundly hearing-impaired individuals who are not benefited from conventional amplification (hearing aids) is covered. This benefit includes services needed to support the mapping and functional assessment of the cochlear device at the authorized Contracted Provider. (For an explanation of speech therapy benefits, please refer to "Outpatient Medical Rehabilitation Therapy.")
12. **Dental Treatment Anesthesia** – See "Oral Surgery and Dental Services: Dental Treatment Anesthesia."
13. **Diabetic Management and Treatment** – Coverage includes outpatient self-management training, education and medical nutrition therapy services. The diabetes outpatient self-management training, education and medical nutrition therapy services covered under this benefit will be provided by

appropriately licensed or registered health care professionals. These services must be provided under the direction of and prescribed by a Contracted Provider.

14. **Diabetic Self-Management Items** – Equipment and supplies for the management and treatment of diabetes are covered, based upon the medical needs of the Member, including, but not necessarily limited to: blood glucose monitors; blood glucose monitors designed to assist the visually impaired; strips; lancets and lancet puncture devices; pen delivery systems (for the administration of insulin); insulin pumps and all related necessary supplies; ketone urine testing strips; insulin syringes, podiatry services and devices to prevent or treat diabetes-related complications.

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

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

16. **Digestive Disorders** – Enteral formulas for use at home that are prescribed or ordered by a Contracted Provider as Medically Necessary for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after birth, or amino acid, organic acid, carbohydrates, or fat are covered as identified on the *Summary of Benefits*. Medically Necessary special food products are covered as identified on the *Summary of Benefits*. This coverage is required whether or not the condition existed when the health maintenance policy was purchased.

    "Inherited metabolic disease" means a disease caused by an inherited abnormality of the body chemistry of a person.

    "Special food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a Physician for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

17. **Durable Medical Equipment (Rental, Purchase or Repair)** – Durable Medical Equipment is covered when it is designed to assist in the treatment of an injury or illness of the Member, and the equipment is primarily for use in the home. Durable Medical Equipment is medical equipment that can exist for a reasonable period of time without significant deterioration. Examples of covered Durable Medical Equipment include wheelchairs, hospital beds and standard oxygen-delivery systems.

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

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

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

20. **Health Education Services** – Programs include wellness services. PacifiCare also makes health and wellness information available to Members. For more information, call the PacifiCare Customer Service department at **1-800-347-8600/TDHI 1-800-360-1797**.

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

21. **Home Health Care Visits** – A Member is eligible to receive Home Health Care Visits if the Member: (a) is confined to the home ("home" is wherever the Member makes his or her home but does not include acute care, rehabilitation or Skilled Nursing Facilities); (b) needs Medically Necessary skilled nursing visits or needs physical, speech or occupational therapy; and (c) the Home Health Care Visits are provided under a plan of care established and periodically reviewed and ordered by a PacifiCare Contracted Physician.

    "Skilled Nursing Services" means the services provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a Home Health Aide. Skilled nursing visits may be provided by a registered nurse or licensed vocational nurse.

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

    a. Skilled nursing visits;

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

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

    d. Medical supplies, Durable Medical Equipment;

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

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

    Please refer to the *Summary of Benefits* for any applicable Copayments, Coinsurance and deductible amounts, and Benefit Limitations.

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

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

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

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

23. **Immunizations** – Immunizations for children (through age 18) years are covered only if the immunizations are consistent with the most current version of the Recommended Childhood and Adolescent Immunizations Schedule – United States.[1] An exception is made if, within 45 days of the published date of the schedule, the State Department of Health Services determines that the schedule is not consistent with state law. Immunizations for adults are covered only if the immunizations are consistent with the most current version of the Recommended Adult Immunization Schedule – United States[2].

    For children under two years of age, refer to "Periodic Health Evaluations – Well Baby Care."

    Routine boosters and immunizations must be obtained through Member's Contracted IPA. Travel and/or required work immunizations are not covered.

24. **Infertility Services (Basic)** –Please refer to the *Summary of Benefits* for coverage, if any. Coverage for Infertility Services is only available if purchased by the Subscriber's Employer Group as a supplemental benefit. If the Member's Health Plan includes an Infertility Services supplemental benefit, a supplement to the *Evidence of Coverage* will be provided to the Member.

25. **Injectable Drugs (Infusion Therapy, Outpatient Injectable Medications and Self-Injectable Medications) –**

    - **Infusion Therapy** – Infusion therapy refers to the therapeutic administration of drugs or other prepared or compounded substances by the Intravenous route. Infusion therapy is covered when furnished as part of a treatment plan authorized by the Member's Primary Care Physician, Contracted IPA, or PacifiCare. The infusions must be administered in the Member's home, Contracted Physician's office or in an institution, such as a board and care, Custodial Care, or assisted living facility, that is not a hospital or institution primarily engaged in providing Skilled Nursing Services or Rehabilitation Services.
    - **Outpatient Injectable Medications** – Outpatient injectable medications include those drugs or preparations which are not usually self-administered, and which are given by the Intramuscular or

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

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

Subcutaneous route. Outpatient injectable medications are covered when administered as a customary component of a Physician's office visit, and when not otherwise limited or excluded (e.g., certain immunizations. Infertility drugs, or off-label use of covered injectable medications). Outpatient injectable medications must be obtained through a Contracted Provider, the Member's Contracted IPA, or PacifiCare Designated Pharmacy and may require Preauthorization by PacifiCare.

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

26. **Laboratory Services** – Medically Necessary diagnostic and therapeutic laboratory services are covered.
27. **Maternity Care, Tests, Procedures and Genetic Testing** – Physician visits, laboratory services and radiology services are covered for prenatal and postpartum maternity care. Licensed nurse midwife services are covered when available within the Member's Contracted IPA and authorized by PacifiCare.

    Genetic Testing and Counseling are covered when authorized by the Member's Contracted IPA as part of an amniocentesis or chorionic villus sampling procedure.
28. **Medical Supplies and Materials** – Medical supplies and materials necessary to treat an illness or injury are covered when used or furnished while the Member is treated in the Contracted Provider's office, during the course of an illness or injury, or stabilization of an injury or illness, under the direct supervision of the Contracted Provider. Examples of items commonly furnished in the Contracted Provider's office to treat the Member's illness or injury are gauzes, ointments, bandages, slings and casts.
29. **Mental Health Services** – Services to treat Severe Mental Illness for adults and Children are covered up to 40 visits per year for outpatient treatment of a Severe Mental Illness. Services are covered on an individual, couple or family basis when all individuals treated are Members of PacifiCare. See your supplement to this *Evidence of Coverage* for a description of this coverage. Refer to the *Summary of Benefits* for additional coverage of Mental Health Services, if any. Severe Mental Illness means any of the following Mental illnesses that are biologically based:
    - Schizophrenia
    - Schizoaffective disorder
    - Bipolar disorder
    - Major depressive disorders
    - Panic disorder
    - Obsessive-compulsive disorder
30. **OB/GYN Physician Care** – See "Physician OB/GYN Care."
31. **Oral Surgery and Dental Services** – Emergency Services for stabilizing an acute injury to sound natural teeth, the jawbone or the surrounding structures are covered. Coverage is limited to treatment provided within 48 hours of injury. Other covered Oral Surgery and Dental Services include:

- Biopsy and excision of cysts or tumors of the jaw, treatment of malignant neoplastic disease, and treatment of temporomandibular joint syndrome (TMJ);
- Tooth extraction prior to a major organ transplant or radiation therapy to the head or neck;
- Preventive fluoride treatment prior to an aggressive chemotherapeutic or radiation therapy protocol.

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

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

    The Member's dentist must obtain Preauthorization from the Member's Contracted IPA or PacifiCare before the dental procedure is provided.

    Dental Anesthesia in a dental office or dental clinic is not covered. Charges for the dental procedures itself, including, but not limited to, professional fees of the dentist or oral surgeon, X-ray and laboratory fees or related dental supplies provided in connection with the care, treatment, filling, removal or replacement of teeth or structures directly supporting the teeth are not covered except for services covered by PacifiCare under the outpatient benefit captioned, "Oral Surgery and Dental Services."
33. **Outpatient Medical Rehabilitation Therapy** – Services provided by a registered physical, speech or occupational therapist for the treatment of an illness, disease or injury are covered.
34. **Outpatient Services** – Medically Necessary services, treatments or procedures performed in a hospital outpatient services department setting or a free-standing facility that is not a certified ambulatory surgical center or outpatient surgery department of an acute hospital are covered. Examples include, but are not limited to: endoscopies, hyperbaric oxygen and wound care.
35. **Outpatient Surgery** – Short-stay, same-day or other similar outpatient surgery facilities and professional services are covered when provided as a substitute for inpatient care.
36. **Periodic Health Evaluation** – Periodic Health Evaluations are covered as recommended by PacifiCare's Preventive Health Guidelines and the Member's Primary Care Physician. This may include, but is not limited to, the following screenings:
    - **Breast Cancer Screening and Diagnosis** – Services are covered for the screening and diagnosis of breast cancer. Screening and diagnosis will be covered consistent with generally accepted medical practice and scientific evidence, upon request by the Member's Primary Care Physician.

Mammography for screening or diagnostic purposes is covered as authorized by the Member's contracted nurse practitioner, contracted licensed nurse midwife or Contracted Provider.

- **Hearing Screening** – Routine hearing screening by a contracted health professional is covered to determine the need for hearing correction. Hearing aids are not covered, nor is their testing or adjustment.
- **Prostate Screening** – Evaluations for the screening and diagnosis of prostate cancer is covered (including, but not limited to, prostate-specific antigen testing and digital rectal examination). These evaluations are provided when consistent with good professional practice.
- **Vision Screening** – Annual routine eye health assessment and screening by a Contracted Provider are covered to determine the health of the Member's eyes and the possible need for vision correction. An annual retinal examination is covered for Members with diabetes.
- **Well-Baby Care** – Up to the age of two, preventive health services are covered (including immunizations) when provided by the child's Contracted IPA.
- **Well-Woman Care** – Medically Necessary services, including a Pap smear (cytology), are covered. The Member may receive obstetrical and gynecological Physician services directly from an OB/GYN or family practice Physician or surgeon (designated by the Member's Contracted IPA as providing OB/GYN services) affiliated with Member's Contracted IPA.

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

37. **Phenylketonuria (PKU) Testing and Treatment** – Testing for Phenylketonuria (PKU) is covered to prevent the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU enzyme deficiency. PKU includes those formulas and special food products that are part of a diet prescribed by a Contracted Physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease and who participates in or is authorized by PacifiCare, provided that the diet is deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. Special food products do not include food that is naturally low in protein, but may include a special low-protein formula specifically approved for PKU and special food products that are specially formulated to have less than one gram of protein per serving.
38. **Physician Care (Primary Care Physician and Specialist)** – Diagnostic, consultation and treatment services provided by the Member's Primary Care Physician are covered. Services of a specialist are covered upon referral, or upon Preauthorization, by Member's Contracted IPA or PacifiCare. A specialist is a licensed health care professional with advanced training in an area of medicine or surgery.
39. **Physician OB/GYN Care** – The Member may obtain obstetrical and gynecological Physician services directly from an OB/GYN or family practice Physician (designated by the Member's Contracted IPA as providing OB/GYN services) affiliated with the Member's Contracted IPA.
40. **Prosthetics and Corrective Appliances** – Prosthetics (except for bionic or myoelectric as explained below) are covered when Medically Necessary as determined by both the Member's Contracted IPA and PacifiCare. Prosthetics are durable, custom-made devices designed to replace all or part of a permanently inoperative or malfunctioning body part or organ. Examples of covered prosthetics include initial contact lens in an eye following a surgical cataract extraction and removable, non-dental prosthetic devices such as a limb that does not require surgical connection to nerves, muscles or other tissue.

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

- Bionic, myoelectric, microprocessor-controlled and computerized prosthetics are not covered.
- Deluxe upgrades that are not Medically Necessary are not covered.
- Replacements, repairs and adjustments to corrective appliances and prosthetics coverage are limited to normal wear and tear or because of a significant change in the Member's physical condition. Repair or replacement must be authorized by both the Member's Contracted IPA and PacifiCare.
- Refer to "Footwear" in "Outpatient Benefits."

41. **Radiation Therapy (Standard and Complex) –**
    - Standard photon beam radiation therapy is covered.
    - Complex radiation therapy is covered. This therapy requires specialized equipment, as well as specially trained or certified personnel to perform the therapy. Examples include, but are not limited to: brachytherapy (radioactive implants), conformal photon beam radiation. (For purpose of determining Copayments/Coinsurance, gamma knife procedures and stereotactic procedures are covered as outpatient surgeries.) Please refer to your *Summary of Benefits* for applicable Copayment, if any.
42. **Reconstructive Surgery** – Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. The purpose of reconstructive surgery is to improve function. Reconstructive procedures require Preauthorization by the Member's Contracted IPA or PacifiCare.
43. **Refractions** – Routine testing every 12 months is covered to determine the need for corrective lenses (refractive error), including a written prescription for eyeglass lenses. (Coverage for frames and lenses may be available if your Health Plan includes a vision supplemental benefit.) Coverage under this benefit also includes one initial pair of eyeglasses when prescribed following a cataract surgery with an intraocular lens implant. Eyeglasses must be obtained through Contracted IPAs.
44. **Standard X-rays** – Standard X-rays are covered for the diagnosis of an illness or injury, or to screen for certain defined diseases. Standard X-rays are defined to include conventional plain film X-rays, oral and rectal contrast gastrointestinal studies (such as upper GIs, barium enemas and oral cholecystograms), mammograms, obstetrical ultrasounds and bone mineral density studies (including ultrasound and DEXA scans).
45. **Specialized Scanning and Imaging Procedures** – Specialized Scanning and Imaging Procedures are covered for the diagnosis of an illness or injury. Specialized procedures are defined to include those which, unless specifically classified as Standard X-rays, are digitally-processed, or computer-generated, or which require contrast administered by injection or infusion. Examples of Specialized Scanning and Imaging Procedures include, but are not limited to, the following scanning and imaging procedures: CT, PET, SPECT, MRI, MRA, EEG, EMG, and nuclear scans, angiograms (includes heart catherization), arthrograms, myelograms, and non-obstetrical ultrasounds.

III. Exclusions and Limitations of Benefits

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

Please refer to your *Summary of Benefits* for further information, including, but not limited to, any applicable Copayments/Coinsurance and Limitations for all provisions listed in Section 5.

General Exclusions

Services that are not Medically Necessary, as defined in the **Definitions** section of this *Evidence of Coverage* are not covered. Payment for these services will be the Member's financial responsibility.

Services not specifically included in this *Evidence of Coverage*, or any supplement purchased by the Member's Employer Group, are not covered. Payment for these services will be the Member's financial responsibility.

1. Services that are rendered without Preauthorization from both the Member's Contracted IPA and PacifiCare (except for Emergency Services or Urgently Needed Services) described in this *Evidence of Coverage*, and for obstetrical and gynecological Physician services obtained directly from an OB/GYN, family practice Physician or surgeon designated by the Members Contracted IPA as providing OB/GYN services are not covered.
2. Services obtained from Non-Contracted Providers or Contracted Providers who are not affiliated with the Member's Contracted IPA without authorization from PacifiCare or the Member's Contracted IPA are not covered.
3. Services rendered prior to the Member's effective date of enrollment or after the effective date of disenrollment are not covered.
4. PacifiCare does not cover the services or costs associated with a services that is not a Covered Service under the Member's PacifiCare Health Plan, including, but not limited to, cosmetic surgery, and Experimental and Investigational procedures. This means that PacifiCare will not cover follow-up care or complications associated with or arising from a non-Covered Service when:
    a. the services or expenses are incurred in preparation for a non-Covered Service;
    b. the complications or services are associated with non-Covered Services provided by another health plan or insurance company even if the service was covered under the prior plan;
    c. the complications or services are associated with non-Covered Services the Member paid for out-of-pocket (e.g., cosmetic surgery, Experimental and Investigational procedures).
5. Services obtained outside the Geographic Service Area are not covered except for Emergency Services or Urgently Needed Services.
6. Services performed by immediate relatives or members of your household are not covered.
7. Treatment for an injury or condition sustained as a result of the Member's commission of a felony or attempt to commit a felony is not covered. This exclusion does not apply to injuries or conditions resulting from an act of domestic violence, or a physical or mental medical condition.

Other Exclusions and Limitations

1. **Acupuncture and Acupressure** – Acupuncture and Acupressure are not covered. Coverage for Acupuncture and Acupressure may be available if purchased by the Subscriber's employer as a supplemental benefit. If the Member's Health Plan includes an Acupuncture and Acupressure supplemental benefit, a brochure describing it will be enclosed with these materials.
2. **Air Conditioners, Air Purifiers or Other Environmental Equipment** – Air conditioners, air purifiers and other environmental equipment are not covered.
3. **Ambulance** – Ambulance service is not covered when used only for the Member's convenience or when another available form of transportation would be more appropriate. Wheelchair transportation services (e.g., a specifically designed van or taxi) and personal transportation costs such as gasoline costs for a private vehicle or taxi fare are also not covered. Please refer to "Ambulance" in the "Outpatient Benefits" section and "Organ Transplants" in the "Exclusions and Limitations" section.

4. **Artificial Hearts and Ventricular Assist Devices (VADs)** –
   - Artificial hearts are not covered.
   - Ventricular Assist Devices (VADs) are limited to use as a bridge or temporary device for Members authorized for heart transplantation or to support circulation of blood following open-heart surgery (postcardiotomy).
   - Ventricular Assist Devices (VADs) as destination therapy devices are not covered. Destination therapy is defined as, "the VAD is placed with the expectation that the patient will likely require permanent mechanical cardiac support."
5. **Behavior Modification and Non-Crisis Mental Health Counseling and Treatment** – Behavior Modification and non-crisis mental health counseling and treatment are not covered. Examples include, but are not limited to, art therapy, music therapy and play therapy.
6. **Biofeedback** – Biofeedback services are not covered except for urinary incontinence, fecal incontinence or constipation for Members with organic neuromuscular impairment when part of an authorized treatment plan.
7. **Bloodless Surgery Services** – Bloodless surgery services are only covered to the extent available within the Member's Contracted IPA.
8. **Bone Marrow and Stem Cell Transplants** – Autologous or allogeneic bone marrow or stem cell transplants are not covered when they are Experimental or Investigational. The testing for compatible unrelated donors and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors conducted through a registry are covered when the Member is the intended recipient. Costs for such searches are covered up to a maximum of $15,000 per procedure. Unrelated Donor Searches must be performed at a PacifiCare approved transplant center. (See "Designated Facility" in Definitions.)
9. **Cancer and Chronic Fatigue Syndrome Study or Clinical Trials** – An approved study or clinical trial for cancer or chronic fatigue syndrome must be Preauthorized by PacifiCare's Medical Director. A Member who is diagnosed with cancer or chronic fatigue syndrome and whose Contracted Provider recommends that the Member participate in a study or clinical trial must meet the following criteria:
   - There is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study; and
   - There is reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment.

   Health care services that are specifically excluded from coverage as defined in this *Evidence of Coverage* are not covered regardless whether such services are provided under the clinical trial or study.

   Please refer to the benefit described above under Inpatient "Cancer and Chronic Fatigue Syndrome Study or Clinical Trials."
10. **Chiropractic Care** – Care and treatment provided by a chiropractor are not covered unless this *Evidence of Coverage* provides coverage for treatment of an illness that is within the authorized scope of practice of a licensed chiropractor. (Any additional coverage for Chiropractic Care may be available if purchased by the Subscriber's employer as a supplemental benefit. If your Health Plan includes a Chiropractic Care supplemental benefit, a brochure describing it will be enclosed with these materials.)
11. **Communication Devices** – Computers, personal digital assistants and any speech-generating devices (except artificial larynxes) are not covered.

12. **Complementary and Alternative Medicine** – Complementary and Alternative Medicine is not covered unless purchased by the Subscriber's employer as a supplemental benefit. (See the definition for Complementary and Alternative Medicine.) Religious nonmedical health care is not covered.

13. **Cosmetic Surgery and Services** – Cosmetic surgery and cosmetic services are not covered. Cosmetic surgery and cosmetic services are defined as surgery and services performed to alter or reshape structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered. Surgeries or services that would ordinarily be classified as cosmetic will not be reclassified as reconstructive, based on a Member's dissatisfaction with his or her appearance, as influenced by that Member's underlying psychological makeup or psychiatric condition.

14. **Custodial Care** – Custodial Care is not covered, except for those services provided by an appropriately licensed Hospice agency or appropriately licensed Hospice facility incident to a Member's terminal illness as described in the explanation of "Hospice Services" in the "Medical Benefits" section of this *Evidence of Coverage*. The mere provision of Custodial Care by a medical professional, such as a Physician, licensed nurse or registered therapist, does not mean the services are not custodial in nature. If the nature of the services can be safely and effectively performed by a trained nonmedical person, the services will be considered Custodial Care.

15. **Dental Care, Dental Appliances and Orthodontics** – Except as otherwise provided under the Outpatient Benefit captioned, "Oral Surgery and Dental Services," dental care, dental appliances and orthodontics are not covered. Dental Care means all services required for prevention and treatment of diseases and disorders of the teeth, including, but not limited to: oral exams, X-rays, routine fluoride treatment; plaque removal, tooth decay, routine tooth extraction, dental embryonal tissue disorders, periodontal disease, crowns, fillings, dental implants, caps, dentures, braces, and orthodontic procedures. (Coverage for Dental Care may be available if purchased by the Subscriber's employer as a separate benefit. If your Health Plan includes a Dental Care separate benefit, a brochure describing it will be enclosed with these materials.) TMJ (Temporomandibular Joint Dysfunction) treatment is not covered except when it meets PacifiCare criteria.

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

17. **Dialysis** – Chronic dialysis (peritoneal or hemodialysis) is not covered outside of the Member's Contracted IPA. The fact that the Member is outside the Geographic Service Area served by the Member's Contracted IPA will not entitle the Member to coverage for maintenance of chronic dialysis to facilitate travel.

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

19. **Drugs and Prescription Medication (Outpatient)** – Outpatient drugs and prescription medications are not covered; however, coverage for prescription medications may be available as a supplemental benefit. If your Health Plan includes a supplemental benefit, a brochure describing it will be enclosed with these materials. Infusion drugs and infusion therapy are not considered outpatient drugs for the purposes of this exclusion. Refer to Outpatient Benefits, "Injectable Drugs" for benefit coverage.

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

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

22. **Elective Enhancements** –

    - Procedures, technologies, services, drugs, devices, items and supplies for elective, non-Medically Necessary improvements, alterations, enhancements or augmentation of appearance, skills, performance capability, physical or mental attributes, or competencies are not covered. This exclusion includes, but is not limited to, elective improvements, alterations, enhancements, augmentation, or genetic manipulation related to hair growth, aging, sexual performance, mental performance, athletic performance, intelligence, height, weight or cosmetic appearance. Cranial banding is not covered. Please refer to "Reconstructive Surgery" for a description of Reconstructive Surgery services covered by your Health Plan.
    - Human growth hormone for idiopathic short stature syndrome is not covered.

23. **Emergency Services or Urgently Needed Services (Follow-Up Care)** – Services following discharge after receipt of Emergency Services or Urgently Needed Services, including, but not limited to, treatments, procedures, X-rays, lab work, Physician visits, rehabilitation and Skilled Nursing Services are not covered without the Contracted IPA's or PacifiCare's authorization. The fact that the Member is outside the Geographic Service Area and that it is inconvenient for the Member to obtain the required services from the Contracted IPA will not entitle the Member to coverage.

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

25. **Experimental and/or Investigational Procedures, Items and Treatments** –Experimental and/or Investigational Procedures, Items and Treatments are not covered. Unless otherwise required by federal or state law, decisions as to whether a particular treatment is Experimental or Investigational and therefore not a covered benefit are determined by a PacifiCare Medical Director, or his or her designee. For the purposes of this *Evidence of Coverage*, procedures, studies, tests, drugs or equipment will be considered Experimental and/or Investigational if any of the following criteria/guidelines is met:

    - It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use.
    - It is a subject of a current investigation of new drug or new device (IND) application on file with the FDA.

- It is the subject of an ongoing clinical trial (Phase I, II, or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and Department of Health and Human Services (DHHS).
- It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum-tolerated dose or effectiveness in comparison to conventional treatments.
- It is being delivered or should be delivered subject to approval and supervision of an institutional review board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).
- Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as Experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect.
- The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
- It is not Experimental or Investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that is Experimental or Investigational (e.g., lab tests or imaging ordered to evaluate the effectiveness of an Experimental therapy).

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

- The Member's medical records
- The protocol(s) pursuant to which the drug, device, treatment or procedure is to be delivered
- Any informed consent document the Member, or his or her representative, has executed or will be asked to execute, in order to receive the drug, device, treatment or procedure
- The published authoritative medical and scientific literature regarding the drug, device, treatment or procedure
- Expert medical opinion
- Opinions of other agencies or review organizations, e.g., ECRI Health Technology Assessment Information Services, HAYES New Technology Summaries, or MCMC Medical Ombudsman
- Regulations and other official actions and publications issued by agencies such as the Food and Drug Administration (FDA), Department of Health and Human Services (DHHS) and Agency for Health Care Policy and Research (AHCPR)

26. **Eyewear and Corrective Refractive Procedures** – Corrective lenses and frames, contact lenses, contact lens fitting and measurements are not covered (except for initial post-cataract extraction or corneal bandages, and for the treatment of keratoconus and aphakia). Surgical and laser procedures to correct or improve refractive error are not covered. (Coverage for frames and lenses may be available if the Subscriber's employer purchased a vision supplemental benefit. If your Health Plan includes a vision supplemental benefit, a brochure describing it will be enclosed with these materials.) Routine screenings for glaucoma are limited to Members who meet the medical criteria.
27. **Family Planning** – Family planning benefits, other than those specifically listed in the *Summary of Benefits* that accompanies this document, are not covered.

28. **Foot Care** – Except as Medically Necessary, routine foot care including, but not limited to, removal or reduction of corns and calluses and clipping of toenails, is not covered.
29. **Foot Orthotics/Footwear** – Specialized footwear, including foot orthotics, custom-made or standard orthopedic shoes, are not covered except for Members with diabetic foot disease or when an orthopedic shoe is permanently attached to a Medically Necessary orthopedic brace.
30. **Genetic Testing and Counseling** – Genetic testing, treatment, or counseling are excluded for all of the following:
    - Non-PacifiCare Members
    - Solely to determine the gender of a fetus
    - Nonmedical reasons (e.g., court-ordered tests, work-related tests, paternity tests)
    - Screening of newborns, children or adolescents to determine carrier status for inheritable disorders when there would not be an immediate medical benefit or when results would not be used to initiate medical interventions during childhood
    - Members who have no clinical evidence or family history of a genetic abnormality
    - Members who do not meet PacifiCare's Medical Necessity criteria for genetic testing and counseling

    Refer to "Maternity Care, Test, Procedures and Genetic Testing" in the "Outpatient Benefits" section for coverage of amniocentesis and chorionic villus sampling.
31. **Government Services and Treatment** – Any services that the Member receives from a local, state or federal government agency are not covered, except when coverage under this Health Plan is expressly required by federal or state law.
32. **Hearing Aids and Hearing Devices** – Hearing aids and nonimplantable hearing devices are not covered. Audiology services (other than screening for hearing acuity) are not covered. Hearing aid supplies are not covered. Implantable hearing devices are not covered except for cochlear devices for bilaterally, profoundly hearing-impaired individuals or for prelingual Members who have not benefited from conventional amplification (hearing aids).
33. **Hospice Service** – Hospice services are not covered for:
    - Members who do not meet the definition of terminally ill. Terminal illness is defined as a medical condition resulting in a prognosis of life expectancy of one year if the disease follows its natural course.
    - Hospice services that are not reasonable and necessary for the management of a terminal illness (e.g., care provided in a noncertified Hospice program).
34. **Immunizations** – Immunizations solely required for work, insurance, school, marriage, adoption, immigration, camp, volunteer work, travel, licensure, certification, registration, sports or recreational activities are not covered. Immunizations that are not specifically listed on the most current version of the Recommended Childhood and Adolescent Immunization Schedule – United States and Recommended Adult Immunization Schedule – United States are not covered.
35. **Implants** – The following implants are not covered:
    - Removal and/or replacement of breast implants for nonmedical reasons;
    - Replacement of breast prosthesis and the prosthesis itself following cosmetic breast augmentation mammoplasty.
36. **Infertility Reversal** – Reversals of sterilization procedures are not covered.

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

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

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

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

41. **Mental Health and Nervous Disorders** – Mental Health Services are not covered except for diagnosis and treatment of severe mental illness for adults and children. Please refer to the behavioral health supplement to this *Evidence of Coverage* for a description of this coverage. Academic or educational testing, as well as educational counseling or remediation is not covered. Coverage for crisis intervention may also be available as an additional benefit. Please refer to the *Summary of Benefits* for coverage, if any.

42. **Morbid Obesity Treatment and Bariatric Surgery** – Surgical treatment of morbid obesity, e.g. Gastric stapling, gastroplasty, gastric banding and other similar restrictive gastrointestinal surgery, is not covered for the sole purpose of weight loss and/or weight management. Medically Necessary bariatric surgery will be covered when it meets PacifiCare's accepted criteria which requires the Member to participate in a PacifiCare sponsored/approved program for no less than 12 months which includes, but is not limited to, a multidisciplinary non-surgical approach to supervised diet, exercise and behavioral modification. PacifiCare reserves the right to identify the contracted, preferred network based on a number of factors including quality, cost and efficacy. The network facilities may be located outside the Geographic Service Area. Surgical treatments for morbid obesity and services related to this surgery are subject to prior approval by PacifiCare's Medical Director or designee limited to one procedure per Member's lifetime with a maximum pay-out of $12,000 for all related services. Please also see "Weight Alteration Programs (Inpatient or Outpatient)."

43. **Non-Physician Health Care Practitioners** – This Plan may not cover services for all non-Physician health care practitioners. Treatment by non-Physician health care practitioner, such as acupuncturists, psychologists, chiropractors, licensed clinical social workers, and marriage and family therapists, may be available if purchased by your employer as a supplemental benefit. If your Health Plan includes a supplemental acupuncturist, chiropractic and/or Mental Health benefit, a brochure describing it will be enclosed with these materials.

44. **Nursing Services, Private Duty** – Private-duty nursing services are not covered. Private-duty nursing services encompass nursing services for recipients who require more individual and continuous care than

is available from a visiting nurse or routinely provided by the nursing staff of the hospital or Skilled Nursing Facility.

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

46. **Off-Label Drug Use** – Off-label drug use, means that the Provider has prescribed a drug approved by the Food and Drug Administration (FDA) for a use that is different from that for which the FDA approved the drug. PacifiCare excludes coverage for off-label drug use, including off self-injectable drugs, except as described in this *Evidence of Coverage*. If a drug is prescribed for off-label use, the drug and its administration will be covered only when it satisfies the following criteria:

    - The drug is approved by the FDA;
    - The drug is prescribed by a Contracted Provider for the treatment of a life-threatening condition or for a chronic and seriously debilitating condition;
    - The drug is Medically Necessary to treat the condition;
    - The patient has failed, is intolerant of, or has contraindications to standard therapies;
    - The drug has been recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following: *The American Hospital Formulary Service Drug Information, The United States Pharmacopoeia Dispensing Information, Volume 1*, or in two articles from major peer-reviewed medical journals that present data supporting the proposed Off-Label Drug Use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal;
    - The drug is covered under the injectable drug benefit described in the "Outpatient Benefits" section of this *Evidence of Coverage*.

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

47. **Oral Surgery and Dental Services** – Dental Services, including, but not limited to, crowns, fillings, dental implants, caps, dentures, braces and orthodontic procedures are not covered. Please see "Oral Surgery and Dental Services" in the "Outpatient Benefits" section.

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

49. **Organ Donor Services** – Medical and Hospital Services, as well as other costs of a donor or prospective donor, are only covered when the recipient is a Member. The testing of blood relatives to determine compatibility for donating organs is limited to sisters, brothers, parents and natural children. The testing for compatible unrelated donors and costs for computerized national and international searches for unrelated allogeneic bone marrow or stem cell donors conducted through a registry are covered when the Member is the intended recipient. Costs for such searches are covered up to a maximum of $15,000 per procedure. Donor searches are only covered when performed by a Provider in a Designated Facility.

50. **Organ Transplants** – All organ transplants must be Preauthorized by PacifiCare and performed in a Designated Facility, except in an emergency. (See "Emergency Medical Condition Transplant Services" below).

    - Transportation is limited to the transportation of the Member and one escort to a Designated Facility greater than 60 miles from the Member's Primary Residence or out of state regardless of mileage as Preauthorized by PacifiCare. Transportation and other nonclinical expenses of the living donor are

excluded, and are the responsibility of the Member who is the recipient of the transplant. (See the definition for "Designated Facility.")

- Food and housing is not covered unless the Designated Facility is located more than 60 miles from the Member's Primary Residence or out of state regardless of mileage from the Member's Primary Residence, in which case food and housing is limited to $125 a day to cover both the Member and escort, if any (excludes alcoholic beverages and products and tobacco products, and personal care items). Food and housing expenses are not covered for any day a Member is not receiving Medically Necessary transplant services.
- Listing of the Member at a second Designated Facility is a covered benefit unless the Regional Organ Procurement Agency (the agency that obtains the organ is the same for both facilities. Organ transplant listing is limited to two Designated Facilities. If the Member is listed at two facilities, PacifiCare will only cover the costs associated with the transplant surgical procedure (includes donor surgical procedure and services) and post-transplant services at the facility where the transplant is performed. The Member is responsible for any duplicated diagnostic costs for a transplant evaluation incurred at the second facility. (See the definition for "Regional Organ Procurement Agency.")
- Artificial heart implantation and non-human organ transplantation are excluded.

Emergency Medical Condition Transplant Services:

- If the Member is out of the Geographic Service Area and experiences an Emergency Medical Condition that requires transplant services and the treating Physician determines the Member is not medically stable for transfer to a National Preferred Transplant Network Facility, PacifiCare will cover all Medically Necessary Emergency transplant services at the non-National Preferred Transplant Network Facility. The Member, or someone else on the Member's behalf, must notify PacifiCare within 48 hours, or as soon as reasonably possible, after admission to the non-National Preferred Transplant Facility.
- Following the stabilization of the Emergency Medical Condition that required Emergency transplant services at a non-National Preferred Transplant Facility, PacifiCare reserves the right to transfer the Member to a National Preferred Transplant Network Facility in lieu of authorizing post-stabilization services at the treating facility.

51. **Orthognathic Surgery** – Orthognathic surgery is not covered.
52. **Pain Management** – Pain management for chronic and acute pain is covered ONLY when authorized and provided by a Contracted IPA. Multidisciplinary pain management programs are not covered.
53. **Phenylketonuria (PKU) Testing and Treatment** – Food products naturally low in protein are not covered.
54. **Physical or Psychological Examinations** – Physical or psychological examinations for court hearings, travel, premarital, pre-adoption, employment, or other nonpreventive health reasons are not covered. Court-ordered or other statutorily allowed psychological evaluation, testing, and treatment are not covered unless Medically Necessary and Preauthorized by PacifiCare. Competency evaluations unrelated to immediate medical care are not covered.
55. **Private Rooms and Comfort Items** – Personal or comfort items, and non-Medically Necessary private rooms during inpatient hospitalization are not covered.
56. **Prosthetics and Corrective Appliances** – Replacement of prosthetics or corrective appliances which are lost or damaged by abuse beyond normal wear and tear are not covered. Bionic, myoelectric, microprocessor-controlled and computerized prosthetics are not covered. Deluxe upgrades that are not Medically Necessary are not covered.

57. **Pulmonary Rehabilitation Programs** – Pulmonary rehabilitation programs are not covered.

58. **Reconstructive Surgery** – Reconstructive Surgery is not covered:

    - when there is another more appropriate surgical procedure that has been offered to the Member; and
    - the surgery does not restore body function.
    - Orthognathic surgery is not covered.

    This exclusion does not apply to breast reconstructive surgery required by the Women's Health and Cancer Rights Act of 1998.

    Preauthorization is required for Reconstructive Surgery.

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

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

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

    Rehabilitation Services and therapies for the following conditions are not covered:

    - Learning Disability
    - Mental Retardation and Related Conditions

    The following special evaluations and therapies are not covered:

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

- Psychological Testing
- Vocational Rehabilitation

61. **Respite Care** – Respite Care is not covered unless part of an authorized Hospice Plan and is necessary to relieve the primary caregiver in a Member's residence. Respite care is covered only on an occasional basis not to exceed five consecutive days at a time.
62. **Routine Laboratory Testing Out-of-Area** – Routine laboratory tests are not a covered benefit while the Member is outside of the Geographic Service Area served by the Member's Contracted IPA. Although it may be Medically Necessary, Out-of-Area routine laboratory testing is not considered an Urgently Needed Service because it is not unforeseen and is not considered an Emergency Service.
63. **Services Provided at No Charge to Member** – Services and supplies that are provided free of charge if the Member did not have coverage under this Health Plan or for which the Member will not be held financially responsible are not covered, unless PacifiCare has agreed to payment arrangements prior to the provision of services or supplies to the Member.
64. **Services While Confined or Incarcerated** – Services required for injuries or illnesses experienced while under arrest, detained, imprisoned, incarcerated or confined pursuant to federal, state or local law are not covered. However, PacifiCare will reimburse Members their out-of-pocket expenses for services received while confined/incarcerated or, if a juvenile, while detained in any facility, if the services were provided or authorized by your Primary Care Physician or Contracted IPA in accordance with the terms of this Health Plan or were Emergency Services or Urgently Needed Services. This exclusion does not restrict PacifiCare's liability with respect to expenses for Covered Services solely because the expenses were incurred in a state or county hospital; however, PacifiCare's liability with respect to expenses for Covered Services provided in a state or county hospital is limited to the rate PacifiCare would pay for those Covered Services if provided by a Contracted Hospital.
65. **Sex Transformations** – Procedures, services, medications and supplies related to sex transformations are not covered.
66. **Sexual Dysfunction or Inadequacy Medications** – Sexual dysfunction or inadequacy medications/drugs, procedures, services, and supplies, including penile implants/prosthesis except testosterone injections for documented low testosterone levels, are not covered.
67. **Skin Reduction Surgery** – Surgical removal of excessive skin following massive weight loss associated with bariatric surgery or other weight loss programs is not covered.
68. **Sleep Apnea** – Medically necessary services for the diagnosis and treatment of sleep apnea, including but not limited to sleep studies, are covered when Member meets PacifiCare criteria for coverage.
69. **Surrogacy** – Infertility and maternity services for non-Members are not covered.
70. **Telehealth and Telemedicine** – Telehealth and Telemedicine services are not covered unless determined to be Medically Necessary by a PacifiCare Medical Director.
71. **Transportation** – Transportation is not a covered benefit except for Ambulance transportation as defined in this *Evidence of Coverage*.
72. **Third Party Liability** – PacifiCare has the independent right to be reimbursed for the reasonable value of any services or benefits provided to the Member due to liable third parties, except auto medical pay or other first party automobile coverage, as described in the Section "PacifiCare's Responsibility When an Injury or Sickness is Caused by a Third Party's Act or Omission."
73. **Veterans Affairs Services** – Except for Emergency or Urgently Needed Services, services provided in a Veterans Affairs facility are not covered.

74. **Vision Care** – See “Eyewear and Corrective Refractive Procedures” listed in Exclusions and Limitations.
75. **Vision Training** – Vision therapy rehabilitation and ocular training programs (orthoptics) are not covered.
77. **Visual Aids** – Visual aids are not covered, except as specified under the outpatient benefit for “Diabetic Self-Management Items.” Electronic and non-electronic magnification devices are not covered. (Coverage for frames and lenses may be available if the Subscriber’s employer purchased a vision supplemental benefit.)
78. **Weight Alteration Programs (Inpatient or Outpatient)** – Weight loss or weight gain programs are not covered. These programs include, but are not limited to, dietary evaluations, counseling, exercise and behavioral modification, food and food supplements, and/or vitamins and other nutritional supplements. Also excluded are surgery and laboratory tests associated with monitoring weight loss or weight gain, except as described under the Morbid Obesity exclusion.

SECTION 6. PAYMENT RESPONSIBILITY

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

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

What are Premiums? (Prepayment Fees)

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

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

What are Copayments (Other Charges)?

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

Annual Copayment Maximum

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

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

PacifiCare of Nevada, Inc.
Customer Service Department
700 East Warm Springs Road
Las Vegas, NV 89119

Remember, it's important to send us **all** Copayment receipts along with your letter. They confirm that you've reached your Annual Copayment Maximum. You will be reimbursed by PacifiCare for Copayments you make beyond your individual or family Annual Copayment Maximum.

Note: The calculation of your Annual Copayment Maximum will not include supplemental benefits that may be offered by your Employer Group (e.g., coverage for outpatient prescription drugs).

If You Get a Bill (Reimbursement)

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

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

    PacifiCare of Nevada, Inc.
    Customer Service Department
    P.O. Box 60125
    Phoenix, AZ 85082-0125

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

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

What is a *Summary of Benefits*?

Your *Summary of Benefits* is printed separately from this document and lists the Covered Services unique to your plan. It also includes your Copayments, as well as the Annual Copayment Maximum and other important information. If you need assistance understanding your *Summary of Benefits*, or need a new copy, please call our Customer Service department at 1-800-347-8600/TDHI 1-800-360-1797.

Bills From Non-Contracted Providers

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

You should file a claim within 180 days, or as soon as reasonably possible, of receiving any services and related supplies. Forward the bill to:

PacifiCare of Nevada, Inc.
Customer Service Department
P.O. Box 60125
Phoenix, AZ 85082-0125

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

PacifiCare will make a determination within 30 days from the date you submit a claim containing all information reasonably necessary to decide the claim. PacifiCare will not pay any claim that is filed more than one year from the date the services or supplies were provided. PacifiCare also will not pay for excluded services or supplies unless authorized by your Primary Care Physician, your Contracted IPA or directly by PacifiCare.

Any payment assumes you have not exceeded your benefit limits. If you've reached or exceeded any applicable benefit limit, these bills will be your responsibility.

How to Avoid Unnecessary Bills

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

Your Billing Protection

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

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

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

Coordination of Benefits

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

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

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

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

Definitions

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

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

   1. "Plan" includes: group insurance, closed panel (HMO, POS, PPO or EPO) coverage or other forms of group or group-type coverage (whether fully insured or self-insured); hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as Skilled Nursing

Care; or other governmental benefits, as permitted by law. (Medicare is not included as a "Plan" as defined here; however, PacifiCare does coordinate benefits with Medicare. Please refer to **Section 6**: *"*Important Rules for Medicare Members.*"*

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

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

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

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

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

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

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

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

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

Order of Benefit Determination Rules

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

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

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

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

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

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

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

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

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

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

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

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

      - The Plan of the Custodial Parent;
      - The Plan of the Spouse of the Custodial Parent;
      - The Plan of the noncustodial parent; and then
      - The Plan of the Spouse of the noncustodial parent.

3. **Active or Inactive Employee.** The Plan that covers a person as an employee who is neither laid off nor retired (or his or her Dependent) is primary in relation to a Plan that covers the person as a laid off or retired employee (or his or her dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided an individual by one Plan as a retired worker and by another Plan as a dependent of an actively working Spouse will be determined under the rule labeled D(1).
4. **COBRA Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal (COBRA) or state law (similar to COBRA) also is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree (or as that person's Dependent) is primary, and the continuation coverage is secondary. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
5. **Longer or Shorter Length of Coverage.** If the preceding rules do not determine the order or payment, the Plan that covered the person as an employee, member, subscriber or retiree for the longer period is primary.

Effect on the Benefits of This Plan

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

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

Right to Receive and Release Needed Information

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

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

PacifiCare's Right to Pay Others

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

Right of Recovery

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

Important Rules for Medicare and Medicare-Eligible Members

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

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

Workers' Compensation

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

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

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

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

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

Applicability

This provision applies when a Member suffers an injury or sickness through an act or omission of another person(s) (the "Third Party").

Subrogation and Reimbursement

Subrogation is the substitution of one person or entity in the place of another with reference to a lawful claim, demand or right. Immediately upon paying or providing any Benefit, we shall be subrogated to and shall succeed to all rights of recovery, under any legal theory of any type for the reasonable value of any services and Benefits we provided to you by Third Parties as set forth below.

PacifiCare's Right to the Reimbursement if Health Care Expenses Are Paid by PacifiCare

In addition to any subrogation rights and in consideration of the coverage provided by this plan, PacifiCare shall also have an independent right to be reimbursed by you for the reasonable value of any services and Benefits we provide to you, from any or all of the following Third Parties:

- Third parties, including any person alleged to have caused you to suffer injuries or damages.
- Your employer.
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, (auto, homeowners or otherwise but not including automobile medical pay or other first party automobile coverage), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity who is liable for payment to you on any equitable or legal liability theory.

PacifiCare will pay for a Member's health care expenses incurred as a result of a Third Party's act or omission, in consideration of the benefits paid under this plan and subject to the following agreement.

PacifiCare shall:

1. be reimbursed for the total amount paid by PacifiCare for the injury or sickness from any money paid to the Member (or his or her representative) on account of the Third Party's act or omission, by way of any final judgment, compromise, settlement, agreement or payment, from parties including, but not limited to, the Third Party, or the Third Party's insurers but not including first party automobile coverage, even if such money becomes available at some future time, regardless of whether the Member is fully compensated; and
2. have a lien against any money paid to the Member (or his or her representative) for the purpose of enforcing its reimbursement right(s); and/or
3. if permitted by applicable state or federal law, be subrogated to the Member's rights to the extent of the health care expenses paid by PacifiCare.

In the event PacifiCare is required to institute legal action to enforce this agreement, the Member shall reimburse PacifiCare for reasonable attorneys' fees and costs.

Under this agreement, and in consideration of benefits paid, You agree:

- That you will cooperate with us in protecting our legal and equitable rights to subrogation and reimbursement, including, but not limited to:
  - providing any relevant information requested by us,
  - signing and/or delivering such documents as we or our agents reasonably request to secure the subrogation and reimbursement claim,
  - responding to requests for information about any accident or injuries,
  - making court appearances, and
  - obtaining our consent or our agents' consent before releasing any party from liability or payment of medical expenses.
- That Member is expected to cooperate with the company in pursuing any rights provided under this provision.
- That no court costs or attorneys' fees may be deducted from PacifiCare's recovery without PacifiCare's express written consent; any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right, and PacifiCare is not required to participate in or pay court costs or attorneys' fees to the attorney hired by you to pursue your damage/personal injury claim.

- That benefits paid by PacifiCare may also be considered to be benefits advanced.
- That if you receive any payment from any potentially responsible party as a result of an injury or illness, whether by settlement (either before or after any determination of liability), or judgment, you will serve as a constructive trustee over the funds, and failure to hold such funds in trust will be deemed as a breach of your duties hereunder.
- That you or an authorized agent, such as your attorney, must hold any funds due and owing PacifiCare, as stated herein, separately and alone, and failure to hold funds as such will be deemed as a breach of contract, and may result in the termination of health benefits or the instigation of legal action against you.
- That you will not accept any settlement that does not fully compensate or reimburse PacifiCare without PacifiCare's written approval, nor will you do anything to prejudice PacifiCare's rights under this provision.
- That you will assign to PacifiCare all rights of recovery against Third Parties, to the extent of the reasonable value of services and benefits PacifiCare provided, plus reasonable costs of collection.
- That PacifiCare's rights will be considered as the first priority claim against Third Parties, including tortfeasors for whom you are seeking recovery, to be paid before any other of your claims are paid.
- That PacifiCare may, at our option, take necessary and appropriate action to preserve its rights under these subrogation/reimbursement provisions, including filing suit in your name, which does not obligate PacifiCare in any way to pay you part of any recovery PacifiCare might obtain. However, PacifiCare shall not be obligated in any way to pursue this right independently or on your behalf.
- That in the case of your wrongful death, the provisions of this section will apply to your estate, the personal representative of your estate, and your heirs.
- That the provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs medical expenses caused by a Third Party. If a parent or guardian may bring a claim for damages arising out of a minor's injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

SECTION 7. MEMBER ELIGIBILITY

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

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

Who is a PacifiCare Member?

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

The following Family Members are eligible to enroll in PacifiCare:

- The Subscriber's Spouse,
- The unmarried biological children of the Subscriber or the Subscriber's Spouse (stepchildren) who are under the Limiting Age established by the employer (for an explanation of "Limiting Age," see **Definitions**);
- Children who are legally adopted or placed for adoption with the Subscriber or the Subscriber's Spouse who are under the Limiting Age established by the employer;
- Children for whom the Subscriber or the Subscriber's Spouse has assumed permanent legal guardianship. Legal evidence of the guardianship, such as a certified copy of a court order, must be furnished to PacifiCare upon request; and
- Children for whom the Subscriber or the Subscriber's Spouse is required to provide health insurance coverage pursuant to a Qualified Medical Child Support Order, assignment order, or medical support order, in this section.

Your Dependent children cannot be denied enrollment and eligibility due to the following:

- Was born to a single person or unmarried couple;
- Is not claimed as a dependent on a federal income tax return;
- Does not reside with the Subscriber or within the PacifiCare Geographic Service Area.

Eligibility

All Members must meet all eligibility requirements established by the Employer Group and PacifiCare. PacifiCare's eligibility requirements are:

- Have a Primary Residence or work, within the PacifiCare of Nevada, Inc. Geographic Service Area;
- Select a Primary Care Physician within 25 miles of his or her Primary Residence or Primary Workplace (except children enrolled as a result of a Qualified Medical Child Support Order);

- Meet any other eligibility requirements established by the Employer Group, such as exhaustion of a waiting period before an employee can enroll in PacifiCare. Employers will also establish the "Limiting Age," the age limit for providing coverage to unmarried children.

Eligible Family Members must enroll in PacifiCare at the same time as the Subscriber or risk not being eligible to enroll until the employer's next Open Enrollment Period, as explained below. Circumstances which allow for enrollment outside the Open Enrollment Period are also explained below. All applicants for coverage must complete and submit to PacifiCare all applications, medical review questionnaires, or other forms or statements that PacifiCare may reasonably request.

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

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

What is a Geographic Service Area?

PacifiCare is licensed by the Nevada Division of Insurance to arrange for medical and Hospital Services in certain Geographic Service Areas of Nevada. These service areas are defined by ZIP codes. Please call our Customer Service department for information about PacifiCare's Service Area.

Open Enrollment

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

Adding Family Members to Your Coverage

The Subscriber's Spouse and Eligible Dependents may apply for coverage with PacifiCare during the employer's Open Enrollment Period. If you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your Dependents in PacifiCare if you or your Dependents lose eligibility for that other coverage (or if the Employer Group stops contributing toward your or your Dependents' other coverage).However, you must request enrollment within 31 days after your or your Dependents' other coverage ends (or after the Employer Group stops contributing toward the other coverage). In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your Dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption. (Guardianship is not a Qualifying Event for other Family Members to enroll). To request special enrollment or obtain more information, contact PacifiCare's Customer Service department. Under the following circumstances, new Family Members may be added outside the Open Enrollment Period.

- **Getting Married.** When a new Spouse or child becomes an eligible Family Member as a result of marriage, coverage begins on the first day of the month following the date of marriage. An application to enroll a Spouse or child eligible as a result of marriage must be made within 31 days of the marriage.
- **Having a Baby.** Newborns are covered for the first 31 days of life. In order for coverage to continue beyond the first 31 days of life, the Subscriber must submit a Change Request Form to PacifiCare prior to the expiration of the 31 day period for coverage to continue beyond the first 31 days of life.

- **Adoption or Placement for Adoption.** Receive an adoptive placement from a recognized county or private agency, or adopted as documented by a health facility minor release form, a medical authorization form, or a relinquishment form, granting you or your Spouse the right to control the health care for the adoptive child. Absent such a document, on the date there exists evidence of the Subscriber's or Spouse's right to control the health care of the child placed for adoption. For adopted children, coverage is effective on the date of adoption or placement for adoption. An application must be received within 31 days of the adoption placement.
- **Guardianship.** To enroll a Dependent child for whom the Subscriber has assumed legal guardianship, the Subscriber must submit a Change Request Form to PacifiCare along with a certified copy of a court order granting guardianship within 31 days of when the Subscriber assumed legal guardianship. Coverage will be retroactively effective to date the Subscriber assumed legal guardianship.

Qualified Medical Child Support Order

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

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

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

Continuing Coverage for Student and Disabled Dependants

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

Continuing Coverage for Student Dependents

An unmarried Dependent who is registered on a full-time basis (at least 12 semester units or the equivalent as determined by PacifiCare) at an accredited school or college may continue as an Eligible Dependent through the Limiting Age established by the employer for full-time students, if proof of such status is provided to PacifiCare on a periodic basis, as requested by us. If the Dependent student resides outside of the Service Area, the student must maintain a permanent address inside the Geographic Service Area with the Subscriber and the student must select a Contracted IPA within 25 miles of that address. All health care coverage must be provided or arranged in the Geographic Service Area by the designated Contracted IPA, except for Emergency and Urgently Needed Services.

Continuing Coverage for Certain Disabled Dependents

Unmarried enrolled Dependents who attain the Limiting Age established by the employer may continue enrollment in the Health Plan beyond the Limiting Age if the unmarried Dependent meets all of the following:

- The unmarried Dependent resides within the Geographic Service Area with the Subscriber or the Subscriber's separated or divorced Spouse;
- The unmarried Dependent is incapable of self-sustaining employment by reason of mental retardation or physical handicap;

- The unmarried Dependent is chiefly dependent upon the Subscriber for support and maintenance; and
- The mental or physical condition existed continuously prior to reaching the Limiting Age.

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

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

Late Enrollment

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

1. The eligible employee (on his or her own behalf, or on behalf of any eligible Family Members) declined in writing to enroll in PacifiCare when they were first eligible because they had other health care coverage; and
2. The other health care coverage is no longer available due to:
    a. The employee or eligible Family Member has exhausted COBRA continuation coverage under another group health plan; or
    b. The termination of employment or reduction in work hours of a person through whom the employee or eligible Family Member was covered; or
    c. The termination of the other health plan coverage; or
    d. The cessation of an employer's contribution toward the employee or eligible Family Member coverage; or
    e The death, divorce or legal separation of a person through whom the employee or eligible Family Member was covered.
3. The Court has ordered health care coverage be provided for your Spouse or minor child.

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

Notifying You of Changes in Your Plan

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

Updating Your Enrollment Information

Please notify your employer of any changes to the information you provided on the enrollment application within 31 days of the change. This includes changes to your name, address, telephone number, marital status or the status of any enrolled Family Members. For reporting changes in marital and/or dependent status, please see

"Adding Family Members to Your Coverage." If you wish to change your Primary Care Physician or Contracted IPA, you may contact PacifiCare's Customer Service department at **1-800-347-8600/TDHI 1-800-360-1797**.

Renewal and Reinstatement (Renewal Provisions)

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

About your PacifiCare Identification (ID) Card

Your PacifiCare ID card is important for identifying you as a Member of PacifiCare. Possession of this card does not entitle a Member to services or benefits under this Health Plan. A Member should show this card each time he or she visits a Primary Care Physician or, upon referral, any other Contracted Provider.

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

Ending Coverage (Termination of Benefits)

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

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

When the Group Agreement between the Employer Group and PacifiCare is terminated, all Members covered under the Group Agreement become ineligible for coverage on the date of termination. If the Group Agreement is terminated by PacifiCare for nonpayment of Premiums, coverage for all Members covered under the Group Agreement will be terminated effective the last day of the month for which Premiums were received. According to the terms of the Group Agreement, the Employer Group is responsible for notifying you if and when the Group Agreement is terminated for any reason, including the nonpayment of Health Plan Premiums. PacifiCare is not obligated to notify you that you are no longer eligible or that your coverage has been terminated.

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

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

Termination for Good Cause

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

- **Failure to Pay.** Your coverage may be terminated if your fail to pay any required Copayments, coinsurance or charges owed to a Provider or PacifiCare for Covered Services. To be subject to termination under this

provision, you must have been billed by the Provider for two different billing cycles and have failed to pay or make appropriate payment arrangements with the Provider. PacifiCare will send you written notice, and you will be subject to termination if you do not pay or make appropriate payment arrangements within the 30-day notice period.

- **Fraud or Misrepresentation.** Your coverage may be terminated, rescinded, or re-rated if you knowingly provide false information (or misrepresent a meaningful fact) on your enrollment form or fraudulently or deceptively use services or facilities of PacifiCare, its Contracting Providers or other health care Providers (or knowingly allow another person to do the same), including altering a prescription. Termination is effective immediately on the date PacifiCare mails the notice of termination, unless PacifiCare has specified a later date in that notice.

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

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

Ending Coverage: Special Circumstances for Enrolled Family Members

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

Total Disability

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

Coverage Options Following Termination

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

Federal COBRA Continuation Coverage

If the Subscriber's Employer Group is subject to the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), you may be entitled to temporarily extend your coverage under the Health Plan at group rates, plus an administration fee, in certain instances where your coverage under the Health Plan would otherwise end. This discussion is intended to inform you, in a summary fashion, of your rights and obligations under COBRA. However, your Employer Group is legally responsible for informing you of your specific rights under COBRA. Therefore, please consult with your Employer Group regarding the availability and duration of COBRA continuation coverage.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of group health plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse and your Dependent children could become qualified beneficiaries if coverage under the group health plan is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage may be required to pay for COBRA continuation coverage. Please consult with your Employer Group regarding any applicable Premiums.

If you are a Subscriber covered by this Health Plan, you have a right to choose COBRA continuation coverage if you lose your group health coverage because either of the following qualifying events happens:

- Your hour of employment are reduced to less than the number of hours required for eligibility, or
- Your employment ends for any reason other than gross misconduct on your part.

If you are the Spouse of a Subscriber covered by this Health Plan, you have the right to choose COBRA continuation coverage for yourself if you lose group health coverage under this Health Plan because *any* of the following qualifying events happens:

1. Your Spouse dies;
2. Your Spouse's hours of employment are reduced to less than the number of hours required for eligibility;
3. Your Spouse's employment ends (for reasons other than his or her gross misconduct)
4. Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. You become divorced or legally separated from your Spouse.

In the case of a Dependent child of a Subscriber enrolled in this Health Plan, he or she has the right to continuation coverage if group health coverage under this Health Plan is lost because *any* of the following qualifying events happens:

1. The Subscriber dies;
2. The Subscriber's hours of employment are reduced to less than the number of hours required for eligibility;
3. The Subscriber's employment ends (for reasons other than his or her gross misconduct);
4. The Subscriber becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The Subscriber becomes divorced or legally separated; or
6. The Dependent child ceases to be a Dependent eligible for coverage under this Health Plan.

When is COBRA coverage available?

Your Employer Group (or, if applicable, its COBRA administrator) will offer COBRA continuation coverage to qualified beneficiaries only after they have been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Subscriber, or the Subscriber

becoming entitled to Medicare benefits (under Part A, Part B, or both), your Employer Group must notify its COBRA administrator of the qualifying event. (Similar rights may apply to certain retirees, Spouses and Dependent children if your Employer Group commences a bankruptcy proceeding and these individuals lose coverage).

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the Subscriber or a Dependent child losing eligibility for coverage as a Dependent child under the Health Plan), the Subscriber or enrolled Family Member has the responsibility to inform the Employer Group (or, if applicable, its COBRA administrator) within 60 days after the qualifying event occurs. Please consult your Employer Group regarding its plan procedures for providing notice of qualifying events.

How is COBRA coverage provided?

Once your Employer Group (or, if applicable, its COBRA administrator) receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered by the Employer Group (or its COBRA administrator) to each of the qualified beneficiaries. Upon federal law, you must be given at least 60 days to elect COBRA continuation coverage. The 60-day election period is measured from the later of:

1. the date coverage ends due to a qualifying event; or
2. the date you receive the election notice provided by your Employer Group (or its COBRA administrator).

Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Subscribers covered by this Health Plan may elect COBRA continuation coverage on behalf of their Spouses and parents or legal guardians may elect COBRA continuation coverage on behalf of Dependent children. **If you do not choose COBRA continuation coverage on a timely basis, your group health insurance coverage under this Health Plan will end.**

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Subscriber, the Subscriber becoming entitled to Medicare benefits (under Part A, Part B, or both), the Subscriber's divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child under this Health Plan, COBRA continuation coverage lasts for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the Subscriber's hours of employment, and the Subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Subscriber lasts until 36 months after the date of Medicare entitlement. For example, if a Subscriber becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and Dependent children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). Otherwise, when the qualifying event is the end of employment or reduction of the Subscriber's hours or employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or any of your Family Members covered under this Health Plan is determined by the Social Security Administration to be disabled and you notify your Employer Group (of, if applicable, its COBRA administrator) in a timely fashion, you and your entire Family Members may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Please consult your Employer Group regarding their plan procedures for providing notice of disability.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If a Family Member experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the notice of the second qualifying event is properly given to your Employer Group (or, if applicable, COBRA administrator). This extension may be available to the Spouse and any Dependent children receiving continuation coverage if the Subscriber dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent child stops being eligible under this Health Plan as a Dependent child, but only if the event would have caused the Spouse or Dependent child to lose coverage under this Health Plan had the first qualifying event not occurred.

Please contact your Employer Group (or, if applicable, its COBRA administrator) for more information regarding the applicable length of COBRA continuation coverage available.

COBRA May Terminate Before Maximum Coverage Period Ends

Under COBRA, the continuation coverage may terminate before the maximum coverage period if *any* of the following events occur:

1. Your Employer Group no longer provides group health coverage to any of its employees;
2. The Premium for continuation coverage is not paid on time;
3. The qualified beneficiary becomes covered after the date he or she elects COBRA continuation coverage under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition he or she may have;
4. The qualified beneficiary becomes entitled to Medicare after the date he or she elects COBRA continuation coverage; or
5. The qualified beneficiary extends coverage for up to 29 months due to disability and there has been a final determination that the individual is no longer disabled.

COBRA Premium

Under the law, you may have to pay all of the Premium for your continuation coverage. Premiums for COBRA continuation coverage is generally 102 percent of the applicable Health Plan Premium. However, if you are on a disability extension, your cost will be 150 percent of the applicable Premium. You are responsible for the timely submission of the COBRA Premium to the Employer Group or COBRA administrator. Your Employer Group or COBRA administrator is responsible for the timely submission of Premium to PacifiCare. At the end of the 18 month, 29 month or thi36 month continuation coverage period, qualified beneficiaries will be allowed to enroll in a PacifiCare individual conversion Health Plan (see the explanation under “Extending Your Coverage: Converting to an Individual Plan.

If You Have Questions About COBRA

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

Mini COBRA or State Continuation Coverage

If an Employer employs less than 20 individuals and has a Group health policy with PacifiCare of Nevada, Inc. then our policy permits an employee to elect to continue identical coverage under the policy if:

1. The employee’s employment is ended for any reason other than gross misconduct or the number of his working hours is lessened so that he ceases to be eligible for coverage;
2. The employee dies;
3. The employee and his or her Spouse are divorced or legally separated.

4. The Dependent child is no longer eligible for coverage under the terms of the policy; or
5. The Spouse is no longer eligible for coverage after becoming eligible for Medicare.

Coverage provided for vision or dental care would be excluded.

The period of continued coverage is limited to 18 months for an employee and 36 months for an employee's Spouse or Dependent child.

Not Eligible Under Mini COBRA

An employee would not be eligible for Mini COBRA according to the following:

1. Voluntarily leaves his or her employment, or
2. The Spouse or Dependent child of that employee is not eligible to continue coverage according to this section, or
3. An employee, Spouse or Dependent child that has not been covered under any group policy of the Employer for at least 12 consecutive months before the termination of this coverage.

Notices

An employee, Spouse or Dependent Child shall tell the Employer Group that he is eligible to continue his coverage according to this Section no later than 60 days after he becomes eligible to do so. The Group, in 14 days after getting informed, will provide adequate information to the Employee, Spouse or Dependent child about the election to continue coverage and the Health Plan Premium needed to be paid. If the Employee, Spouse or Dependent child chooses to proceed with coverage, he shall tell the Employer Group of his election and pay to the Group the Health Plan Premium needed. The Group shall transmit such Health Plan Premiums to PacifiCare along with the Group's Health Plan Premiums due under this Agreement.

Extending Your Coverage: Converting to an Individual Conversion Plan

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

An application for the conversion plan must be received by PacifiCare within 31 days of the date of termination of your group coverage. However, if the Employer Group terminates its Group Agreement with PacifiCare or replaces the PacifiCare group coverage with another carrier, transfer to the individual conversion health plan is not permitted. You also will not be permitted to transfer to the individual conversion Health Plan under any of the following circumstances:

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

Benefits or rates of an individual conversion plan health plan are different from those in your group plan.

An individual conversion health plan is also available to:

1. Dependents, if the Subscriber dies;
2. Dependents who marry or exceed the maximum age for dependent coverage under the group plan;
3. Dependents, if the Subscriber enters military service;
4. Spouse of the Subscriber, if their marriage has terminated.

Written applications for all conversions must be received by PacifiCare within 30 days of the loss of group coverage. For more details, please contact our Customer Service department.

Note: If you accept conversion coverage at the end of coverage under a group Health Plan or at the end of COBRA or similar state continuation coverage, you may give up some protections under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This may include the ability to qualify as a HIPAA-eligible individual. To retain that guarantee, your most recent coverage must have been group health plan coverage.

Certificate of Creditable Coverage

According to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a Certificate of Creditable Coverage will be provided to the Subscriber by either PacifiCare or the Employer Group when the Subscriber or a Dependent ceases to be eligible for benefits under the employer's health benefit plan. Certificates of Creditable Coverage will also be provided upon request while the Subscriber or Dependent is covered under the Health Plan and up to 24 months after coverage under the Health Plan ceases. A Certificate of Creditable Coverage may be used to reduce or eliminate a pre-existing condition exclusion period imposed by a subsequent health plan. Creditable Coverage information for Dependents will be included on the Subscriber's *Certificate*, unless the Dependent's address of record or coverage information is substantially different from the Subscriber's. Please contact the PacifiCare Customer Service department at 1-800-347-8600, TDHI 1-800-360-1797 if you need a duplicate Certificate of Creditable Coverage. If you meet HIPAA eligibility requirements, you may be able to obtain individual coverage using your Certificate of Creditable Coverage.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

Continuation coverage under this Health Plan may be available to you through your employer under the Uniform Services Employment and Reemployment Rights Act of 1994, as amended (USERRA). The continuation coverage is equal to, and subject to the same limitations as, the benefits provided to other Members regularly enrolled in this Health Plan. These benefits may be available to you if you are absent from employment by reason of service in the United States uniformed services, up to the maximum 24-month period if you meet the USERRA requirements. USERRA benefits run concurrently with any benefits that may be available through COBRA. Your employer will provide written notice to you for USERRA continuation coverage.

If you are called to active military duty and are stationed outside of the Geographic Service Area, you or your eligible Dependents must still maintain a permanent address inside the Geographic Service Area and must select a Contracted IPA within 25 miles of that address. To obtain coverage, all care must be provided or arranged in the Geographic Service Area by the designated Contracted IPA, except for Emergency and Urgently Needed Services.

The Health Plan Premium for USERRA continuation of benefits is the same as the Health Plan Premium for other PacifiCare Members enrolled through your employer plus a 2 percent additional surcharge or administrative fee, not to exceed 102 percent of your employer's active group Premium. Your employer is responsible for billing and collecting Health Plan Premiums from you or your Dependents and will forward your Health Plan Premiums to PacifiCare along with your employer's Health Plan Premiums otherwise due under this Agreement. Additionally, your employer is responsible to maintain accurate records regarding USERRA continuation Member Health Plan Premium, qualifying events, terminating events and any other information that may be necessary for PacifiCare to administer this continuation benefit.

SECTION 8. OVERSEEING YOUR HEALTH CARE DECISIONS

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

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

How PacifiCare Makes Important Health Care Decisions

Authorization, Modification and Denial of Health Care Services

Medical Necessity reviews may be conducted by PacifiCare, or in many situations, by a Contracted IPA. Processes are used to review, approve, modify, or deny, based on Medical Necessity, requests by Providers for authorization of the provision of health care services to Members.

The reviewer may also use criteria or guidelines to determine whether to approve, modify or deny, based on Medical Necessity, requests by Providers of health care services for Members. The criteria used to modify or deny requested health care services in specific types of cases will be provided free of charge to the provider, the Member, and the public upon request.

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

The reviewer makes these decisions within at least the following time frames required by state law:

Decisions to approve, modify, or deny requests for authorization of health care services based on Medical Necessity will be made in a timely fashion appropriate for the nature of the Member's condition, not to exceed 14 business days from PacifiCare's, or in many situations, the Contracted IPA's, receipt of the information reasonably necessary and requested to make the decision.

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

If the decision cannot be made within these time frames because (i) PacifiCare, or in many situations, the Contracted IPA is not in receipt of all of the information reasonably necessary and requested or (ii) Consultation by an expert reviewer is required, the reviewer will notify the provider and the Member, in writing, upon the earlier of the expiration of the required time frames above or as soon as the reviewer becomes aware that they will not be able to meet the required time frames.

The notification will specify the information requested but not received and the anticipated date on which a decision may be rendered following receipt of all reasonably necessary requested information. Upon receipt of all information reasonably necessary and requested by PacifiCare, or in many situations, the Contracted IPA, the

reviewer shall approve, modify or deny the request for authorization within the applicable time frame specified above.

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

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

If you would like a copy of PacifiCare's policy and procedure, a description of the processes utilized for the authorization, modification or denial of health care services, or are seeking information about the utilization management process and the authorization of care, you may contact the PacifiCare Customer Service department at **1-800-347-8600/TDHI 1-800-360-1797**.

PacifiCare's Utilization Management Policy

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

Technology Assessment

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

In determining whether to cover a service, PacifiCare uses proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for an individual Member, a PacifiCare Medical Director makes a Medical Necessity determination based on individual Member medical documentation; review of published scientific evidence and when appropriate seeks relevant specialty or professional opinion from an individual who has expertise in the technology.

Medical Management Guidelines

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

Utilization Criteria

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

- Nationally published guidelines for utilization management (specific guideline information available upon request
- HCIA-Sachs Length of Stay© Guidelines (average length of hospital stays by medical or surgical diagnoses)
- PacifiCare Medical Management Guidelines (MMG), and Benefit Interpretation Policies (BIP). (*PacifiCare's Medical Management Guidelines Manual* and *Commercial HMO Benefit Interpretation Policy Manual* are available at **www.pacificare.com**.)

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

Denial or modification of health care services based on Medical Necessity must be made by an appropriately qualified licensed Physician or a qualified licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the Provider.

Denials may be made for administrative reasons that include, but are not limited to, the fact that the patient is not a PacifiCare Member, or that the service being requested is not a benefit provided by the Member's plan.

Preauthorization determinations are made once the Member's Contracted IPA Medical Director or designee receives all reasonably necessary medical information. PacifiCare makes timely and appropriate initial determinations based on the nature of the Member's medical condition in compliance with state and Federal Requirements.

Release of Medical Information

PacifiCare may require access to the Member's medical records and other necessary information to help coordinate and manage the Member's health care. By enrolling in PacifiCare, Member agrees to cooperate with PacifiCare and its Contracted Providers by obtaining and providing medical records and other necessary information in response to reasonable requests by PacifiCare and its Contracted Providers. Member agrees to cooperate in the provision of such information as may be reasonably necessary for utilization review, quality assurance, claims adjudication, as well as for other treatment, payment, and health care operations purposes.

What to Do if You Have a Problem

Sometimes you may have an unexpected problem. When this happens, your first step should be to call our Customer Service department. Our Customer Service department will assist you and attempt to find a solution to your situation.

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

If you feel your problem is not resolved or that your situation requires additional action, you may also file a Grievance requesting an Appeal or Quality Review. To learn more about this, read the following sections, "Submitting a Grievance" and "Appeal Procedures."

Informal Complaints

PacifiCare encourages the informal resolution of Complaints through PacifiCare Customer Service. As such PacifiCare will attempt to resolve any Complaint you may have. However, if your Grievance cannot be resolved in this manner, a more formal Grievance procedure is available to you.

Submitting a Grievance

PacifiCare's Grievance system provides members with a method for addressing Member dissatisfaction regarding coverage decisions, care or services.

You have the right to file a Complaint, also called a Grievance, about problems you observe or experience including:

- complaints about the quality of services that you receive;
- complaints regarding issues such as office waiting times, Physician behavior, adequacy of facilities or other similar concerns; and
- confidentiality and release of your Member information.

To use the formal Grievance procedure, you must submit your Grievance in writing to the following address:

PacifiCare Appeal and Grievance Department
Mail Stop CO53-0665
P.O. Box 4306
Englewood, CO 80155-4306

Phone: 1-800-347-8600/TDHI 1-800-360-1797
Fax: 1-866-449-2847
Expedited Fax: 1-866-449-2903

Quality of Clinical Care and Quality of Service Review

All quality of clinical care and quality of service complaints are investigated by PacifiCare's Health Services Department. PacifiCare conducts this quality review by investigating the complaint and consulting with your Contracted Medical Group, treating Providers, and other PacifiCare internal departments. Medical records are requested and reviewed as necessary, and as such you may need to sign an authorization to release your medical records.

We will respond to your complaint in a manner, appropriate to the clinical urgency of your situation. Please be aware that the results of the quality of clinical care review are confidential and protected from legal discovery in accordance with Nevada law.

Our appeal and quality review procedures are designed to deliver a timely response and resolution to your Grievance. This is done through a process that includes a thorough and appropriate investigation, as well as an evaluation of the Grievance. To initiate an appeal or request quality review, call our Customer Service department or write the Appeals Department at:

PacifiCare of Nevada, Inc.
Appeals Department
700 East Warm Springs Road
Las Vegas, NV 89119

This written request will initiate the following Appeals or Quality Review Process except in the case of "expedited reviews" as discussed below. You may submit written comments, documents, records and any other information

relating to your appeal regardless of whether this information was submitted or considered in this initial determination. You may obtain, upon request and free of charge, copies of all documents, records and other information relevant to your appeal. The appeal will be reviewed by an individual who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person.

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

PacifiCare will advise you of PacifiCare's resolution of the Grievance within 30 days of its receipt, unless good cause exists that preclude PacifiCare from resolving the issue within this time frame.

Appeal Procedures

- As a Member of PacifiCare, you have the right to appeal. You may appeal any decision regarding PacifiCare's payment for or PacifiCare's failure to provide what you believe are Covered Services on this plan. These include: The reimbursement for Emergency Services anywhere in the world or Out-of-Area Urgently Needed Services.
- A denied claim for any other health service furnished by a Non-Contracted Medical Provider that you believe should have been arranged for, or reimbursed by PacifiCare;
- Those services you have not received, but which you feel are the responsibility of PacifiCare to pay for or arrange.
- The discontinuation of services in which you believe are Medically Necessary Covered Services.

PacifiCare has a standard appeal procedure and an expedited 72 hour appeal procedure.

Our appeal procedures are designed to deliver a timely response and resolution to your Grievance. This is done through a process that includes a thorough and appropriate investigation, as well as an evaluation of the appeal.

You may submit written comments, documents, records and any other information relating to your appeal regardless of whether this information was submitted or considered in this initial determination. You may obtain, upon request and free of charge, copies of all documents, records and other information relevant to your appeal. The appeal will be reviewed by an individual who is neither the individual who made the initial determination that is the subject of the appeal nor the subordinate of that person.

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

For appeals involving the delay, denial or modification of health care services, PacifiCare's written response will describe the specific reason for the decision, describe the criteria or guidelines or benefit provisions on which the denial decision was based, and notification that upon request, the Member may obtain a copy of the actual benefit provision, guideline, protocol, or other similar criterion on which the denial is based.

Who May File an Appeal?

You may file an appeal or someone else may file the appeal on your behalf if you appoint them, in writing, as your representative.

Upon request, PacifiCare will appoint an employee to assist you or your representative in filing a complaint or appealing a decision.

Support for Your Appeal

You are not required to file more information to support your request for service, payment for services already received, or your request for an appeal. PacifiCare will gather all necessary information. However, it may be helpful if you include more information to clarify or support your request. For example, in support of your request you may want to include information such as medical records or Physician opinions. To get medical records, you may send a written request to your Primary Care Physician. Another Contracted Medical Provider's medical records may not be included in your medical records received from your Primary Care Physician. You will then need to separately ask the Contracted Medical Provider who provided medical services to you. This may include a contracted specialist as well as a Contracted Hospital.

You have the ability to give more information in person or in writing. In the case of an expedited decision or appeal, you or your authorized representative may provide evidence in person, via telephone, or in writing.

A. **Standard Appeal Procedure**

Requests for payment or provision of services are submitted to PacifiCare. As this occurs, you will be notified in writing of the decision. If the decision is a denial (partial or complete), the notice will state the reasons for the denial as well as inform you of your rights to appeal.

If you decide to appeal the decision you receive in the notice, you should send a written request for an appeal. Please mail your written request to:

PacifiCare Appeal and Grievance Department
Mail Stop CO53-0665
P.O. Box 4306
Englewood, CO 80155-4306

Fax: 1-866-449-2847
Expedited Fax: 1-866-449-2903

You must send your request within 180 days of the initial decision.

- The 180-day limit may be increased for good cause. You should include in your request the reason why you could not file within that time frame. Within 30 days of receipt of the Appeal request, PacifiCare will conduct an investigation, reconsider the issue, and notify you in writing of the decision.

During the Appeal process, you or your representative may present or give relevant facts and/or more evidence for review either in person, via telephone, or in writing.

B. **Expedited 72-Hour Initial Determination**

You have the right to request and receive expedited decisions affecting your medical treatment in time-sensitive situations. A time-sensitive situation is one where waiting for a decision to be made within the standard decision time frame could seriously jeopardize your life or health; or your ability to regain maximum function. PacifiCare will determine if your situation is time-sensitive based on medical criteria or if your Physician calls or writes in support of your request. If PacifiCare (or your Physician) decides that your situation is time-sensitive, a decision will be issued within 72 hours from the time the request was received.

C. **Expedited 72-Hour Review**

How to ask for an Expedited 72-Hour Review

To ask for an expedited 72-hour review, you or your authorized representative may call, write, fax; or visit PacifiCare. Be sure to ask for an expedited 72-hour review when you make your request.

Call:	1-800-347-8600/TDHI 1-800-360-1797 7 a.m. to 8 p.m. PST
Write:	PacifiCare of Nevada, Inc. Expedited Appeals Analyst Mail Stop CO53-4306 P.O. Box 4306 Englewood, CO 80155-4306
Fax:	1-866-449-2903 Attention: Expedited Appeals Analyst
Walk-in:	PacifiCare of Nevada, Inc. 700 East Warm Springs Road Las Vegas, Nevada 89119 8 a.m. to 5 p.m. Monday through Friday (except holidays)

D. **Independent External Review**

PacifiCare offers an independent external review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure, based upon a lack of Medical Necessity. The process is available at no charge to Members who meet all of the following criteria:

- The Member has received an initial denial for the service or procedure from PacifiCare of Nevada, Inc.;
- The denial is based on a lack of Medical Necessity, as defined in this *Evidence of Coverage*;
- The Member has Appealed the denial to PacifiCare of Nevada, Inc. as described in this *Evidence of Coverage*;
- PacifiCare has upheld the denial at the plan level; and
- The cost of the service or procedure requested is more than $500.

If you meet all of the criteria listed above, you may request an external review. If you request an external review, an independent Physician or Provider who is not affiliated with PacifiCare of Nevada, Inc. will review the denial. As with a Standard Appeal, you may submit whatever information you believe is relevant in support of your request. However, neither you nor PacifiCare will have an opportunity to meet with the reviewer or participate in the reviewer's decision.

All requests for an independent external review must be made within 60 calendar days of the date that you receive PacifiCare's appeal denial. You, your Physician, or your designated representative may request an external review. To do so, please call PacifiCare Customer Service at 1-800-347-8600/TDHI 1-800-360-1797 or send your request in writing to:

PacifiCare Appeal and Grievance Department
Mail Stop CO53-0665
P.O. Box 4306
Englewood, CO 80155-4306

The independent external review will be performed by an independent Physician or Provider who is qualified to decide whether the requested service or procedure is or is not Medically Necessary. The reviewer will not have material affiliation or interest with PacifiCare. Neither you nor PacifiCare will choose or control the choice of reviewer. In certain cases, a panel of Physicians or Providers, as deemed appropriate by the external independent review organization, will perform the independent external review.

PacifiCare will notify you, your authorized representative (if any) and your treating Physician that we have received your request for external review within five days after receipt of your request. PacifiCare will also forward your request to The Office for Consumer Health Assistance within five days of receipt of your request. The Office for Consumer Health Assistance can be contacted by dialing their toll-free telephone number, 1-888-333-1597, their direct number, (702) 486-3587, or information can be faxed to (702) 486-3586. The Office for Consumer Health Assistance will assign an external review organization. Within five days after receiving notification from The Office for Consumer Health Assistance specifying the external review organization, PacifiCare will provide the external organization the following:

- All relevant medical records pertaining to your case;
- A copy of the provisions of the health care plan upon which the final denial was based;
- All documents PacifiCare used in determining that the service or procedure is not Medically Necessary;
- The reasons for the denial;
- Insofar as practicable, a list that specifies each Provider of health care who has provided health care to the insured and the medical records of the Provider of health care relating to the external review; and
- All other information or evidence that you or your Physician have submitted to PacifiCare.

As stated above you or your Physician may wish to submit additional information in support of your request. Please submit all pertinent information you wish to be included with your request. PacifiCare will include this information along with all other documents forwarded to the independent external review organization. PacifiCare will also include with your request all previous information you have submitted. The external review decision will be made within 15 days after the external review organization receives the information required to make their determination. The external review organization will submit a copy of its determination, including the reasons for the determination, to you, your authorized representative (if any), your treating Physician and PacifiCare.

Expediting your Independent External Review

The independent external review process will be expedited if you meet all of the criteria for independent external review as noted above, and have previously completed an expedited 72-hour review as described in the previous section. The independent external review process will also be expedited if your Physician provides proof that failure to proceed in an expedited manner may jeopardize your life or health. PacifiCare will assign the request for an external review organization within one business day after approving the request. The external review organization will complete its external review within two working days after receiving the assignment unless the Member and PacifiCare agree to a longer period of time.

Not later than one working day after completing its review, the external review organization will notify you, your authorized representative (if any), your treating Physician, and PacifiCare by telephone of its determination. In addition, not later than five working days after completing its review, the external review organization will provide a written decision to these same individuals.

Independent External Review Decision

The external reviewer's decision will be in writing within the applicable time frames as noted above. The reviewer's decision must be based on the following:

- Documented evidence, including any recommendation by the treating Physician;
- Medical evidence, including (a) professional standards of safety and effectiveness for diagnosis, care, and treatment that are generally recognized in the United States; (b) any report published in literature that is peer-review; (c) evidence-based medicine, including reports and guidelines that are published by professional organizations that are recognized nationally and that include supporting scientific data; and (d) an opinion of

an independent Physician who, as determined by the external review organization, is an expert in the health specialty that is the subject of the external review; and

- The terms and conditions for benefits set forth in this *Evidence of Coverage* issued to the Member by PacifiCare.

Requesting Reconsideration of the External Review Decision

If the determination of the external review organization is in favor of the Member, the determination is final, conclusive, and binding upon PacifiCare.

If either you or PacifiCare disagrees with the reviewer's decision, either you or PacifiCare may request that the reviewer's decision be reconsidered on the following grounds:

- Error on the face of the information or evidence submitted;
- Fraud; or
- New information or evidence which was not available at the time the reviewer made his or her decision.

Requests for reconsideration must be submitted within 15 calendar days of your receipt of the reviewer's decision. Your reconsideration request must be submitted to the independent external review organization. The independent external review organization will determine whether the reviewer's decision will be reconsidered. If neither you nor PacifiCare requests reconsideration within such 15 calendar days, the reviewer's decision shall be considered final.

If either you or PacifiCare requests reconsideration, the independent external review organization will promptly review the request. You, as well as PacifiCare, will be notified in writing as to whether or not the reviewer's decision will be reconsidered. A decision shall be provided to you and PacifiCare within the following time frames:

- Standard independent external review (not expedited) – within 30 calendar days following the organization's receipt of the request for reconsideration.
- Expedited independent external review – within 10 calendar days following the organizations receipt of the request for reconsideration.

However, either of the above-noted time frames may be extended if the reviewer should require additional information to make a decision.

If the independent external review decision is that the service or procedure is Medically Necessary, PacifiCare will accept the decision and provide coverage for such service or procedure in accordance with the terms and conditions of your *Evidence of Coverage*.

If the independent external review decision is that the service or procedure is not Medically Necessary or is Experimental or Investigational, PacifiCare will not be obligated to provide coverage for the service or procedure, and you will be deemed to have exhausted the Appeal process unless you request voluntary Binding Arbitration. PacifiCare's voluntary Binding Arbitration process for independent external review decisions follows the rules of the American Arbitration Association. To obtain further information, or to request voluntary Binding Arbitration, please call PacifiCare Customer Service at 1-800-347-8600/TDHI 1-800-360-1797.

To obtain further information regarding PacifiCare's independent external review process, please call PacifiCare Customer Service at 1-800-347-8600/TDHI 1-800-360-1797.

Voluntary Binding Arbitration (available at the discretion of the Member)

PacifiCare does not require, suggest, or recommend that a Member resolve a dispute through Binding Arbitration. A member always has the right to pursue an appeal. Nothing in this voluntary Binding Arbitration provision interferes with those rights. The following voluntary Binding Arbitration provision only applies after the Member and PacifiCare have exhausted all

the appeals processes available and the issue has not been resolved to the Member's satisfaction. The Member is not required to resolve a dispute through Binding Arbitration. Binding Arbitration is strictly voluntary at the discretion of the Member and upon agreement with PacifiCare.

Any and all disputes of any kind whatsoever, including claims relating to the delivery of services under the Health Plan and claims of medical malpractice (that is, as to whether any medical services rendered under the Health Plan were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), except for claims subject to ERISA, between Member (including any heirs, successors or assigns of Member) and PacifiCare of Nevada, Inc., or any of its parents, subsidiaries or affiliates (collectively, "PacifiCare Entities"), may, at the request of the Member, be submitted to voluntary Binding Arbitration. If a Member voluntarily elects Binding Arbitration, the dispute will not be resolved by a lawsuit or resort to court process, except as the Federal Arbitration Act provides for judicial review of arbitration proceedings. When the parties voluntarily elect to use voluntary Binding Arbitration, the Member and PacifiCare are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and are instead accepting the use of voluntary Binding Arbitration by a single arbitrator in accordance with the Comprehensive Arbitration Rules and Procedures of JAMS, and administration of the arbitration shall be performed by JAMS or such other arbitration service as the parties may agree in writing. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within 30 days following the date demand for arbitration is made, the arbitrator appointment procedures in the Comprehensive Arbitration Rules and Procedures will be utilized.

Arbitration hearings shall be held in the county in which the Member lives or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a Superior Court of Nevada, including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by federal and Nevada State law. The parties shall divide equally the expenses of JAMS and the arbitrator. In cases of extreme hardship, PacifiCare Entities may assume all or part of the Member's share of the fees and expenses of JAMS and the arbitrator, provided the Member submits a hardship application to JAMS. The approval or denial of the hardship application will be determined solely by JAMS.

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

Review by the Nevada Division of Insurance

In addition to the appeals processes described above, you may contact the State of Nevada Department of Business and Industry, Division of Insurance. The Nevada Division of Insurance is responsible for regulating health care service plans. The department has an in-state toll-free telephone number (**1-888-872-3234**) to receive complaints regarding Health Plans. The hours of operation of the Division of Insurance are Monday through Friday from 8 a.m. to 5 p.m. Pacific Standard Time. You may also access the Division of Insurance by contacting their Carson City office at (775) 687-4270 or their Las Vegas office at (702) 486-4009. The Division's Internet Web site (**www.doi.state.nv.us**) has complaint forms and instructions online. If you have a Grievance against PacifiCare, you should first telephone us at **1-800-347-8600/TDHI 1-800-360-1797** and use our 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 PacifiCare, or a Grievance that has remained unresolved for more than 30 days, you may call the Division for assistance. PacifiCare's Grievance process and the Division's complaint review process are in addition to any other dispute resolution procedures that may be

available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

Complaints Against Contracted IPAs, Providers, Physicians and Hospitals

Claims against a Contracted IPA, the group's Physicians, or Providers, Physicians or Hospitals – other than claims for benefits under your coverage – are not governed by the terms of this plan. You may seek any appropriate legal action against such persons and entities deemed necessary.

In the event of a dispute between you and a Contracted Provider for claims not involving benefits, PacifiCare agrees to make available the Member appeals process for resolution of such dispute. In such an instance, all parties must agree to this resolution process. Any decision reached through this resolution process will not be binding upon the parties except upon agreement between the parties. The Grievance will not be subject to voluntary Binding Arbitration except upon agreement between the parties. Should the parties fail to resolve the Grievance, you or the Contracted Provider may seek any appropriate legal action deemed necessary. Member claims against PacifiCare will be handled as discussed above under "Appeal Procedures."

ERISA Rights

The following is a general description of the claims procedures applicable to Employers subject to the Employee Retirement Income Security act of 1974, as amended (ERISA). Members should contact their Employer's benefit administrator to determine whether the Employer is subject to ERISA.

1. A description of PacifiCare's claims procedures, including the process for obtaining Preauthorization of a Covered Service, is set forth in this *Evidence of Coverage*.
2. PacifiCare processes initial requests from Members (or their authorized representatives) for Covered Services pursuant to the following time frames:
    a. **Non-Urgent Pre-Service Requests.** Members will be notified to decisions to authorize or requests for Covered Services within a reasonable period of time appropriate to the medical condition of the Member but not later than 15 days from the receipt of the request. PacifiCare may extend the initial time frame for up to 15 days due to circumstances beyond its control. However, if the extension is necessary due to the Member's failure to submit the information necessary for PacifiCare to make a decision regarding the request, the Member will be notified of the extension, informed of the specific information necessary to make a decision, and provided at least 45 days to provide the specified information. In addition, the time period for making the determination is suspended from the date on which extension notification is received by the Member until the date on which (i) the Member responds with the specified information or (ii) the end of the period of time provided to submit the specified information, whichever is earlier.
    b. **Urgent Requests.** A request for Covered services will be treated as an "urgent request" if making a determination pursuant to the time frames in Section (a) above (i) could seriously jeopardize the life or health of the Member, or (ii) if in the opinion of a Physician with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. In the event of an urgent request, PacifiCare will notify the Member of its determination to authorize or deny as soon as possible, taking into account the Member's medical condition, but not later than 72 hours after receipt of the urgent request. In the event PacifiCare does not have the information necessary to make a decision regarding the request, PacifiCare will notify the Member as soon as reasonably possible, but not later than 24 hours after receipt of the request and will inform the Member of the specific information necessary for PacifiCare to make a determination regarding the request and the reasonable time frame (no less than 48 hours) for the Member to provide the specified information. PacifiCare will make a determination as soon as possible but no later than 48 hours after the earlier of (i) the receipt of the requested information, or (ii) the end of the period of time provided to submit the specified information.

c. **Concurrent Care Requests.** If the Member requests an extension of a previously authorized and currently ongoing course of treatment, and the request is an "urgent request" as defined in Section (b) above, PacifiCare will approve or deny the request as soon as possible, taking into account the Member's medical condition, and will notify the Member of the decision within 24 hours of the request, provided the Member made the request to PacifiCare at least 24 hours prior to the expiration of the previously authorized course of treatment. If the concurrent care request if not an "urgent request" as defined in Section (b) above, PacifiCare will treat the request as a new request for a Covered Service under the Health Plan and will follow the time frame for non-urgent requests as discussed in Section (a) above.

d. **Post-Service Claim.** Members will be notified of denials (in whole or in part) of an initial post-service claim within a reasonable period of time, but not later than 30 days after receipt of the claim. PacifiCare may extend the initial time frame for up to 15 days due to circumstances beyond its control. However, if the extension is necessary due to the Member's failure to submit the information necessary for PacifiCare to make a decision regarding the request, the Member will be notified of the extension, informed of the specific information necessary to make a decision, and provided at least 45 days to provide the specified information. In addition, the time period for making the determination is suspended from the date on which extension notification is received by the Member until the date on which (1) the Member responds with the specified information or (2) the end of the period of time provided to submit the specified information, whichever is earlier.

3. **Appeal.** Members have up to 180 days following receipt of an adverse determination within which to appeal the determination. The 180-day limit may be increased for good cause. Members should include in the request the reason why the appeal could not be filed within that time frame. Members are entitled to a full and fair appeals process. Members may submit written comments, documents, records and information in support of their appeal. PacifiCare will notify the Member of its decision regarding the appeal no later than:
   - 72 hours for an urgent request
   - 30 days for a non-urgent pre-service request (the denial of an initial request for a service not yet provided)
   - 60 days for a post-service claim (the denial of a claim for services already provided but not yet paid for)
4. The Member agrees that their Provider will be their "authorized representative (pursuant to ERISA) regarding the receipt of approvals of requests for Covered Services for purposes of medical management.
5. ERISA provides for a maximum of two mandatory appeal levels. Members enrolled in employee welfare benefit plans subject to ERISA may have the right to bring civil action under Section 502(a) of ERISA if all required reviews of their claim have been completed and the claim has not been approved.
6. A Member's participation in a voluntary appeal level does not affect their legal rights provided under ERISA. Any statute of limitations applicable to pursuing civil action will be tolled during the period of a voluntary level of appeal.
7. Voluntary Binding Arbitration of claims, as described in this section of this *Evidence of Coverage,* will be limited to claims that are not subject to ERISA.

SECTION 9. GENERAL INFORMATION

- **How to Replace your Card**
- **Translation Assistance**
- **Speech- and Hearing-Impaired**
- **Nondiscrimination Notice**
- **Coverage in Extraordinary Situations**
- **Compensation for Providers**
- **Public Policy Participation**

What follows are answers to some common and uncommon questions about your coverage. If you have any questions of your own that haven't been answered, please call our Customer Service department.

What should I do if I lose or misplace my membership card?

If you should lose your card, simply call our Customer Service department. Along with sending you a replacement card, they can make sure there is no interruption in your coverage.

Does PacifiCare offer a translation service?

PacifiCare uses a telephone translation service for almost 140 languages and dialects. That's in addition to select Customer Service representatives who are fluent in Spanish.

Does PacifiCare offer hearing- and speech-impaired telephone lines?

PacifiCare has a dedicated telephone number for the hearing- and speech-impaired. This phone number is 1-800-360-1797.

How is my coverage provided under extraordinary circumstances?

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

Nondiscrimination Notice

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

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

How Does PacifiCare Compensate its Contracted Providers?

PacifiCare itself is not a Provider of health care. PacifiCare typically contracts with independent medical associations to provide medical services to its Members, and with hospitals to provide Hospital Services. Once they are contracted, they become PacifiCare Contracted Providers.

Contracted IPAs contract with individual Physicians. None of the Contracted IPAs or Contracted Hospitals, or their Physicians or employees, are employees or agents of PacifiCare. Likewise, neither PacifiCare nor any employee of PacifiCare is an employee or agent of any Contracted IPA, Contracted Hospital or any other Contracted Provider.

Some of our Contracted IPAs receive an agreed-upon monthly payment from PacifiCare to provide services to our Members. This monthly payment may be either a fixed dollar amount for each Member or a percentage of the monthly Premium received by PacifiCare. The monthly payment typically covers professional services directly provided, or referred and authorized, by the Contracted IPA. Most of our Contracted IPAs have agreed upon discounted reimbursements as payment in full from PacifiCare.

A majority of PacifiCare's Contracted Hospitals are paid on a discounted fee-for-service or fixed charge per day of hospitalization. Most acute care, Subacute and Transitional Care, and Skilled Nursing Facilities are paid on a fixed charge per day basis for inpatient care.

Stop-loss insurance protects Contracted IPAs and Contracted Hospitals from large financial expenses for health care services. PacifiCare provides stop-loss protection to our Contracted IPAs and Contracted Hospitals. If any Contracted Hospital or Contracted IPA does not obtain stop-loss protection from PacifiCare, it must obtain stop-loss insurance acceptable to PacifiCare.

PacifiCare arranges with additional Providers or their representatives for the provision of Covered Services that cannot be performed by your assigned Contracted IPA or Contracted Hospital. Such services include authorized Covered Services that require a specialist not available through your Contracted IPA or Contracted Hospital, or Emergency and Urgently Needed Services. PacifiCare or your Contracted IPA pays these Providers at the lesser of the Provider's reasonable charges or agreed to rates. Your responsibility for Covered Services received from these Providers is limited to payment of applicable Copayments. (For more about Copayments, see **Section 6. Payment Responsibility**.) You may obtain additional information on PacifiCare's compensation arrangements by contacting PacifiCare or your Contracted IPA.

SECTION 10. DEFINITIONS

PacifiCare is dedicated to making its services easily accessible and understandable. To help you understand the precise meanings of many terms used to explain your benefits, we have provided the following definitions. These definitions apply to the capitalized terms used in your Evidence of Coverage, as well as the Summary of Benefits.

Annual Copayment Maximum – The maximum amount of Copayments a Member is required to pay for certain Covered Services in a Benefit Plan Year. (Please refer to your *Summary of Benefits*.)

Appeal – A request made by a Member to PacifiCare regarding PacifiCare's payment for or failure to provide what the Member believes are Covered Services.

Benefit Plan Year – The twelve (12)-month period that begins on the first day of the month the Group Service Agreement between your Employer and PacifiCare becomes effective.

Binding Arbitration – The submission of a dispute to one or more impartial persons for a final and binding decision, except for fraud or collusion on the part of the arbitrator. This means that once the arbitrator has issued a decision, neither party may appeal the decision.

Biofeedback – Biofeedback therapy provides visual, auditory or other evidence of the status of certain body functions so that a person can exert voluntary control over the functions, and thereby alleviate an abnormal bodily condition. Biofeedback therapy often uses electrical devices to transform bodily signals indicative of such functions as heart rate, blood pressure, skin temperature, salivation, peripheral vasomotor activity, and gross muscle tone into a tone or light, the loudness or brightness of which shows the extent of activity in the function being measured.

Calendar Year – The twelve (12)-month period that begins on January 1 and ends twelve (12) consecutive months later on December 31.

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

Chronic Condition – A medical condition that is continuous or persistent over an extended period of time and requires ongoing treatment for its management.

Claim Determination Period – A Calendar Year.

Cognitive Behavioral Therapy – Psychotherapy where the emphasis is on the role of thought patterns in moods and behaviors.

Cognitive Rehabilitation Therapy – Cognitive Rehabilitation Therapy is therapy for the treatment of functional deficits as a result of traumatic brain injury and cerebral vascular insult. It is intended to help in achieving the return of higher level cognitive ability. This therapy is direct (one-on-one) patient contact.

Complementary and Alternative Medicine – Defined by the National Center for Complementary and Alternative Medicine as the broad range of healing philosophies (schools of thought), approaches and therapies that Conventional Medicine does not commonly use, accept, study or make available. Generally defined, these treatments and health care practices are not taught widely in medical schools and not generally used in hospitals. These types of therapies used alone are often referred to as "alternative." When used in combination with other alternative therapies, or in addition to conventional therapies, these therapies are often referred to as "complementary."

Consolidated Omnibus Budget Reconciliation Act (COBRA) – The federal law requiring that certain employer Health Plans give employees and qualified Family Members the opportunity to continue their health care coverage at employer rates in specific instances where coverage would otherwise end.

Contract Year – The twelve (12)-month period that begins on the first day of the month the Group Service Agreement between your employer and PacifiCare becomes effective.

Contracted Hospital – Any general acute care hospital licensed by the State of Nevada that has entered into a written agreement with PacifiCare to provide Hospital Services to PacifiCare's Members. Contracted Hospitals are independent contractors and are not employees of PacifiCare.

Contracted IPA – An independent practice association (IPA) made up of Physicians that have entered into a written agreement with PacifiCare to provide Physician services to PacifiCare's Members. An IPA contracts with independent contractor Physicians who work at different office sites. Contracted IPAs are independent contractors and are not employees of PacifiCare.

Contracted Provider – A hospital or other health care entity, a Physician or other health care professional, or a health care vendor that has entered into a written agreement to provide Covered Services to PacifiCare's Members. A Contracted Provider may contract directly with PacifiCare, with a Contracted IPA or with another Contracted Provider. Contracted Providers are independent contractors and are not employees of PacifiCare.

Conventional Medicine – Defined by the National Center for Complementary and Alternative Medicine as medicine as practiced by holders of M.D. (medical doctor) or D.O. (doctor of osteopathy) degrees. Other terms for Conventional Medicine are allopathic, Western, regular and mainstream medicine.

Copayments – The fee that a Member is obligated to pay, if any, at the time he or she receives a Covered Service. Copayments may be a specific dollar amount of the Covered Services. Copayments are fees paid by the Member in addition to the Premium paid by an Employer Group and any payroll contributions required by the Member's Employer Group.

Covered Services – Medically Necessary services or supplies provided under the terms of this *Evidence of Coverage*, your *Summary of Benefits* and supplemental benefit materials.

Custodial Care – Care and services that assist an individual in the activities of daily living. Examples include: assistance in walking, getting in or out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial Care includes all homemaker services, respite care, convalescent care or extended care not requiring Skilled Nursing. Custodial Care does not require the continuing attention of trained medical or paramedical personnel. The mere provision of Custodial Care by a medical professional, such as a Physician, licensed nurse or registered therapist, does not mean the services are not custodial in nature. If the nature of the services can be safely and effectively performed by a trained nonmedical person, the services will be considered Custodial Care.

Customer Service – A department of PacifiCare dedicated to answering your questions concerning your Membership, benefits, Appeal and Grievance. A Customer Service associate is available to assist you during regular business hours, Monday through Friday, 7 a.m. to 8 p.m. (PST) by calling 1-800-347-8600 / TDHI 1-800-360-1797 or by writing to P.O. Box 60125, Phoenix, AZ 85082-0125.

Dependent – A Member of a Subscriber's family who is enrolled with PacifiCare after meeting all of the eligibility requirements of the Subscriber's Employer Group and PacifiCare, and for whom applicable Health Plan Premiums have been received by PacifiCare.

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

Developmental and Neurodevelopmental Testing – Developmental and Neurodevelopmental Testing is a battery of diagnostic tests for the purpose of determining a child's developmental status and need for early intervention services. This may include, but is not limited to, psychological and behavioral developmental profiles.

Eligible Dependent – A Member of a Subscriber's family who meets all the eligibility requirements of the Subscriber's Employer Group and PacifiCare.

Eligible Employee – Is a permanent employee of a small Employer Group, who has a regular working week of at least thirty (30) hours.

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 jeopardy to the health of an unborn child;*
- *serious impairment to bodily functions;*
- *serious dysfunction of any bodily organ or part;*

Emergency Services – Medical screening, examination and evaluation by a Physician, or other personnel – to the extent provided by law – to determine if an Emergency Medical Condition exists. If this condition exists, Emergency Services include the care, treatment and/or surgery by a Physician necessary to relieve or eliminate the Emergency Medical Condition within the capabilities of the facility. (For a detailed explanation of Emergency Services, see **Section 3. Emergency and Urgently Needed Services**.)

Employer Group – The single employer, labor union, trust, organization, or association through which you enrolled for coverage.

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

ERISA – The Employee Retirement Income Security Act (ERISA) of 1974 is a federal law designed to protect the rights of participants and beneficiaries of employee welfare benefit plans. Please contact your employer's benefit administrator to determine whether your employer is subject to ERISA.

Evidence of Coverage – This document, which explains Covered Services, Exclusions and Limitations, and defines your rights and roles as a Member and those of PacifiCare.

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

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

Geographic Service Area – The area within which PacifiCare arranges Covered Services. You must live or work in the Geographic Service Area to become and remain a Member of PacifiCare.

Grievance (Complaint) – A written or oral expression of dissatisfaction regarding the plan and/or Provider, including quality of care concerns, and shall include a Complaint, dispute, request for reconsideration or Appeal made by a Member or the Member's representative.

Group Service Agreement – The Group Service Agreement entered into between PacifiCare and the employer, labor union, trust, organization or association through which you enroll for coverage.

Health Plan/PacifiCare Health Plan – Your benefit plan as described in this *Evidence of Coverage*, *Summary of Benefits* and supplemental benefit materials.

Home Health Aide – A person, who has completed Home Health Aide Training as required by the state in which the individual is working. Home Health Aides must work under a plan of care ordered by a Physician and under the supervision of a licensed nurse or licensed therapist.

Home Health Aide Services – Medically Necessary personal care such as bathing, exercise assistance and light meal preparation, provided by trained individuals and ordered along with Skilled Nursing and/or therapy visits.

Home Health Care Visit – Defined as up to two hours of skilled services by a registered nurse or licensed vocational nurse or licensed therapist or up to four hours of Home Health Aide Services.

Hospice – Specialized form of interdisciplinary health care for a Member with a life expectancy of a year or less due to a terminal illness. Hospice programs or services are designed to provide palliative care; alleviate the physical, emotional, social and spiritual discomforts of a Member who is experiencing the last phase of life due to the existence of a terminal disease; and provide supportive care to the primary caregiver and family of the Member receiving Hospice services.

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

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

Hypnotherapy – Medical Hypnotherapy is treatment by hypnotism or inducing sleep.

Infertility – Either: (1) the inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception, or (2) the presence of a demonstrated condition recognized by a licensed Physician who is a Contracted Provider as a cause of Infertility.

Intramuscular – Injection into the muscle.

Intravenous – Injection into the vein.

Late Enrollee – An employee or employee's dependent who declined enrollment in the PacifiCare Health Plan when offered and who subsequently requests enrollment outside the designated Open Enrollment Period.

Learning Disability – A Learning Disability is a condition which manifests as a significant discrepancy between estimated cognitive potential and actual level of educational performance and which is not a result of generalized Mental Retardation, educational or psychosocial deprivation, psychiatric disorder or sensory loss.

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

Medical Director – The Physician, licensed in the State of Nevada, so named by PacifiCare as the Medical Director.

Medically Necessary (or Medical Necessity) – Services or products a prudent Physician would provide to a Member to prevent, diagnose or treat an illness, injury or disease or any symptoms thereof that are necessary and (1) provided in accordance with generally accepted standard of medical practice; (2) clinically appropriate with regard to type, frequency, extent, location and duration; (3) not primarily provided for the convenience of the patient, Physician or other Provider of health care; (4) required to improve a specific health condition of a Member or to preserve the Member's existing state of health; and (5) the most clinically appropriate level of health care that may be safely provided to the Member.

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

Medicare-Eligible – Those Members who meet eligibility requirements under Title XVIII of the Social Security Act, as amended.

Member – The Subscriber or any Dependent who is eligible, enrolled, and covered by PacifiCare.

Mental Retardation and Related Conditions – An individual is determined to have mental retardation based on the following three criteria:

- intellectual functioning level (IQ) is below 70-75;
- significant limitations exist in two or more adaptive skill areas; and
- the condition is present from childhood (defined as age 18 or less)

Non-Contracted Providers – A hospital or other health care entity, a Physician or other health care professional, or a health care vendor that has not entered into a written agreement to provide Covered Services to PacifiCare's Members.

Open Enrollment Period – The time period determined by PacifiCare and the Subscriber's Employer Group when all Eligible Employees and their eligible Family Members may enroll in PacifiCare.

PacifiCare-Designated Pharmacy – PacifiCare contracted pharmacy designed to dispense injectable medications. A PacifiCare-Designated Pharmacy may include Prescription Solutions® Mail Service Pharmacy or alternative specialty injectable vendor as determined by PacifiCare.

Physician – Any licensed allopathic or osteopathic Physician.

Premiums – The payments made to PacifiCare by an Employer Group on behalf of a Subscriber and any enrolled Family Members for providing and continuing enrollment in PacifiCare.

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

Primary Care Physician – A Contracted Provider who is a Physician trained in internal medicine, general practice, family practice or pediatrics, and who has accepted primary responsibility for coordinating a Member's health care services. Primary Care Physicians are independent contractors and are not employees of PacifiCare.

Primary Residence – The home or address where the Member actually lives most of the time. A residence will no longer be considered a Primary Residence if: (1) the Member moves without the intent to return; (2) the Member is absent from the residence of 90 consecutive days, or (3) the Member is absent from the residence for more than 100 days in any six-month period.

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

Private-Duty Nursing Services – Private-Duty Nursing Services encompass nursing services for recipients who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or Skilled Nursing Facility.

Provider – A person, group, facility or other entity that is licensed or otherwise qualified to deliver any of the health care services described in this *Evidence of Coverage* and supplemental benefit materials.

Prudent Layperson – A person without medical training who reasonably draws on practical experience when making a decision regarding whether Emergency Services are needed.

Psychological Testing – Psychological Testing includes the administration, interpretation and scoring of tests such as WAIS-R, Rorschach, MMPI and other medically accepted tests for evaluation of intellectual strengths, psychopathology, psychodynamics, mental health risks, insight, motivation and other factors influencing treatment and prognosis.

Regional Organ Procurement Agency – An organization designated by the federal government and responsible for procurement of organs for transplantation and the promotion of organ donation.

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

Skilled Nursing Facility – A comprehensive free-standing rehabilitation facility, or a specially designed unit within a hospital licensed in the State of Nevada in which they operate to provide Skilled Nursing Services.

Skilled Nursing Services – The services provided directly by or under the direct supervision of licensed nursing personnel, including the supportive care of a Home Health Aide.

Skilled Rehabilitation Care – The care provided directly by or under the direct supervision of licensed nursing personnel or licensed physical, occupational or speech therapist.

Spouse – The Subscriber's husband or wife who is legally recognized as a husband or wife under the laws of the State of Nevada.

Student Dependents – Dependent unmarried children who are registered on a full-time basis, with a minimum of twelve (12) credit hours per grading period, at an accredited institution of higher education who may continue as Eligible Dependents through the Limiting Age specified in the Group Service Agreement for Student Dependents, provided proof of such status is submitted to PacifiCare on a periodic basis as requested by PacifiCare.

Subacute and Transitional Care – Care provided to a Member as an inpatient of a Skilled Nursing Facility that is more intensive licensed Skill Nursing Services than is provided to the majority of the patients in a Skilled Nursing Facility.

Subcutaneous – Injection under the skin.

Subscriber – The person enrolled in the Health Plan for whom the appropriate Premiums have been received by PacifiCare, and whose employment or other status, except for family dependency, is the basis for enrollment eligibility.

Summary of Benefits – An important part of your *Evidence of Coverage* that provides benefit information specific to your Health Plan, including Copayment information.

Surrogacy Arrangements or Surrogate Pregnancy A situation in which a woman enters a contract, agreement or other understanding in which a woman (the surrogate) agrees to become pregnant and to surrender the newborn upon birth to another person or persons who intend to raise the newborn.

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

In determining whether to cover a service, PacifiCare uses proprietary technology guidelines to review new devices, procedures and drugs, including those related to behavioral health. When clinical necessity requires a rapid determination of the safety and efficacy of a new technology or new application of an existing technology for a individual Member, a PacifiCare Medical Director makes a Medical Necessity determination based on

individual Member medical documentation; review of published scientific evidence and when appropriate seeks relevant specialty or professional opinion from an individual who has expertise in the technology.

Telehealth – A health service, other than a Telemedicine, delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification who does not perform a Telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

1. Compressed digital interactive video, audio or data transmission;

1. Clinical data transmission using computer imaging by way of still-image capture and store and forward; and

2. Other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine – The use of interactive audio, video or other electronic media to deliver health care. This includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data and medical education. This term does not include services performed using a telephone or facsimile machine.

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

Urgently Needed Services – Covered Services that are provided when your Contracted IPA is temporarily unavailable or inaccessible. This includes when the Member is temporarily absent from the Geographic Service Area served by the Member's Contracted IPA. These services must be Medically Necessary and cannot be delayed because of an unforeseen illness, injury or condition.

Usual and Customary Charges (U&C) – Charges for medical services or supplies for which PacifiCare is legally liable and which do not exceed the average charged rate charged for the same or similar services or supplies in the geographic region where the services or supplies are received. Usual and Customary Charges are determined by referencing the percentile of the most current survey published by Medical Data Research (MDR) for such services or supplies. The MDR survey is a product of Ingenix, Inc., formerly known as Medicode.

Utilization Review Committee – A committee used by PacifiCare or a Contracted IPA to promote the efficient use of resources and maintain the quality of health care. If necessary, this committee will review and determine whether particular services are Covered Services.

Vocational Rehabilitation – The process of facilitating an individual in the choice of or return to a suitable vocation. When necessary, assisting the patient to obtain training for such a vocation. Vocational Rehabilitation can also mean preparing an individual regardless of age, status (whether U.S. citizen or immigrant), or physical condition (disability other than ESRD) to cope emotionally, psychologically and physically with changing circumstances in life, including remaining at school or returning to school, work or work equivalent (homemaker).

SECTION 11. PACIFICARE OF NEVADA, INC. GEOGRAPHIC SERVICE AREA

You are eligible for enrollment and continued coverage as long as you work or reside in the PacifiCare of Nevada, Inc. Geographic Service Area.

Please note that Contracted Medical Providers may not be available in every ZIP Code. Contact PacifiCare Customer Service to locate a Contracted Medical Provider closest to you.

Southern Nevada Plan

Clark County (including but not limited to):

88901	89019	89039	89104	89118	89131	89146	89162
88905	89021	89040	89106	89119	89132	89147	89163
89004	89024	89046	89107	89120	89133	89148	89164
89005	89025	89052	89108	89121	89134	89149	89170
89006	89026	89053	89109	89122	89135	89150	89173
89007	89027	89070	89110	89123	89137	89151	89177
89009	89028	89074	89111	89124	89138	89152	89180
89011	89029	89077	89112	89125	89139	89153	89185
89012	89030	89084	89113	89126	89141	89154	89191
89014	89031	89086	89114	89127	89142	89155	89193
89015	89032	89101	89115	89128	89143	89156	89195
89016	89033	89102	89116	89129	89144	89159	89199
89018	89036	89103	89117	89130	89145	89160	

Carson/Douglas Plan

Carson City County

89701	89703	89706	89711	89712	89713	89714	89721
89702							

Douglas County

89410	89411	89413	89423	89448	89449	89460	89705
89444	89706						

Esmeralda County

89010	89013	89047

Lyon County

89403	89408	89428	89429	89430	89444	89447	89706

Mineral County

89415	89420	89422	89427

Nye County

89003	89022	89023	89041	89045	89048	89049	89409
89020	89060	89061					

Storey County

89440	89403	897434	89511	89521

Note: This *Evidence of Coverage* constitutes only a summary of the PacifiCare Health Plan. The Group Agreement between PacifiCare and the Employer must be consulted to determine the exact terms and conditions of coverage. A copy of the Group Service Agreement will be furnished upon request and is available at PacifiCare and your Employer Group's Personnel office.

SECTION 12. MEMBER RIGHTS AND RESPONSIBILITIES

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

You have the right to:

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

Your responsibilities are to:

- Review information regarding your benefits, Covered Services, any exclusions, limitations, deductibles or Copayments, and the rules you need to follow as stated in your *Evidence of Coverage*.
- Provide PacifiCare and Contracted Providers, to the degree possible, the information needed to provide care to you.
- Follow treatment plans and care instructions as agreed upon with your Contracted Provider. Actively participate, to the degree possible, in understanding and improving your own medical and behavioral health condition and in developing mutually agreed upon treatment goals.
- Accept your financial responsibility for Health Plan Premiums, and any other charges owed, and any Copayment or coinsurance associated with services received while under the care of a Contracted Provider or while a patient in a facility.

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

700 East Warm Springs Road
Las Vegas, NV 89119-4323

Customer Service:
1-800-347-8600
1-800-360-1797 (TDHI)
www.pacificare.com

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