



WASHINGTON

2003 Combined Evidence of Coverage and Disclosure Form (MCO)

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Inside Front Cover



Welcome

Welcome to PacifiCare of Washington

Since 1995, we've been providing health care coverage in the state of Washington. 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 enrolled properly in our plan and meet our eligibility requirements. To learn more about these requirements, see "Section Seven: Member Eligibility."

What is this publication?

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

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

What else should I read to understand my benefits?

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

What if I still need help?

After you become familiar with your benefits, you may still need assistance. Please don't hesitate to call our Customer Service department at 1-800-932-3004 or 1-800-786-7387 (TTY) Monday through Friday, 7 a.m. to 9 p.m. Our Address is: PacifiCare of Washington, Customer Service Center, PO Box 6092, Cypress CA, 90630-0092. **Note:** Your *Combined Evidence of Coverage and Disclosure Form* provides the terms and conditions of your coverage with PacifiCare and all applicants have a right to view this document prior to enrollment. The *Combined Evidence of Coverage and Disclosure Form* should be read completely and carefully. Individuals with special health needs should pay special attention to those sections that apply to them.

The Washington State Office of the Insurance Commissioner (WA OIC) is responsible for regulating health care service plans. The WA OIC has a toll-free telephone number for receiving comments: 1-800-562-6900.

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SECTION ONE

Getting Started: Your Primary Care Practitioner

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

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

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

Introduction

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

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

What Is a Primary Care Practitioner?

When you become a Member of PacifiCare, one of the first things you do is choose a doctor to be your Primary Care Practitioner. 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 Practitioner is trained in internal medicine, general practice, family practice, pediatrics or obstetrics/gynecology.

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

Choosing a Primary Care Practitioner

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

- Your doctor is selected from the list of Primary Care Practitioners in PacifiCare's *Provider Directory*.
- We recommend that your doctor is located within a 30-mile radius of either your Primary Residence or Primary Workplace.

You'll find a list of our participating Primary Care Practitioners 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 Practitioner for your newborn.)

What Is a Participating Medical Group/Network?

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

To learn more about a particular Participating Medical Group/Network, 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.

Getting Started: Your Primary Care Practitioner

SECTION ONE



Your Provider Directory – Choice of Practitioners and Hospitals (Facilities)

Along with listing our participating Practitioners, your *Provider Directory* has detailed information about our Participating Medical Groups and other Practitioners. This includes a quality index for helping you become familiar with our Participating Medical Groups. There's also a quick way to identify any group that offers additional services to Members.

Every Subscriber should receive a *Provider Directory*. If you need a copy or would like assistance selecting your Primary Care Practitioner, please call our Customer Service department. You can also find an online version of the *Directory* at www.pacificare.com.

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

What Is Continuity of Care?

Under certain circumstances, new Members of PacifiCare may be able to temporarily continue receiving services from a Non-Participating 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 third trimester; being in an acute hospital or hospital services scheduled immediately after your PacifiCare coverage becomes effective; undergoing a course of chemotherapy, radiation therapy, or psychiatric counseling; 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 3 business days. If you qualify, you will be notified by telephone of the decision and provided with the plan for your care. If you don't qualify, you will be notified either by telephone or in writing within 3 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 Practitioner or other Non-Participating Provider, even for a Chronic Condition. You should not continue care with a Non-Participating Provider without our formal approval. *If you do not receive Preauthorization from PacifiCare or your Participating Medical Group, payment for services performed by a Non-Participating Provider will be your responsibility.*

Continuing Care With a Terminated Practitioner

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

Continued care from the terminated Practitioner may be provided for an acute or serious Chronic Condition for up to 90 days or a longer period until you can be safely transferred to another Practitioner. Continued care from a terminated Practitioner may be provided if you have a high-risk pregnancy or a pregnancy in the 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 Practitioner. 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 Practitioner beyond the termination date.

PacifiCare must Preauthorize or coordinate services for continued care. If you have any questions, 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 Eight: Overseeing Your Health Care.")



SECTION ONE

Getting Started: Your Primary Care Practitioner

Choosing a Primary Care Practitioner for Each Enrolled Family Members

Every PacifiCare Member must have a Primary Care Practitioner; however, the Subscriber and any enrolled Family Members do not need to choose the same doctor. Each PacifiCare Member can choose his or her own Primary Care Practitioner, so long as the doctor is selected from PacifiCare's list of Primary Care Practitioners and we recommend that the doctor is located within a 30-mile radius of either the Member's Primary Residence or Primary Workplace.

If a Family Member doesn't make a selection during enrollment, PacifiCare will choose the Member's Primary Care Practitioner.

If You Are Pregnant

Every Member of PacifiCare needs a Primary Care Practitioner, including your newborn. If you are pregnant, we encourage you to plan ahead and pick a Primary Care Practitioner for your baby. If the parents have other children, the newborn(s) will be assigned to the children's Primary Care Practitioner. If the parents do not have other children, the newborn(s) remain enrolled with the mother's Participating Medical Group from birth until discharge from the hospital. You may enroll your newborn with a different Primary Care Practitioner or Participating Medical Group following the newborn's discharge by calling PacifiCare's Customer Service department. You can learn more about changing Primary Care Practitioners in "Section Four: Changing Your Doctor or Medical Group." (For more about adding a newborn to your coverage, see "Section Seven: Member Eligibility.")

Does your Group or Hospital Restrict Any Reproductive Services?

Some hospitals and other Practitioners 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 Health Plan Customer Service department at 1-800-932-3004 or 1-800-786-7387 (TTY) to ensure that you can obtain the health care services that you need.

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

Confidentiality of Medical Records

PacifiCare will keep your medical records confidential. However, by accepting the benefits of this Health Plan, you authorize the release of information about you and access to your medical records for the following purposes:

- Medical Management;
- Utilization Review;
- Peer Review;
- Quality Assurance;
- Claims Processing;
- Regulatory and Financial Audits;
- Coordination of Benefits;
- any purpose reasonably related to the provision of benefits under the Group Agreement.

A STATEMENT DESCRIBING PACIFICARE'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.



Seeing the Doctor

- Your PacifiCare ID Card
- Scheduling Appointments
- Referrals to Specialists
- Seeing the OB/GYN
- Second Medical Opinions
- Prearranging Hospital Stays

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

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

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 Practitioner or upon referral, any other Participating Practitioner.

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.

Seeing the Doctor: Scheduling Appointments

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

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

Referrals to Specialists

Your Primary Care Practitioner 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) Practitioners and Complementary Alternative Health Care Provider. See, "Getting Care *Without* a Referral"; "OB/GYN and Complementary Alternative Care.") If your Primary Care Practitioner determines you need a referral, he or she will submit a request to your Participating Medical Group or PacifiCare. Then a Utilization Review Committee will review the request and if approved 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 Eight: Overseeing Your Health Care."

Request for non-Emergency Services are reviewed within two (2) business days of PacifiCare or the Participating Medical Group upon receipt of all the relevant information.



Standing Referrals to Specialists

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

Referrals are good for thirty (30) calendar days from the date the referral is issued, unless a different time frame is given, and you meet eligibility requirements at time of service. If you lose coverage under the Health Plan, you will receive a letter explaining to you that all existing referrals have expired on the last day you were an eligible Member.

Your Primary Care Practitioner 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 Practitioner with regular reports on your treatment and condition.

Extended Referral for Care by a Specialist

If you have a life-threatening, degenerative or disabling condition or disease that requires specialized medical care over a prolonged period, you may receive an "extended specialty referral." This is a referral to a participating specialist or specialty care center so the specialist can oversee your health care. The Practitioner 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 Practitioner or PacifiCare. Your Primary Care Practitioner must then determine if it is Medically Necessary. Your Primary Care Practitioner will do this in consultation with the specialist or specialty care center, as well as your Participating Medical Group's Medical Director or a PacifiCare Medical Director.

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

Getting Care *Without* a Referral

Woman's Health Provider:

Women may receive annual Obstetrical and Gynecological Women's Health Providers services directly from a Participating Women's Health Providers. This means you may receive these services without Preauthorization or a referral from your Primary Care Practitioner. **In all cases, however, the doctor must be affiliated with PacifiCare.**

Please remember: if you visit a Women's Health Provider not affiliated with PacifiCare without Preauthorization, you will be financially responsible for these services.

Any Women's Health Care inpatient or hospital services, except Emergency Services, need to be Preauthorized in advance by your Participating Medical Group or PacifiCare.

If you would like to receive Women's Health Provider 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 Women's Health Providers affiliated with PacifiCare;
- telephone and schedule an appointment with your selected Participating Women's Health Provider.

After your appointment, your Women's Health Provider will contact your Primary Care Practitioner 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 Five: Your Medical Benefits."



Seeing the Doctor

Complementary Alternative Care:

The plan provides complementary alternative care after an office visit Copayment. Members have direct access to Contracting Chiropractic, Acupuncture and Naturopathic Providers without obtaining a referral. **In all cases, however, the Complementary Alternative Care Provider must be affiliated with PacifiCare.**

Members must receive a referral to access the massage therapy benefit. All services after the initial evaluation, except Emergency Services, must be Preauthorized by American Specialty Health Networks (ASHN). For more information or to obtain a list of contracting Providers, please contact Customer Service at 1-800-932-3004.

Second Medical Opinions

A second medical opinion is a re-evaluation of your condition or health care treatment by an appropriately qualified Practitioner. This Practitioner must be either a Primary Care Practitioner or a specialist affiliated with your Primary Care Practitioner 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. Referrals to non-Contracting Medical Providers or Facilities will be approved only when the services requested are not available within Contracting Medical Practitioner's network or PacifiCare's network, if appropriate. Upon completing the examination, the Practitioner's opinion is included in a consultation report.

You have the right to a second medical opinion regarding any medical diagnosis or treatment plan by submitting a request for a second medical opinion to your Participating Medical Group; however, in some cases, the request is submitted to PacifiCare. To find out how you should submit your request, talk to your Primary Care Practitioner.

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

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

Please note: The fact that an appropriately qualified Practitioner 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 Practitioner who gives your second medical opinion.

**Prearranging Hospital Stays**

Your Primary Care Practitioner will prearrange any Medically Necessary hospital or facility care, including inpatient Transitional Care or care provided in a Subacute/Skilled Nursing Facility. If you've been referred to a specialist and the specialist determines you need hospitalization, your Primary Care Practitioner and specialist will work together to prearrange your hospital stay. Your hospital costs, including semi-private room, tests and office visits, will be covered, minus any required Copayments as well as any Deductibles. Under normal circumstances, your Primary Care Practitioner will coordinate your admission to a local PacifiCare Participating Hospital or facility; however, if your situation requires it, you could be transported to a regional medical center. If Medically Necessary, your Primary Care Practitioner may discharge you from the hospital to a Subacute/Skilled Nursing Facility. He or she can also arrange for skilled home health care.



Emergency Services

- What Is an Emergency Medical Condition?
- What to Do When You Require Emergency 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. This section will explain how to obtain Emergency Services. It will also explain what you should do following receipt of these services.

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 Practitioner, 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 Practitioner 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 Washington defines an Emergency Medical Condition as An Emergency is defined as “the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy.” Emergency Services are defined as otherwise covered health care services Medically Necessary to evaluate and treat an Emergency Medical Condition, provided in a Hospital emergency department.

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 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.** 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 Practitioner within 24 hours, or as soon as reasonably possible, following your receipt of Emergency Services so that your Primary Care Practitioner can coordinate your care and schedule any necessary follow-up treatment. The phone numbers are located on the PacifiCare Member ID Card. 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.

If your condition is not a medical emergency, you should call your PCP to determine whether they can see you in a reasonable period of time. Most PCP make accommodations in their daily schedule for Member’s Urgent Care needs.

Post-Stabilization and Follow-Up Care

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

Following your discharge from the Hospital, any Medically Necessary follow-up medical or Hospital Services must be provided or authorized by your Primary Care Practitioner 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,



SECTION THREE

Emergency Services

please call your Primary Care Practitioner or PacifiCare's Out-of-Area unit to request authorization. **PacifiCare's Customer Service Center can be reached during regular business hours (7 a.m. – 9 p.m., PST) at 1-800-932-3004, TTY Line 1-800-786-7387.**

Out-of-Area Services

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

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

1. routine follow-up care to Emergency Services, such as treatments, procedures, X-rays, lab work and doctor visits, Rehabilitation Services, Skilled Nursing Care, or home health care;
2. maintenance therapy and durable medical equipment including, but not limited to, routine dialysis (unless prior authorization), routine oxygen, routine laboratory testing or a wheelchair to assist you while traveling outside the geographic area served by your Participating Medical Group; and
3. medical care for a known or Chronic Condition without acute symptoms as defined under Emergency Services.

Ambulance services are limited to transportation to the nearest facility with the expertise for treating your condition.

Your Participating Medical Group provides 24-hour access to request authorization for out-of-area care. You can also request authorization by calling the PacifiCare Customer Service during regular business hours (7 a.m. – 9 p.m., PST) at 1-800-932-3004 or 1-800-786-7387 (TTY).

International Emergency Needed Services (Worldwide Emergency Care)

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

Note: Under certain circumstances, you may need to initially pay for your Emergency 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 Six: Payment Responsibility."

Dealing With Disasters

There are certain situations beyond the control of PacifiCare, which may make it difficult, if not impossible, for PacifiCare to arrange care in accordance with the terms of this Agreement. These could include a natural or man-made disaster, epidemic, complete or partial destruction of a facility, war, riot or civil insurrection. If such a situation occurs, PacifiCare, as well as its Contracting Medical Groups, Primary Care Practitioners, Practitioners and Hospitals will provide or attempt to arrange for Medical and Hospital Services, according to their best judgement. However, in these situations neither PacifiCare nor any contracting medical group or Primary Care Practitioner will have any liability for unavailability of delay or failure to provide or arrange for Medical and Hospital Services because of the circumstances described above.

Changing Your Doctor or Medical Group

SECTION FOUR



- How to Change Your Primary Care Practitioner
- How to Change Your Participating Medical Group
- When We Change Your Practitioner or Medical Group

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

Changing Your Primary Care Practitioner

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

In addition, PacifiCare recommends that you meet the following criteria:

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

PacifiCare reviews these requests on a case-by-case basis. You may change your PCP by calling PacifiCare's Customer Service department at any time. The change will be effective on the first day of the next month. If you are hospitalized or in the middle of a course of treatment, PacifiCare may recommend that you delay your transfer so that your care is not disrupted. Changing your PCP may also change the specialists and facilities from whom/where you receive care. All existing referrals given by your former PCP will no longer be valid. You will be expected to establish a relationship with your new PCP and work with him/her to establish new referrals if needed.

If you are hospitalized, confined in a Skilled Nursing Facility, being followed by a Case Management program, or receiving acute institutional or non-institutional care at the time of your request, a change in your Primary Care Practitioner or Participating Medical Group will not be effective until the first day following your

discharge from the institution or upon termination of treatment. When PacifiCare's Case Management is involved, the case manager is also consulted about the effective date of your Practitioner change request.

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

When We Change Your Participating Medical Group

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

PacifiCare will also notify the Member in the event that the agreement terminates between PacifiCare and the Member's Participating Medical Group. If this occurs, PacifiCare or the Member's Employer Group (the single employer, labor union, trust, organization, or association through which the Member enrolled for coverage in PacifiCare) will provide 30 days' notice of the termination. PacifiCare will also assign the Member a new Primary Care Practitioner. If the Member would like to select a different Primary Care Practitioner, 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 Practitioner.

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



SECTION FOUR

Changing Your Doctor or Medical Group

What Is PacifiCare's Case Management Program?

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



Your Medical Benefits

- Inpatient Benefits
- Outpatient Benefits
- Exclusions and Limitations

This section explains your medical benefits, including what is and isn't covered by PacifiCare. You can find some helpful definitions in the back of this publication. For any Copayments that may be associated with a benefit, you should refer to your *Schedule of Benefits*. Your *Schedule of Benefits* is explained in "Section Four: Payment Responsibility."

Your Medical Benefits

I. Inpatient Benefits

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

With the exception of Emergency, a Member will only be admitted to acute care, subacute care, transitional inpatient care and skilled nursing care facilities that are authorized by the Member's Participating Medical Group under contract with PacifiCare or authorized by PacifiCare. Emergency room services are subject to an Emergency room Copayment as shown on the *Schedule of Benefits*. This Copayment is waived if the Member is admitted to the Hospital directly from the Emergency room.

1. **Chemical Dependency** – The Plan will provide for Medically Necessary treatment of Chemical Dependency by an approved alcoholism or drug treatment program. The term Medically Necessary with respect to chemical dependency treatment is defined as indicated in the *Patient Placement Criteria for the Treatment of Substance Abuse Related Disorders II* as published in 1996 by the American Society of Addiction Medicine. The term "approved alcoholism or drug treatment program" is defined as any Hospital or public or private treatment program, that provides services for the treatment of Chemical Dependency and operates under the direction and control of the state. PacifiCare Behavioral Health must approve the program.

Chemical Dependency services are provided up to the benefit maximum shown on the *Schedule of Benefits* exclusive of any cost sharing amounts. Covered Services include: Inpatient services, residential and day treatment services, individual and group therapy and family therapy for the affected Member and covered Family Members and medical detoxification associated with acute alcohol, drug or other substance abuse, when currently enrolled in other chemical dependency programs.

Except in an Emergency, treatment must be Preauthorized by PacifiCare Behavioral Health and provided by a PacifiCare Behavioral Health Plan Provider to be covered. No referral is required to access chemical dependency benefits just call 1-800-577-7244. Members can call PacifiCare Behavioral Health 24 hours a day, seven days a week.

In addition to the "Limitations and Exclusions" in *Combined Evidence of Coverage and Disclosure Form*, the Chemical Dependency Benefit does **not** cover:

- volunteer support groups;
 - treatment for addiction to, or dependency on tobacco, nicotine or caffeine;
 - medical detoxification for conditions associated with acute alcohol, drug or other substance; (This benefit is provided under Inpatient Benefits. See "Detoxification.")
 - confinement, treatment, services, or supplies not Preauthorized by PacifiCare Behavioral Health, or supplied by a non-PBHI provider, even if referred by the Primary Care Practitioner, except Emergency Care.
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

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



SECTION FIVE

Your Medical Benefits

who object to such transfusion on religious grounds are covered only when available within the Member's Participating Hospital.

4. **Bone Marrow and Stem Cell Transplants** – Non-Experimental/Non-Investigational autologous and allogenic bone marrow and stem cell transplants are covered. The testing of immediate blood relatives to determine the compatibility of bone marrow and stem cells is limited to immediate blood relatives who are sisters, brothers, parents and natural children. The testing for compatible unrelated donors and costs for computerized national and international searches for unrelated allogenic bone marrow or stem cell donors conducted through a registry are covered when the Member is the intended recipient. A PacifiCare Preferred Transplant Network Facility center approved by PacifiCare must conduct the computerized searches.
5. **Circumcision** – Are covered if the procedure is completed in the first four (4) weeks of life.
6. **Detoxification** – Emergent Medically Necessary detoxification for medical conditions associated with acute alcohol, drug or other substance abuse.
7. **Hospice Services** – Hospice Services are covered for Members with a terminal illness, defined as a medical condition resulting in a prognosis of life of six (6) months 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 Practitioner, 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 aid services and homemaker services under the supervision of a qualified registered nurse; bereavement services; social services/counseling services; medical direction; volunteer services; pharmaceuticals, medical

equipment and supplies that are reasonable and necessary for the palliation and management of the terminal illness and related conditions; physical and occupational therapy and speech-language pathology services for purposes of symptom control, or to enable the Member to maintain activities of daily living and basic functional skills.

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

8. **Inpatient Hospital Benefits/Acute Care** – Medically Necessary inpatient Hospital Services authorized by the Member's Participating Medical Group or PacifiCare are covered, including, but not limited to: semi-private room, nursing and other licensed health professionals, intensive care, operating room, recovery room, laboratory and professional charges by the hospital pathologist or radiologist and other miscellaneous hospital charges for Medically Necessary care and treatment.
9. **Inpatient Practitioner and Specialist Care** – Services from Practitioners, including specialists and other licensed health professionals within, or upon referral and Preauthorization from the Member's Participating Medical Group, are covered while the Member is hospitalized as an inpatient. A specialist is a licensed health care professional with advanced training in an area of medicine or surgery.
10. **Inpatient Rehabilitation Care** – Rehabilitation services that must be provided in an inpatient rehabilitation facility are covered. Inpatient rehabilitation consists of the combined and coordinated use of medical, social, educational and vocational measures for training or retraining individuals disabled by disease or injury. The goal of these services is for the disabled Member to obtain his or her highest level of functional ability. Services are covered only if the rehabilitation can not be provided in a less intensive setting. These

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



Your Medical Benefits

services must be Medically Necessary to restore or improve normal bodily functions lost or impaired due to illness or injury.

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

11. Mastectomy, Breast Reconstruction After Mastectomy and Complications From Mastectomy

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

12. Maternity Care

– The Plan covers prenatal care, childbirth, postpartum care and services related to pregnancy for the Subscriber or enrolled spouse. The Plan does not cover maternity care for Dependents. The Covered Services include screening and diagnostic procedures performed during the pregnancy and related genetic counseling for prenatal diagnosis of congenital disorders of the unborn child. Maternity care must be provided by a Plan Provider or authorized Women's Health Provider.

Hospitalization for maternity services must be Preauthorized by the PCP and length of stay will be determined by the Member and the attending Practitioner. For a routine delivery, hospitalization cannot be limited to less than 48 hours and for a Cesarean delivery, hospitalization cannot be limited to less than 96 hours, unless a shorter length of stay is decided by the Member and the attending

Practitioner based on Medical Necessity and individual patient circumstances. Birthing centers are covered when licensed by the state and Preauthorized by the PCP. The Plan does not cover deliveries in settings other than a Hospital or licensed birthing center, such as the home.

13. Organ Procurement, Transplant and Transplant Services

– Non-Experimental and Non-Investigational organ transplants and transplant services are covered when the recipient is a Member and the transplant is performed at a Preferred Transplant Network facility. Members may be accepted by two Preferred Transplant Network facilities for organ transplant listings if the Regional Organ Procurement Agency for each facility is different. If the Member is dual listed, his or her coverage is limited to the **actual transplant facility**. The Member will be responsible for any duplicated diagnostic costs incurred at the second facility. Covered Services for living donors are limited to Medically Necessary clinical services once a donor is identified. Transportation and other nonclinical expenses of the living donor are excluded and are the responsibility of the Member who is the recipient of the transplant. (See the definition for "Preferred Transplant Network".)

14. Reconstructive Surgery

– Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. The purpose of reconstructive surgery is to correct abnormal structures of the body and/or improve physical function to the extent possible. Reconstructive procedures require Preauthorization by the Member's Participating Medical Group or PacifiCare in accordance with standards of care as practiced by Practitioners specializing in reconstructive surgery.

15. Skilled Nursing/Subacute and Transitional Care

– Skilled Nursing Facility services will be provided when authorized by the Member's PCP, in place of a Hospital stay, when Medically Necessary. Prescription drugs are covered when furnished by the Skilled Nursing Facility and used by the Member during a

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



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period of covered Skilled Nursing Facility care. This benefit does **not** cover custodial care and services or supplies not included in the written plan treatment.

16. **Voluntary Termination of Pregnancy** – Refer to the Family Planning section of the *Schedule of Benefits* for the terms of any coverage, if any.

II. Alternative to Inpatient Settings

Alternative care arrangements may be covered when a written treatment plan is developed that allows Medically Necessary, skilled care to take place in an equally or more cost-effective setting than a Hospital or Skilled Nursing Facility. The alternative care must be recommended by the Member's PCP as Medically Necessary and appropriate based upon the Member's medical condition, must be an equally or less expensive alternative to the inpatient Hospital or Skilled Nursing Facility care and shall be made only with the consent of the Member. All other Hospital or Skilled Nursing Facility Benefit terms, maximums and limitations apply to the alternative care.

III. Outpatient Benefits

The following benefits are available on an outpatient basis and must be provided by your Primary Care Practitioner or authorized by your Participating Medical Group or PacifiCare unless the Plan specifically states that no referral is required. All services must be Medically Necessary as defined in this *Combined Evidence of Coverage and Disclosure Form*. The Plan will only cover care by a Practitioner other than a plan specialist who is affiliated with the Member's Primary Hospital if the care is for an Emergency or has been Preauthorized by the Member's PCP.

1. **Chemical Dependency** – The Plan will provide for Medically Necessary treatment of Chemical Dependency by an approved alcoholism or drug treatment facility. The term Medically Necessary with respect to chemical dependency treatment is defined as indicated in the *Patient Placement Criteria for the Treatment of Substance Abuse Related Disorders II* as published in 1996 by the American Society of Addiction Medicine. The term "approved alcoholism or drug treatment facility" is

defined as any Hospital or public or private treatment facility, that provides services for the treatment of chemical dependency and operates under the direction and control of the state. PacifiCare Behavioral Health must approve the facility.

Chemical dependency services are provided up to the benefit maximum shown on the *Schedule of Benefits* exclusive of any cost sharing amounts. Covered Outpatient services include outpatient care, individual and group therapy, and family therapy for the affected Member and covered Family Members.

Except in an Emergency, treatment must be Preauthorized by PacifiCare Behavioral Health and provided by a PacifiCare Behavioral Health Plan Provider to be covered. No referral is required to access chemical dependency benefits, just call 1-800-577-7244. Members can call PacifiCare Behavioral Health 24 hours a day, seven days a week.

In addition to the "Limitations and Exclusions" in *Evidence of Coverage*, the chemical dependency Benefit does **not** cover:

- volunteer support groups;
- treatment for addiction to, or dependency on, tobacco, nicotine or caffeine; and
- confinement, treatment, services, or supplies not Preauthorized by PacifiCare Behavioral Health, or supplied by a non-PBHI provider, even if referred by the Primary Care Practitioner, except Emergency Care.

2. Acupuncture

- An initial examination is performed by the contracting acupuncturist to determine the nature of the Member's problem and, if Covered Services appear warranted, a treatment plan of services is to be furnished is prepared. One initial examination will be provided for each new patient. A Copayment is required.
- A re-examination may be performed by the contracting acupuncturist to assess the need to continue, extend or change a treatment plan approved by American Specialty Networks (ASHN).

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



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All services after the initial evaluation, except Emergency Services, must be Preauthorized by American Specialty Health Networks (ASHN). For more information or to obtain a list of contracting Practitioners, please contact Customer Service at 1-800-932-3004. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a Copayment is required.

- Subsequent office visits, as set forth in a treatment plan approved by ASHN, may involve acupuncture treatment, a brief reexamination and other services, in various combinations.
 - Adjunctive therapy, as set forth in a treatment plan approved by ASHN, may involve therapies such as acupressure, moxibustion, cupping and other therapies.
 - X-rays and clinical laboratory tests are payable in full when referred by a contracting acupuncturist and authorized by ASHN. Radiological consultations are a covered benefit when authorized by ASHN as Medically Necessary services and provided by a medical radiologist, radiology group or hospital which has contracted with ASHN to provide those services.
3. **Allergy Testing** – Services and supplies are covered for the determination of the appropriate course of allergy treatment.
 4. **Allergy Treatment** – Services for the treatment of allergies, including allergens and serum, are covered according to an established treatment plan.
 5. **Ambulance** – The use of an ambulance (land or air) is covered without Preauthorization, if a Prudent Layperson reasonably believes that the medical or psychiatric condition requires Emergency Services and an ambulance transport is necessary to receive these services. Such coverage includes, but is not limited to, ambulance or ambulance transport services provided through the 911 emergency response system. Ambulance transportation is limited to the nearest available emergency facility having the expertise to stabilize the Member's Emergency Medical Condition. Use of an ambulance

for a non-Emergency Services is covered only when specifically authorized by the Member's Participating Medical Group or PacifiCare.

6. **Attention Deficit/Hyperactivity Disorder** – The medical management of Attention Deficit/Hyperactivity Disorder (ADHD) is covered, including the diagnostic evaluation and laboratory monitoring of prescribed drugs. This benefit does not include non-crisis mental health counseling, or behavior modification programs. Rehabilitation services are covered under the "Outpatient Medical Rehabilitation Therapy" section.
7. **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.
8. **Bloodless Surgery** – Please refer to the benefit described above under Inpatient Benefits for Bloodless Surgery. Outpatient services Copayments and/or Deductibles apply for any services received on an outpatient basis.
9. **Bone Marrow and Stem Cell Transplants** – Autologous or allogenic bone marrow or stem cell transplants are not covered when they are Experimental or Investigational unless required by an external, independent review panel as described in Section Eight of this *Combined Evidence of Coverage and Disclosure Form*, under the caption "Independent Medical Review Procedures." Unrelated donor searches must be performed at a PacifiCare-approved transplant center. (See "Preferred Transplant Network" in "Definitions.")
10. **Chiropractic**
 - An initial examination is performed by the Contracting Chiropractor to determine the nature of the Member's problem and, if Covered Services appear warranted, a treatment plan of services to be furnished is prepared. One initial examination is provided for each new patient. A Copayment is required.

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



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- A re-examination may be performed by the Contracting Chiropractor to assess the need to continue, extend or change a treatment plan approved by ASHN. A re-evaluation may be performed during a subsequent office visit or separately. If performed separately, a Copayment is required.
 - Subsequent office visits, as set forth in a treatment plan approved by ASHN, may involve an adjustment, a brief re-examination and other services, in various combinations. A Copayment is required for each visit to the office.
 - Adjunctive therapy, as set forth in a treatment plan approved by ASHN, may involve therapies such as ultrasound, hot packs, cold packs, electrical muscle stimulation and other therapies.
 - X-rays and clinical laboratory tests are payable in full when referred by a contracting chiropractor and authorized by ASHN. Radiological consultations are a covered benefit when authorized by ASHN as Medically Necessary services and provided by a licensed chiropractic radiologist, medical radiologist, radiology group or hospital which has contracted with ASHN to provide those services.
 - Chiropractic appliances are payable up to a maximum of \$50 per year when prescribed by a Contracting Chiropractor and authorized by ASHN, which include; elbow supports, back (thoracic) supports, cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction (cervical or lumbar) units, ankle brace, knee brace, wrist brace, rib supports or other related services.
11. **Cochlear Implant Device** – An implantable cochlear device for bilateral, profoundly hearing-impaired individuals who are not benefited from conventional amplification (hearing aids) is covered. Coverage is for Members at least 18 months of age who have 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.”
12. **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 Participating Practitioner. (For an explanation of speech therapy benefits, please refer to “Outpatient Rehabilitation.”)
13. **Complementary Alternative Care** – The plan provides complementary alternative care after an office visit Copayment. Members have direct access to contracting chiropractic, acupuncture and naturopathic Practitioners without obtaining a referral. Members must receive a referral and authorization to access the massage therapy benefit. All services after the initial evaluation, except Emergency Services, must be Preauthorized by American Specialty Health Networks (ASHN). (Also see “Other Exclusions and Limitations.”) For more information or to obtain a list of contracting Practitioners please contact Customer Service at 1-800-932-3004.
14. **Dental Treatment Anesthesia** – See “Oral Surgery and Dental Services; Dental Treatment Anesthesia.”
15. **Diabetic Management and Treatment** – Coverage includes outpatient self-management training and education when Medically Necessary. The diabetes outpatient self-management training and education services covered under this benefit will be provided by appropriately licensed or registered health care professionals. These services must be provided under the direction of and prescribed by a Participating Practitioner.
16. **Diabetic Self-Management Items** – Equipment and supplies for the management and treatment of Type 1, Type 2 and gestational diabetes are covered, based upon the medical needs of the Member, including, but not necessarily limited to: blood glucose monitors; blood glucose monitors designed to assist the visually impaired; pen delivery systems (for the administration of insulin); insulin pumps and all related necessary supplies; podiatry services

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



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and devices to prevent or treat diabetes-related complications. Members must have coverage under the Outpatient Prescription Drug Benefit for insulin, glucagon, strips; lancets and lancet puncture devices; ketone urine testing strips; insulin syringes and other diabetic medications to be covered.

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

17. **Dialysis** – Acute and chronic hemodialysis services and supplies are covered. For chronic hemodialysis, application for Medicare Part A and Part B coverage must be made. Chronic dialysis (peritoneal or hemodialysis) must be authorized by your Participating Medical Group or PacifiCare and provided within your Participating Medical Group. Dialysis services are subject to prior approval by PacifiCare for temporary absences from the Service Area.

18. **Durable Medical Equipment (Rental, Purchase or Repair)** – Durable medical equipment is defined as equipment that can withstand repeated use; is primarily used to serve a medical purpose; is generally not useful to a person in the absence of illness or injury; is appropriate for use in the home; and is prescribed by a Practitioner.

The Plan will cover the rental of durable medical equipment from a Plan Practitioner Preauthorized by PacifiCare. If the total rental cost is expected to be greater than the purchase price, PacifiCare will Preauthorize only the purchase price. If PacifiCare Preauthorizes the rental of durable medical equipment, benefits will be provided by PacifiCare even if the rental cost exceeds the purchase price. The Member must agree to return purchased equipment to Provider within thirty (30) days after the Member stops using it.

Examples of covered durable medical equipment include: non-motorized wheelchairs, crutches and oxygen equipment. The purchase of a blood glucose monitor, insulin pumps, and diabetic shoes and inserts are also covered when ordered by a Provider to treat diabetes.

This benefit is limited to coverage for standard items such as non-motorized wheelchairs. There is no coverage for deluxe items such as motorized wheelchairs unless Medically Necessary and Preauthorized by the Practitioner.

Equipment which is primarily intended to assist in the activities of daily living or as a convenience to the Member is not covered. Examples of non-covered equipment include, but are not limited to, shower seats, heating pads, vaporizers.

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

19. **Elemental Enteral Formula** – Nonprescription elemental enteral formula is only covered for the treatment of severe intestinal malabsorption. In addition, certain inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which medically standard methods of diagnosis, treatment and monitoring exist are covered. Coverage will include expenses of diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including, but not limited to:

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



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- clinical visits;
- biochemical analysis; and

Elemental enteral formula administered enterally under the supervision of a Practitioner if these formulations comprise the sole source, or an essential source, of nutrition.

20. Family Planning – The following family planning services are covered:

- vasectomy;
- tubal ligation;
- cervical caps;
- IUD;
- injectable birth control;
- implants.

This benefit does **not** cover:

- services to reverse voluntary sterilization, and all related services;
- oral birth control drugs and diaphragms (without Outpatient Prescription Drug Supplement);
- infertility services and all related services unless otherwise stated on the *Schedule of Benefits* or if employer purchased supplemental Rider.

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

22. Health Education Services – PacificCare continually analyzes the type of care provided to our Members, the outcomes of that care, and our compliance with state and federal laws regarding care. Each year, PacificCare targets both preventive and clinical areas for improvement.

In addition to preventive initiatives, PacificCare has identified areas of your health that can be improved through lifestyle choices, behavior changes and better understanding of your own health care needs. To support you in improving your health, PacificCare offers several Health Management programs. For more information about available Health Management programs, please refer to your *PacificCare Health Care Companion* handbook or contact our Customer Service department at 1-800-932-3004.

23. Home Health Care – Part-Time or Intermittent Services, consisting of Skilled Nursing Care and Skilled Rehabilitation Care, are covered in the home. Home Health Care Services must be provided by a licensed nurse or licensed speech, occupational or physical therapist. If the Member's Participating Medical Group or PacificCare determines that Skilled Nursing Care needs are more extensive than Part-Time or Intermittent Services, the Member will be transferred to a Skilled Nursing Facility to obtain coverage for this benefit. PacificCare, in consultation with the Member's Participating Medical Group or PacificCare, will determine the appropriate setting for delivery of the Member's Skilled Nursing Care services.

24. Hospice Services – Hospice Services are covered for Members with a terminal illness, defined as a medical condition resulting in a prognosis of life of six (6) months or less, if the disease follows its natural course. Hospice Services are provided pursuant to the plan of care developed by the Member's interdisciplinary team, which includes, but is not limited to, the Member, the Member's Primary Care Practitioner, a registered nurse, a social worker and a spiritual caregiver.

Hospice Services include skilled nursing services, certified home health aid services and homemaker services under the supervision of a qualified registered nurse; bereavement services; social services/counseling services; medical direction; volunteer services; pharmaceuticals, medical

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



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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. Respite care is limited to an occasional basis and to no more than five (5) consecutive days at a time.

25. **Immunizations** – Immunizations for children (through age 18 years) are covered consistent with the most current version of the Recommended Childhood Immunization Schedule/United States¹. An exception is made if, within 45 days of the published date of the schedule, the State Department of Health Services determines that the schedule is not consistent with state law. Immunizations for adults are covered consistent with the most current recommendations of the Center for Disease Control (CDC) for routine adult immunizations as advised by the Advisory Committee on Immunization Practices. For children under 2 years of age, refer to “Periodic Health Evaluations – Well-Baby.”

Routine boosters and immunizations must be obtained through Member’s Participating Medical Group.

26. **Infertility Services** – Please refer to the *Schedule of Benefits* for coverage, if any.
27. **Infusion Therapy** – Infusion therapy means the therapeutic use of drugs or other substances, administered intravenously, prepared or compounded, and administered by a Participating Practitioner and given to a Member through a needle or catheter. Services must be provided in the Member’s home or an institution that is not a hospital or is not primarily engaged in providing skilled nursing or rehabilitation services. (For example, board and care, custodial care facility and assisted living facility.) Infusion therapy is covered as part of a treatment plan authorized by the Member’s Participating Medical Group or authorized by PacifiCare.

28. **Injectable Drugs (Outpatient Injectable Medications and Self Injectable Medications)** – Outpatient injectable medications administered in the Practitioner’s office are covered when a part of the medical office visit. Self injectable medications (except insulin, glucagon, EpiPens® and AnaKits®*) are covered when the Member is trained in the use of the medication, and the medication has been prescribed by a Participating Practitioner, as authorized by the Member’s Participating Medical Group or PacifiCare.

Outpatient injectable medications, including self-injectables, must be obtained through a Participating Practitioner or through the Member’s Participating Medical Group and may require Preauthorization.

*Insulin, glucagon, EpiPens® and AnaKits® are covered as a pharmacy benefit if you are covered by an Outpatient Prescription Drug Supplemental Benefit and subject to the applicable Copayment. Pen devices for the delivery of medication, other than for insulin, are not covered.

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

30. **Massage Therapy**

- Members need to receive a written referral and Preauthorization for massage therapy services from the Member’s Primary Care Practitioner.
- The Member will submit the referral and Preauthorization to the massage therapist at the first visit. The massage therapist will notify ASHN of the referral and Preauthorization as part of the treatment plan.
- The contracting massage therapist to determine the nature of the Member’s problem performs an initial assessment and, if Covered Services appear warranted, to prepare a treatment plan of services to be furnished. One initial assessment is provided for each new patient. A Copayment is required.

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

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



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- The contracting massage therapist to assess the need to continue, extend or change a treatment plan approved by ASHN may perform a reassessment. A reassessment may be performed during a subsequent office visit or separately. If performed separately, a Copayment is required.
 - Subsequent sessions, as set forth in a treatment plan approved by ASHN, may involve a massage therapy session and/or a brief re-assessment. A Copayment is required for each visit to the office. The subsequent session includes all services related to the massage therapy, a brief reassessment if necessary and any consultative services.
31. **Maternity Care, Tests and Procedures** – Practitioner visits, laboratory services and radiology services are covered for prenatal and postpartum maternity care for Subscribers and Spouses only. Midwife services are covered when available by any licensed midwife.
- Genetic Testing and Counseling is covered when authorized by the Member's Participating Medical Group as part of an amniocentesis or chorionic villus sampling procedure.
32. **Medical Supplies and Materials** – Medical supplies and materials necessary to treat an illness or injury are covered when used or furnished while the Member is treated in the Participating Practitioner's office, during the course of an illness or injury, or stabilization of an injury or illness, under the direct supervision of the Participating Practitioner. Examples of items commonly furnished in the Participating Practitioner's office to treat the Member's illness or injury are gauzes, ointments, bandages, slings and casts. For other items please refer to "Durable Medical Equipment (Rental, Purchase or Repair)" section.
33. **Mental Health Services** – Mental Health care is not covered, unless this Plan contains a supplemental benefit called "Mental Health Care Benefit." If the Plan contains a supplemental benefit called "Mental Health Care", confinement treatment, services, or supplies not Preauthorized by PacifiCare Behavioral Health, or supplied by a non-PBHI practitioner,

even if referred by the Primary Care Practitioner, except Emergency care, are not covered. Refer to the *Schedule of Benefits* and supplement for coverage of Mental Health Services.

Mental Health Services and your Rights

PacifiCare of Washington and state law have established standards to assure the competence and professional conduct of mental health service Practitioners, to guarantee your right to informed consent to treatment, to assure the privacy of your medical information, to enable you to know the limitations on your coverage. If you would like a more detailed description of benefits for mental health services covered under this plan, or if you have a question or concern about any aspect of your mental health benefits, please contact PacifiCare Behavioral Health at 1-800-577-7244.

If you would like to know more about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract on your rights under the law, you may contact the Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the qualifications or professional conduct of your mental health service Practitioner, please call the State Health Department at 360-236-4902.

34. **Naturopathy**

- An initial examination is performed by the contracting naturopath to determine the nature of the Member's problem and, if Covered Services appear warranted, a treatment plan of services is to be furnished is prepared. One initial examination is provided for each new patient. A Copayment is required.
- The contracting naturopath to assess the need to continue, extend or change a treatment plan approved by ASHN may perform a reexamination. A reevaluation may be performed during a subsequent office visit or separately. If performed separately, a Copayment is required.

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



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- An office visit represents an all-inclusive per diem rate for all services associated with the office visit, a brief reevaluation, any consultative services and adjunctive services.
- Adjunctive therapy is limited to non-invasive modalities such as diathermy, electrical stimulation, hot and cold packs, hydrotherapy, manipulation, massage, range of motion exercises and therapeutic ultrasound. If provided independent of an examination, a Copayment is required.
- Diagnostic tests are limited to those required for further evaluation of the Member's condition. Medically Necessary X-rays and laboratory studies must be performed either by an appropriately certified naturopath or staff member, referred to a facility that has been credentialed to meet ASHN criteria, or referred to the Member's PCP.
- Covered Services refer to Medically Necessary services for illness or injury arranged under a naturopathy Plan. Excluded from Covered Services are obstetrics, surgery, invasive procedures, counseling for psychiatric conditions and services listed as "Exclusions."
- Durable medical equipment and supplies provided to the patient by the Naturopath includes equipment and supplies such as orthopedic supports, bandages, etc.

35. Neurodevelopmental Therapy –

Neurodevelopmental therapies are services rendered to children age six (6) and under, who have developmental delay due to diagnosable medical cause such as autism, prematurity or cerebral palsy. Benefits provided will cover the services of those authorized to deliver occupational therapy, speech therapy and physical therapy. Benefits will be payable to restore and improve function and for maintenance of a condition where significant deterioration in the child's condition would result without the service. Inpatient or residential neurodevelopmental programs in the absence of a medical condition requiring acute medical care are never covered.

36. **OB/GYN Practitioner Care** – See "Woman's Care Section."

37. **Obesity Treatment** – Some services (e.g. bariatric surgery and Practitioner prescribed supplemented fasting) in connection with the Medically Necessary treatment of obesity are covered. These services must be an integral and necessary part of the treatment for a specific illness related to the obesity. Bariatric surgery is only covered after other treatments have been tried unsuccessfully and certain serious complications associated with obesity exist. Bariatric surgery is only covered once per lifetime if these criteria are met.

38. **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 initial emergency treatment provided for stabilization services only. Benefits for dental accidents may be provided by a dentist or licensed denturist when services provided are within the scope of the denturists licenses. Other covered Oral Surgery and Dental Services include:

- biopsy and excision of cysts or tumors of the jaw, treatment of malignant neoplastic disease; and
- tooth extraction prior to a major organ transplant or radiation therapy to the head or neck;

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.

39. **Oral Surgery and Dental Services: Dental Treatment Anesthesia** – Anesthesia and associated facility charges for dental procedures provided in a hospital or outpatient surgery center are covered when: (1) the Member's clinical status or underlying medical condition requires use of an outpatient surgery center or inpatient setting for the provision of the anesthesia for a dental procedure(s) that ordinarily would not require anesthesia in a

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



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hospital or outpatient surgery center setting; and
(2) one of the three following criteria is met:

- the Member is under seven (7) years of age;
- the Member is developmentally disabled, regardless of age; or
- the Member's health is compromised and general anesthesia is Medically Necessary, regardless of age.

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

Dental Anesthesia in a dental office or dental clinic is not covered. Professional fees of the dentist are not covered except for services covered by PacifiCare under the outpatient benefit captioned "Oral Surgery and Dental Services."

40. **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. Donor searches are only covered when performed by a Provider included in the Preferred Transplant Network facility.

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

- Transportation is limited to the transportation of the Member and one escort to a Preferred Transplant Network facility greater than 60 miles from the Member's Primary Residence **or out of state regardless of mileage** from Primary Residence as Preauthorized by PacifiCare.
- Food and housing is not covered unless the Preferred Transplant Network Center is located more than 60 miles from the Member's Primary Residence **or out of state regardless of mileage for the Member's Primary Residence**, in which case food and housing is limited to \$125 dollars a day to cover both the Member and escort, if any (excludes liquor and tobacco). Food and

housing expenses are not covered for any day a Member is not receiving Medically Necessary transplant services.

- Listing of the Member at a second Preferred Transplant Network center is excluded, unless the Regional Organ Procurement Agencies are different for the two facilities and the Member is accepted for listing by both facilities. In these cases, organ transplant listing is limited to two Preferred Transplant Network facilities. If the Member is dual listed, his or her coverage is limited to the **actual transplant facility**. The Member is responsible for any duplicated diagnostic costs incurred at the second facility. (See the definition for "Regional Organ Procurement Agency.")

42. **Outpatient Medical Rehabilitation Therapy** – The Plan covers inpatient and outpatient rehabilitation services provided by a speech, occupational or physical therapist who is licensed, registered or certified by the state to provide such services. Inpatient rehabilitative care is covered in a Hospital or Medicare-certified inpatient rehabilitative facility. Services are covered only if the rehabilitation can not be provided in a less intensive setting. These services must be authorized by the Member's PCP, and be Medically Necessary to restore or improve normal bodily functions lost or impaired due to illness or injury.

Speech therapy is limited to speech impairments caused by a defined trauma, disease or surgical procedure (i.e., stroke, injury to mouth or throat, or surgery to mouth or throat).

Services that are primarily oriented toward treating a social, developmental or learning problem rather than a medical problem (i.e., autism, asperger, sensory integration disorder, attention deficit hyperactivity disorder or dyslexia) are not covered.

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



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43. **Outpatient Surgery** – Short stay, same day or other similar outpatient surgery facilities are covered when provided as a substitute for inpatient care and performed in an outpatient hospital setting or ambulatory surgery center.
44. **Periodic Health Evaluation** – Periodic health evaluations are covered as recommended by PacifiCare's preventive health guidelines. This includes:
 - **Breast Cancer Screening and Diagnosis** – Services are covered for the screening and diagnosis of breast cancer. Screening and diagnosis will be covered consistent with generally accepted medical practice and scientific evidence, upon referral by the Member's Primary Care Practitioner. Mammography for screening or diagnostic purposes is covered.
 - **Hearing Screening** – Routine hearing screening by a participating health professional is covered to determine the need for hearing correction. Hearing aids are not covered (unless supplemental Rider was purchased), 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 Participating Practitioner are covered to determine the health of the Member's eyes and the possible need for vision correction. An annual retinal examination is covered for Members with diabetes.
 - **Well-Baby Care** – Up to the age of 2, preventive health services are covered (including immunizations) when provided by the child's Participating Medical Group.
 - **Well-Child Care** – From birth to age 1 – six visits; age 1 through age 5 – 6 visits; and age 6 and above – one visit per year.
45. **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. Covered Services include FDA-approved special low-protein formulas specifically approved for PKU and food products that are specially formulated to have less than one gram of protein per serving. Food products naturally low in protein are not covered.
46. **Practitioner Care (Primary Care Practitioner and Specialist)** – Diagnostic and treatment services provided by the Member's Primary Care Practitioner are covered. Services of a specialist are covered upon referral and Preauthorization by Member's Participating Medical Group or PacifiCare. A specialist is a licensed health care professional with advanced training in an area of medicine or surgery.
47. **Practitioner OB/GYN Care** – See the "Women's Health Care" section.
48. **Prosthetics and Corrective Appliances** – Prosthetics (except for bionic or myoelectric as explained below) are covered when Medically Necessary as determined by the Member's Participating Medical Group or PacifiCare. Prosthetics are durable, custom-made devices designed to replace all or part of a permanently inoperative or malfunctioning body part or organ. Examples of covered prosthetics include initial contact lens in an eye following a surgical cataract extraction and removable, non-dental prosthetic devices such as a limb that does not require surgical connection to nerves, muscles or other tissue.

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

 - Bionic and myoelectric prosthetics are not covered. Bionic prosthetics are prosthetics that require surgical connection to nerves, muscles or other tissues. Myoelectric prosthetics are prosthetics, which have electric motors to enhance motion.



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- Replacements, repairs and adjustments to corrective appliances and prosthetics coverage are limited to normal wear and tear or because of a significant change in the Member's physical condition. Repair or replacement must be authorized by the Member's Participating Medical Group or PacifiCare.
 - Refer to "Footwear" in "Benefits Available on an Outpatient Basis."
49. **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. Gamma knife procedures and stereotactic procedures are covered as outpatient surgeries for purpose of determining Copayments.
50. **Radiology Services:**
- Standard X-ray films (with or without oral, rectal, injected or infused contrast medium) for the diagnosis of an illness or injury are covered. Standard X-ray services are X-ray(s) of an extremity, abdomen, head, chest, back, mammograms, nuclear studies, barium studies and bone density studies. Also see "Maternity and Periodic Health Evaluations."
 - Specialized scanning and imaging procedures, such as CT, SPECT, PET, MRAs and MRI (with or without contrast media), are covered.
51. **Reconstructive Surgery** – Reconstructive surgery is covered to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. The purpose of reconstructive surgery is to correct abnormal bodily function and/or improve physical function to the extent possible. Reconstructive procedures require Preauthorization by the Member's Participating Medical Group or PacifiCare in accordance with standards of care as practiced by Practitioners specializing in reconstructive surgery.
52. **Refractions** – Routine testing covered to determine the need for corrective lenses (refractive error), including a written prescription for eyeglass lenses. See the *Schedule of Benefits* for coverage amounts, if any. (Coverage for frames and lenses may be available if your health plan includes a Vision Supplemental Benefit.)
53. **Temporomandibular Joint Disorders (TMJ)** – The temporomandibular joint is the joint that connects the mandible, or jawbone, to the temporal bone of the skull. Temporomandibular Joint Disorders include those disorders that have one or more of the following characteristics: pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limited range of motion of the temporomandibular joint.
- This benefit provides services and supplies that are: provided or referred by the Member's PCP; and; reasonable and appropriate for treatment of a disorder of the temporomandibular joint, and; effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty speaking or difficulty in chewing or swallowing food, and; recognized as effective, according to the professional standards of good medical practice, and; not experimental; and; not primarily for cosmetic purposes. The Plan will cover medical services only. This benefit does not cover dental services.
54. **Women's Health Care** – For female Members, a referral from the Member's PCP is not required for covered Women's Health Care Services when the services are provided by a Plan Women's Health Care Practitioner. If the Women's Health Care Practitioner diagnoses a condition that requires a referral to another contracted specialist, the Member or the Practitioner must contact the Member's PCP for any necessary Plan authorization and care coordination. Any facility-based services the Member may need, including inpatient hospital care, require prior authorization under the PacifiCare plan.
- Women's Health Care Plan Practitioners include:
- Osteopaths;
 - Osteopathic Practitioner's Assistants;
 - Practitioners;



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- Practitioners' Assistants;
- Gynecologists;
- Obstetricians;
- Nurses (includes RNs, ARNPs, LPNs and RN Midwives);
- Licensed Midwives.

Referrals are not required for the following Women's Health Care Services:

- maternity care;
- reproductive health care;
- gynecological care;
- prevention care as medically appropriate;
- medically appropriate follow-up visits.

The following services do not require referrals from the PCP when ordered by a Women's Health Care Practitioner:

- mammograms, X-rays and ultrasounds;
- complete blood counts, blood glucose tests, pregnancy tests and Rh-factor tests;
- antibody tests (such as HIV or measles);
- urinalysis, urine chemistry and urine cultures;
- pathology for biopsies;
- other health problems discovered and treated during the course of a women's health care visit as long as it is within the practitioner's scope of practice.

Referral and/or Preauthorization is required for:

- all other diagnostic tests or services not listed above;
- care provided by any other Practitioner than a Women's Health Care Practitioner listed above;
- services not within the scope of a Women's Health Care Practitioner license;
- inpatient care, outpatient surgery, birthing centers, home health or Hospice care;
- durable medical equipment, prostheses and corrective appliances.

Note: This benefit does **not** cover:

- services to reverse voluntary sterilization;
- oral birth control drugs and diaphragms (without Outpatient Prescription Drug Supplemental); and
- infertility services.

Please call PacifiCare's Customer Service to get the names of Plan specialists that are Women's Health Care Practitioners. PacifiCare also recommends that the Member call Customer Service to make sure that the services are Medically Necessary and covered by the Plan. The Member should notify her PCP about any Women's Health Care Services she receives without a referral.

55. Voluntary Termination – Voluntary termination of pregnancy is covered for Subscriber or enrolled spouse. The Plan does not cover voluntary termination of pregnancy for Dependents.

IV. Exclusions and Limitations of Benefits

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

General Exclusions

Services that are not Medically Necessary, as defined in the "Definitions" section of this *Combined Evidence of Coverage and Disclosure Form*, are not covered.

Services not specifically included in this *Combined Evidence of Coverage and Disclosure Form*, or any supplement purchased by your employer, are not covered.

1. Services that are rendered without authorization from the Member's Participating Medical Group or PacifiCare (except for Emergency Services or Urgently Needed Services described in this *Combined Evidence of Coverage and Disclosure Form*, and for obstetrical and gynecological Practitioner services obtained directly from an OB/GYN, Family Practice Practitioner or surgeon designated by the Member's Participating Medical Group as providing OB/GYN services) are not covered.



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2. Services obtained from Non-Participating Practitioners or Participating Practitioners who are not affiliated with the Member's Participating Medical Group, when such services were offered or authorized by the Member's Participating Medical Group and the Member refused to obtain the services as offered by the Member's Participating Medical Group, are not covered.
3. Services rendered prior to the Member's effective date of enrollment or after the effective date of disenrollment are not covered.
4. PacifiCare does not cover the cost of services that result from a treatment plan for a non-Covered Service and that are the sole, direct and predictable consequence of a non-Covered Service (as recognized by the organized medical community in the state of Washington). However, PacifiCare will cover Medically Necessary services required to treat an illness or injury that may be a consequence of non-Covered Services but are not predictable in advance, such as unexpected, life-threatening complications of cosmetic surgery.

Other Exclusions and Limitations

1. **Acupuncture** – The following services are not covered:

- any services or treatments not authorized by ASHN, except for an initial examination and Emergency Services;
- any services or treatments not delivered by contracting acupuncturists or other ASHN contracted Practitioner for the delivery of acupuncture care to Members, except for Emergency Services;
- services for examinations and/or treatments for conditions other than those related to neuromusculoskeletal disorders, nausea or pain syndromes from contracting acupuncturists;
- hypnotherapy, behavior training, sleep therapy and weight programs;
- thermography;
- services, lab tests, X-rays and other treatments not documented as Medically Necessary as appropriate or classified as Experimental or Investigational and/or as being in the research stage as determined in accordance with professionally recognized standards of practice;

- services and/or treatments that are not documented as Medically Necessary services;
- magnetic resonance imaging, CAT scans, bone scans, nuclear radiology and any types of diagnostic radiology other than covered plain film strips;
- transportation costs including local ambulance charges;
- education programs, nonmedical self-care or self-help or any self-help physical exercise training or any related diagnostic testing;
- services or treatments for pre-employment physicals or vocational rehabilitation;
- any services or treatments caused by or arising out of the course of employment or covered under any public liability insurance;
- air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all chiropractic appliances or durable medical equipment;
- prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order;
- Services provided by an acupuncturist practicing outside the Service Area, except for Emergency services;
- hospitalization, anesthesia, manipulation under anesthesia and other related services;
- all auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids;
- adjunctive therapy not associated with acupuncture.;
- vitamins, minerals, nutritional supplements or other similar products.



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2. **Air Conditioners, Air Purifiers or Other Environmental Equipment** – Air Conditioners, air purifiers and other environmental equipment are not covered.
3. **Alcoholism, Drug Addiction and Other Substance Abuse Rehabilitation** – Methadone treatment for detoxification and maintenance are not covered.
4. **Behavior Modification and Non-Crisis Mental Health Counseling and Treatment** – Behavior modification and noncrisis mental health counseling and treatment are not covered. Examples include, but are not limited to, art therapy, music therapy and play therapy.
5. **Biofeedback** – Biofeedback services are not covered except for bladder rehabilitation as part of an authorized treatment plan.
6. **Bloodless Surgery Services** – Bloodless surgery services are only covered to the extent available within the Member's Participating Hospital.
7. **Bone Marrow and Stem Cell Transplants** – Autologous or allogeneic bone marrow or stem cell transplants are not covered when they are Experimental or Investigational unless required by an external, independent review panel as described in Section 8 of this *Combined Evidence of Coverage and Disclosure Form*, under the caption "Independent Medical Review Procedures." Unrelated donor searches must be performed at a PacifiCare-approved transplant center. (See "Preferred Transplant Network" in "Definitions.")
8. **Chiropractic Care** – The following services are **not** covered:
 - any services or treatments not authorized by ASHN, except for an initial examination and Emergency Services;
 - any services or treatments not delivered by Contracting Chiropractors or other ASHN contracted Practitioners for the delivery of chiropractic care to Members, except for Emergency Services;
 - services for examinations and/or treatments for conditions other than those related to neuromusculoskeletal disorders;
 - hypnotherapy, behavior training, sleep therapy and weight programs;
 - thermography;
 - services, lab tests, X-rays and other treatments not documented as Medically Necessary as appropriate or classified as Experimental or Investigational and/or as being in the research stage, as determined in accordance with professionally recognized standards of practice;
 - services and/or treatments that are not documented as Medically Necessary services;
 - magnetic resonance imaging, CAT scans, bone scans, nuclear radiology and any types of diagnostic radiology other than covered plain filmstrips;
 - transportation costs including local ambulance charges;
 - education programs, nonmedical self-care or self-help or any self-help physical exercise training or any related diagnostic testing;
 - services or treatments for pre-employment physicals or vocational rehabilitation;
 - any services or treatments caused by or arising out of the course of employment or covered under any public liability insurance;
 - air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all chiropractic appliances or durable medical equipment, except as described in this *Schedule of Benefits*;
 - prescription drugs or medicines including a nonlegend or proprietary medicine or medication not requiring a prescription order;
 - services provided by a chiropractor practicing outside the Service Area, except for Emergency Services;
 - hospitalization, anesthesia, manipulation under anesthesia and other related services;
 - all auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids;



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- adjunctive therapy not associated with spinal, muscle, extremity or joint manipulation;
 - vitamins, minerals, nutritional supplements or other similar products.
9. **Communication Devices** – Computers, personal digital assistants and any speech-generating devices are not covered.
 10. **Cosmetic Services and Surgery** – Cosmetic surgery and cosmetic services are not covered. Cosmetic surgery and cosmetic services are defined as surgery and services performed to alter or reshape normal structures of the body in order to improve appearance. Drugs, devices and procedures related to cosmetic surgery or cosmetic services are not covered. Cosmetic surgeries or cosmetic services do not become reconstructive surgery because of a Member's psychological or psychiatric condition.
 11. **Custodial Care** – Custodial Care is not covered. Custodial Care is defined as care and services that assist an individual in the activities of daily living. Examples include: assistance in walking, getting in and out of bed, bathing, dressing, feeding and using the toilet, preparation of special diets and supervision of medication that usually can be self-administered. Services provided at home or in any facility (including, but not limited to, a rest home, a home for the aged or a nursing home) are also not covered if they are custodial in nature.
 12. **Dental Care, Dental Appliances and Orthodontics** – Except as otherwise provided under the outpatient benefit captioned "Oral Surgery and Dental Services," dental care, orthognathic surgery, 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. The Plan will cover dental care to treat an accidental injury to the mouth and natural teeth within 48 hours of the injury limited to stabilization services. Benefits for dental accidents may be provided by a dentist or a licensed denturist when services provided are within the scope of the denturists licenses and would have been covered if provided by a dentist.
 13. **Dental Treatment Anesthesia** – Anesthesia services in conjunction with hospital care for tooth extraction and Dental care, except if Medically Necessary, and the Member: (a) is under the age of seven with a dental condition and the required procedure cannot be safely and effectively performed in a dental office; (b) is physically or developmentally disabled and cannot be safely and effectively treated in a dental office, (c) has at least one medical condition that would create an undue medical risk if treatment is not performed in a hospital or ambulatory surgery center as determined by the patient's Practitioner; such treatment must be approved by the patient's Practitioner Preauthorization is required.
 14. **Dialysis** – Chronic dialysis (peritoneal or hemodialysis) is not covered outside of the Member's Participating Medical Group, without Preauthorization from PacifiCare.
 15. **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.
 16. **Drugs and Prescription Medication (Outpatient)** – Outpatient drugs and prescription medications are not covered; however, coverage for prescription medications may be available as a supplemental benefit. If your health plan includes a supplemental benefit, a brochure will be enclosed with these materials. Infusion drugs and infusion therapy are not considered outpatient drugs for the purposes of this exclusion. Refer to outpatient benefits, "Injectable Drugs" and "Infusion Therapy" for benefit coverage. Pen devices for the delivery of medication, other than insulin or as required by law, are not covered.
 17. **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



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portability or travel, a second piece of equipment with or without additional accessories that is for the same or similar medical purpose as existing equipment, and home and car remodeling.

18. **Educational Services for Developmental Delays and Learning Disabilities** – Educational services to treat developmental delays or learning disabilities are not covered regardless of the license of the Provider. A learning disability (i.e. autism, attention deficit hyperactivity disorder, sensory integration disorders, asperger or dyslexia) 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*.
19. **Elective Enhancements** – Procedures, services and supplies for elective, non-Medically Necessary enhancements (items, devices or services to improve appearance or performance) are not covered. This includes, but is not limited to, elective enhancements related to hair growth, athletic performance, cosmetic changes and anti-aging.
20. **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.
21. **Experimental and/or Investigational Procedures, Items and Treatments** – Experimental and/or Investigational Procedures, Items and Treatments are not covered unless required by an external, independent review panel as described in Section Eight of this *Combined Evidence of Coverage and Disclosure Form* captioned "Eligibility for Independent Medical Review; Experimental or Investigational Treatment Decisions," in the "Inpatient Benefits" and "Outpatient Benefits" sections of this *Combined Evidence of Coverage*

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

- It cannot lawfully be marketed without the approval of the Food and Drug Administration (FDA) and such approval has not been granted at the time of its use or proposed use.
- It is a subject of a current investigation of new drug or new device (IND) application on file with the FDA.
- It is the subject of an ongoing clinical trial (Phase I, II, or the research arm of Phase III) as defined in regulations and other official publications issued by the FDA and Department of Health and Human Services (DHHS).
- It is being provided pursuant to a written protocol that describes among its objectives the determination of safety, efficacy, toxicity, maximum tolerated dose or effectiveness in comparison to conventional treatments.
- It is being delivered or should be delivered subject to approval and supervision of an institutional review board (IRB) as required and defined by federal regulations or other official actions (especially those of the FDA or DHHS).
- Other facilities studying substantially the same drug, device, medical treatment or procedures refer to it as experimental or as a research project, a study, an invention, a test, a trial or other words of similar effect.
- The predominant opinion among experts as expressed in published, authoritative medical literature is that usage should be confined to research settings.
- It is not Experimental or Investigational itself pursuant to the above criteria, but would not be Medically Necessary except for its use in conjunction with a drug, device or treatment that



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is Experimental or Investigational (e.g. lab tests or imaging ordered to evaluate the effectiveness of an experimental therapy).

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

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

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

22. **Eye Wear 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.

23. **Family Planning** – This plan does not cover over-the-counter birth control items or devices, hysterectomy for sterilization purposes or reversal of sterilization.
24. **Follow-Up Care: Emergency Services or Urgently Needed Services** – Services following discharge after receipt of Emergency Services or Urgently Needed Services, including, but not limited to, treatments, procedures, X-rays, lab work, Practitioner visits, rehabilitation and Skilled Nursing Care, are not covered without the Participating Medical Group's or PacifiCare's authorization. The fact that the Member is outside the Service Area and that it is inconvenient for the Member to obtain the required services from the Participating Medical Group will not entitle the Member to coverage.
25. **Foot Orthotics/Footwear** – PacifiCare does not cover heel cups, shoe lifts, shoe inserts, foot pads, orthopedic shoes or other supportive devices for the feet, orthopedic shoes for subluxations of the foot or supportive devices for the feet.
26. **Genetic Testing and Counseling** – Genetic testing of non-Members is not covered. Genetic testing solely to determine the gender of a fetus is not covered. Genetic testing and counseling are not covered when done for nonmedical reasons, or when a Member has no medical indication or family history of a genetic abnormality. General testing and counseling are not covered to screen newborns, children, adolescents, or adults to determine their carrier status for inheritable disorders when there would be no immediate medical benefit or when the test results would not be used to initiate medical interventions during childhood. Genetic testing and counseling are not covered except when determined by PacifiCare's Medical Director or designee to be Medically Necessary to treat the Member for an inheritable disease. Refer to "Maternity Care Test and Procedures" in the "Outpatient Benefits" section for coverage of amniocentesis and chorionic villus sampling.



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27. **Government Services and Treatment** – Any services provided by 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.
28. **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). Supplements may be purchased by your employer.
29. **Immunizations** – Immunizations that are required for work, insurance, school, marriage, adoption, immigration, camp, volunteer work, travel, licensure, certification, registration, sports or recreational activities are not covered.
30. **Infertility Reversal** – Reversals of sterilization procedures are not covered.
31. **Infertility Services** – Infertility Services are not covered unless purchased by the Subscriber's Employer Group. Please refer to your *Schedule of Benefits*. The following services are excluded under the PacifiCare health plan: ovum transplants, ovum or ovum bank charges, sperm or sperm bank charges, and the Medical or Hospital Services incurred by surrogate mothers who are not PacifiCare Members are not covered. Medical and Hospital Infertility Services for a Member whose fertility is impaired due to an elective sterilization, including surgery, medications and supplies, are not covered.

If you are covered for Infertility Services purchased by the Subscriber's Employer Group, the following limitations and exclusions apply:
 - Insemination Procedures are limited to 6 procedures, per lifetime, unless the Member conceives, in which case the benefit renews.
 - Advanced infertility procedures, as well as In Vitro Fertilization (IVF), Gamete Intrafallopian Transfer (GIFT) and Zygote Intrafallopian Transfer (ZIFT) and procedures performed in conjunction with advanced infertility procedures, IVF, GIFT and ZIFT are not covered.
 - Reversal of a sterilization procedure(s) is not a covered benefit.
32. **Institutional Services and Supplies** – Except for Skilled Nursing Services provided in a Skilled Nursing Facility, any services or supplies furnished by a facility that is primarily a place of rest, a place for the aged, a nursing home, or any similar institution, regardless of affiliation or denomination, are not covered. (Skilled Nursing Services are covered as described in this *Combined Evidence of Coverage and Disclosure Form* in the sections entitled "Inpatient Benefits" and "Outpatient Benefits.")
33. **Massage Therapy** – The following services are not covered.
 - any services or treatments not authorized by ASHN, except for an initial assessment;
 - any services or treatments not delivered by contracting massage therapists or other ASHN contracted Practitioners for the delivery of massage therapy care to Members;
 - services for assessments and/or treatments for conditions other than those related to myofascial, neuromusculoskeletal pain syndromes provided by contracting massage therapists;
 - hypnotherapy, behavior training, sleep therapy and weight programs;
 - thermography;
 - services and/or treatments not documented as clinically necessary and appropriate or classified as experimental or Investigational and/or as being in the research stage;
 - transportation costs including local ambulance charges;
 - education programs, nonmedical self-care or self-help or any self-help physical exercise training or any related diagnostic testing;
 - services or treatments for pre-employment physicals or vocational rehabilitation;
 - any services or treatments caused by or arising out of the course of employment or covered under any public liability insurance;
 - therapeutic devices, appliances, supplies or durable medical equipment;



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- prescription drugs or medicines including a nonlegend or proprietary medicine or medication not requiring a prescription order;
 - services provided outside the scope of a massage therapist's license;
 - hospitalization;
 - all auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids;
 - adjunctive therapy whether or not associated with massage therapy;
 - vitamins, minerals, nutritional supplements or other similar products.
35. **Maternity** – Educational courses on lactation, childcare and/or prepared childbirth classes are not covered. Maternity is not covered for Dependents.
36. **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.
37. **Mental Health and Nervous Disorders** – Mental Health Services are not covered unless a supplement is not purchased by your employer. Academic or educational testing, as well as educational counseling or remediation is not covered. Please refer to the *Schedule of Benefits* for coverage, if any.
38. **Midwife Services** – Nurse midwife services are covered only when available within the Member's Participating Medical Group. Home deliveries are not covered.
39. **Naturopathy** – The following services are **not** covered:
- any services or treatments not authorized by ASHN, except for an initial examination and Emergency services;
 - any services or treatments not delivered by contracting naturopaths or other ASHN contracted Practitioners for the delivery of naturopathic care to Members, except for Emergency services;
 - services for examinations and/or treatments for conditions that are not listed as a covered condition or listed as an exclusion;
 - immunizations, vaccinations, injectables, intravenous infusions (does not include venipuncture for the purpose of obtaining blood samples for laboratory studies);
 - preventive health studies such as Pap smears, PSA studies, mammograms, etc. (to be referred to the Member's PCP);
 - hypnotherapy, behavior training, sleep therapy and weight programs;
 - thermography;
 - services, lab tests, X-rays and other treatments not documented as clinically necessary as appropriate; those classified as Experimental or Investigational; those that are in the research stage as determined in accordance with professionally recognized standards of practice; and/or those not listed above in the "diagnostic tests" section;
 - radiological imaging, including, but not limited to, magnetic resonance imaging, CAT scans, bone scans, nuclear radiology and any types of therapeutic radiology other than covered plain film strips;
 - transportation costs including local ambulance charges;
 - education programs, self-care or self-help programs or any self-help physical exercise training or any related diagnostic testing;
 - services or treatments for pre-employment physicals or vocational rehabilitation;
 - any services or treatments caused by or arising out of the course of employment or covered under any public liability insurance;
 - air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances or durable medical equipment;
 - prescription drugs or medicines, support products not requiring a prescription order (excluding homeopathic remedies as described above);
 - hospitalization, anesthesia, manipulation under anesthesia and other related services;



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- all auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

Adjunctive therapy that is considered by ASHN to be invasive or not listed on the contracting naturopath's payor summary. Please contact your naturopath for specific exclusions and limitations.

40. **Neurodevelopmental Therapy** – Inpatient or residential neurodevelopmental programs in the absence of medical condition requiring acute medical care are never covered. Services to correct disorders and delays in the development of motor, speech, language or cognitive skills such as dyslexia, or stuttering are not covered. Services directed primarily toward vegetative disorders (e.g., pica, bedwetting, sleep disorders), habit disorders (e.g., thumb sucking, nail biting), anxiety disorders (e.g., depression, bipolar disorder) are never covered under the plan.
41. **Nursing, Private Duty** – Private duty nursing is not covered.
42. **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.”
43. **Obesity Treatment** – The following are not covered under any circumstances: coverage for the treatment of obesity without associated complications; intestinal bypass surgery; gastric balloon for the treatment of obesity; nutritional liquid supplements; and weight reduction medications, including diet pills.
44. **Off-Label Drug Use** – Off-Label Drug Use, which means the use of a drug for a purpose that is different from the use for which the drug has been approved for by the FDA, including off-label injectable drugs, is not covered except as follows: If the self-injectable drug is prescribed for Off-Label Use, the drug and its administration is covered only when the following criteria are met:
 - the drug is approved by the FDA;

- the drug is prescribed by a Participating Practitioner for the treatment of a life-threatening condition or for a chronic and seriously debilitating condition;
- the drug is Medically Necessary to treat the condition;
- the drug has been recognized for treatment of the life-threatening or chronic and seriously debilitating condition by one of the following: The American Medical Association *Drug Evaluations*, The American Hospital Formulary Service *Drug Information*, *The United States Pharmacopoeia Dispensing Information, Volume 1*, or in two articles from major peer-reviewed medical journals that present data supporting the proposed Off-Label Drug Use or Uses as generally safe and effective;
- The drug is covered under the Injectable Drug Benefit described in the “Outpatient Benefits” section of this EOC.

Nothing in this section shall prohibit PacifiCare from use of a Formulary, Copayment, technology assessment panel, or similar mechanism as a means for appropriately managing the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA.

45. **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.
46. **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.”)
47. **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. Donor searches are only covered when performed by a Practitioner included in the “Preferred Transplant Network Facility.”



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48. **Organ Transplants** – All organ transplants must be Preauthorized by PacifiCare and performed in a PacifiCare Preferred Transplant Network facility.
- Transportation is limited to the transportation of the Member and one escort to a Preferred Transplant Network facility greater than 60 miles from the Member's Primary Residence as Preauthorized by PacifiCare.
 - Food and housing is not covered unless the Preferred Transplant Network center is located more than 60 miles from the Member's Primary Residence, in which case food and housing is limited to \$125 dollars a day to cover both the Member and escort, if any (excludes liquor and tobacco). Food and housing expenses are not covered for any day a Member is not receiving Medically Necessary transplant services.
 - Listing of the Member at a second Preferred Transplant Network Center is excluded, unless the Regional Organ Procurement Agencies are different for the two facilities and the Member is accepted for listing by both facilities. In these cases, organ transplant listing is limited to two Preferred Transplant Network facilities. If the Member is dual listed, his or her coverage is limited to the actual transplant at the second facility. The Member is responsible for any duplicated diagnostic costs incurred at the second facility.
 - Artificial and nonhuman organs are excluded.
 - Storage costs for organs, stem cell and bone marrow are excluded.
49. **Outpatient Medical Rehabilitation Therapy** – This benefit does not cover: care to halt or slow further physical deterioration; self-help training, such as "Outward Bound" therapy; services to correct disorders and delays in the development of motor, speech, language or cognitive skills (i.e., stuttering, asperger, autism, dyslexia or sensory integration disorder); and social, vocational and cultural rehabilitation.
50. **Phenylketonuria (PKU) Testing and Treatment** – Food products naturally low in protein are not covered.
51. **Physical or Psychological Examinations** – Physical or psychological examinations for court hearings, travel, premarital, preadoption or other nonpreventive health reasons are not covered.
52. **Private Rooms and Comfort Items** – Personal or comfort items, and non-Medically Necessary private rooms during inpatient hospitalization are not covered.
53. **Prosthetics and Corrective Appliances** – Replacement of lost prosthetics or corrective appliances is not covered. Prosthetics that require surgical connection to nerves, muscles or other tissues (bionic) are not covered. Prosthetics that have electric motors to enhance motion (myoelectronic) are not covered.
54. **Public Facility Care** – When state or local law requires treatment in a public facility, care is not covered; however, PacifiCare will reimburse a Member for out-of-pocket expenses incurred for any Covered Service delivered at a public facility that meets the definition of Emergency or Urgently Needed Services. Injuries or illnesses sustained while incarcerated in a state or federal prison, in legal custody, on a legal hold or in legal detention are not covered. Only Emergency and Urgently Needed Services are covered until the Member is stabilized and placed on a police hold. Nothing in this provision will restrict the liability of PacifiCare with respect to Covered Services solely because such services were provided while the Member was in a state hospital.
55. **Reconstructive Surgery** – Reconstructive surgeries are not covered under the following circumstances:
- when there is another more appropriate surgical procedure that has been offered to the Member; or
 - when only a minimal improvement in the Member's physical function and/or a minimal correction of abnormal bodily function is expected to be achieved.
- Preauthorizations for proposed reconstructive surgeries will be reviewed by Practitioners specializing in such reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested. See the "Reconstructive Surgery" section.



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56. **Recreational, Lifestyle, Educational or Hypnotic Therapy** – Recreational, lifestyle, educational or hypnotic therapy, and any related diagnostic testing is not covered.
57. **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.
 - Services that are primarily oriented toward treating a social, developmental or learning problem rather than a medical problem (i.e. autism, asperger, attention deficit hyperactivity disorder or dyslexia) are not covered.
 - 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). Services that are primarily oriented toward treating a social, developmental or learning problem are not covered.
 - 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.
58. **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 5 consecutive days at a time.
59. **Services in the Home** – Services in the home provided by relatives or other household members are not covered.
60. **Sex Transformations** – Procedures, services, medications and supplies related to sex transformations are not covered.
61. **Sexual Dysfunction** – Prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmia or hyporgasmia.
62. **Surrogacy** – Infertility and maternity services for surrogate non-Members are not covered. PacifiCare may seek recovery from a Member who is receiving reimbursement for medical expenses for maternity services while acting as a surrogate.
63. **Temporomandibular Joint (TMJ)** – Treatment of functional impairments that are caused by a dental condition.
64. **Transportation** – Transportation is not a covered benefit except for Ambulance transportation as defined in Emergency and Urgently Needed Services of this *Combined Evidence of Coverage and Disclosure Form*.
65. **Usual, Customary or Reasonable (UCR)** – For Plan Provider, the Eligible Charge is the amount that the Plan Provider has contracted to accept from PacifiCare as payment in full for Covered Services and supplies. For Non-Participating Providers, the Eligible Charge is the UCR. The Member may be responsible for amounts in excess of UCR if a Non-Participating Provider treats you.
66. **Veterans Administration Services** – Except for Emergency or Urgently Needed Services, services provided in a Veterans Administration facility are not covered.
67. **Vision Care** – See "Eye Wear and Corrective Refractive Procedures" listed in "Exclusions and Limitations."
68. **Vision Training** – Vision therapy rehabilitation and ocular training programs (orthoptics) are not covered.
69. **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. Also excluded are surgery, laboratory tests, food and food supplements, vitamins and other nutritional supplements associated with weight loss or weight gain. Surgical treatment for morbid obesity will be covered only when criteria are met as recommended by the National Institutes of Health (NIH).



SECTION SIX

Payment Responsibility

- Premiums, Copayments and Out-of-Pocket Maximums
- Your *Schedule of Benefits*
- What to Do if You Receive a Bill
- Coordinating Benefits
- Medicare Eligibility
- Subrogation (Third Party Claims)

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

What Are Premiums (Prepayment Fees)?

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

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

What Are Copayments (Other Charges)?

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

What Is a "Schedule of Benefits"?

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

Out-of-Pocket Maximum

For certain Covered Services, a limit is placed on the total amount you pay for Copayments and Coinsurance during a Calendar Year. This limit is called your Out-of-Pocket Maximum and when you reach it, for the remainder of the Calendar Year, you will not pay any additional Copayments or Coinsurance for these Covered Services.

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

PacifiCare of Washington
Customer Service Department
P.O. Box 6092
Cypress, CA 90630-0092

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

Note: The calculation of your Out-of-Pocket 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 Practitioner or Participating Medical Group, you should do the following:

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

PacifiCare of Washington
Claims Department
P.O. Box 6092
Cypress, CA 90630-0092



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

Please Note: Your Practitioner 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.

Bills From Non-Participating Practitioners

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

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

PacifiCare of Washington Claims Department
P.O. Box 6092
Cypress, CA 90630-0092

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 Practitioner who authorized your care. No claim form is required.

PacifiCare will not pay any claim that is filed more than 1 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 Practitioner, your Participating Medical Group or directly by PacifiCare.

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

How to Avoid Unnecessary Bills

Always obtain your care under the direction of PacifiCare, your Participating Medical Group, or your Primary Care Practitioner. 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 Services, if you receive services not authorized by PacifiCare or your Participating Medical Group, you may be responsible for payment. This is also true if you receive any services not covered by your plan. (Services not covered by your plan are included in "Section Five: Your Medical Benefits.")

Your Billing Protection

All PacifiCare Members have rights that protect them from being charged for Covered Services in the event a Participating Medical Group does not pay a Practitioner, a Practitioner becomes insolvent, or a Practitioner breaches its contract with PacifiCare. In none of these instances may the Participating Practitioner 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 *Schedule of Benefits*.)

In the event of a Practitioner's insolvency, PacifiCare will continue to arrange for your benefits. If for any reason PacifiCare is unable to pay for a Covered Service on your behalf (for instance, in the unlikely event of PacifiCare's insolvency or a natural disaster), you are not responsible for paying any bills as long as you received proper authorization from your PacifiCare Participating Practitioner.

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

Coordination of Benefits

All of the benefits of this Plan are subject to the following provisions:

Definitions: For the purpose of this Coordination of Benefits provision, the terms below have the following meanings:



SECTION SIX

Payment Responsibility

Plan. A plan providing benefits or services for, or because of, medical or dental care through:

- group or blanket insurance policies and health care service contractor and health maintenance organization group agreements issued by insurers, health care service contractors and health maintenance organizations;
- labor-management trustee plans, labor organization plans, employer organization plans, or Subscriber benefit organization plans;
- governmental programs;
- coverage required or provided by any statute. “Plan” does not include group Hospital indemnity benefits (that is, benefits paid on other than an expense-incurred basis) of \$200 per day or less. The term “Plan” shall be construed separately with respect to each policy, agreement or other arrangement for benefits or services, and separately with respect to the respective portions of any such policy, agreement or other arrangement which do and which do not reserve the right to take the benefits or services of other policies, agreements or other arrangements into consideration in determining its benefits.

Allowable Expense. The Usual, Customary, or Reasonable charge for any necessary health care service or supply when the service or supply is covered at least in part under any of the plans involved. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an Allowable Expense. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition unless the covered person’s stay in a private Hospital room is considered Medically Necessary under at least one of the plans involved.

Claim Determination Period. A calendar year.

Practitioner Please note: If the Member has coverage other than PacifiCare coverage, the Member should submit the claim to PacifiCare and to each other insurer at the same time. In that way, the proper coordinated benefits may be most quickly determined and paid.

Effect on Benefits. During the Claim Determination Period, PacifiCare will coordinate benefits with all other plans under which a Member is eligible for benefits so that the sum of PacifiCare’s benefits and the benefits payable from all the other plans shall not exceed total Allowable Expenses. PacifiCare will coordinate with benefits that would be payable under other plans even if the Member does not submit a claim under the other plans. Except as provided below, PacifiCare will reduce its benefits so that the sum of PacifiCare’s benefits and the benefits of other plans do not exceed the total Allowable Expenses.

PacifiCare will not reduce its benefits if:

1. The other plan’s rules would require it to coordinate benefits with PacifiCare and to determine benefits after PacifiCare; and
2. The rules shown below require PacifiCare to determine its benefits first.

Primary/Secondary Determination Rules. The order for benefit determination is:

1. Benefits of the plan that covers the person as other than a Dependent are determined before benefits of the plan that covers the person as a Dependent.
2. For a Dependent child who is covered by parents not separated or divorced, benefits of the parent whose birthday (month and day) occurs earlier in the calendar Year are determined before benefits of the parent whose birthday occurs later in the calendar Year. If the other plan does not determine benefits based on a similar birthday provision, which results in each plan determining benefits either before the other plan or after the other plan, then the order determined by the other plan shall apply.
3. When the parents who cover a Dependent child are divorced or separated, and there is no decree establishing financial responsibility for medical or dental expenses of the Dependent child, then benefits for the child’s expenses are determined as follows:
 - a. Benefits of the parent with custody are determined before benefits as a Dependent of the parent without custody.



Payment Responsibility

- b. Benefits of the parent with custody and who has remarried are determined first, benefits of the step-parent are determined second, and benefits of the parent without custody are determined third.
4. However, when the parents who cover a Dependent child are divorced or separated, and there is a decree establishing financial responsibility for medical or dental expenses of the Dependent child, benefits of the parent with financial responsibility are determined before benefits of the parent without financial responsibility.
5. When the above rules do not establish an order, benefits of the plan which has covered the person on whose expense claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person for the shorter period of time, except that:
 - a. The benefits of a plan covering the person on whose expenses claim is based as a laid-off or retired Subscriber, or Dependent of such person, shall be determined after the benefits of any other covering such person as an Subscriber, other than a laid-off or retired Subscriber, or Dependent of such person.
 - b. If either plan does not have a provision regarding laid-off or retired Subscribers, which results in each plan determining its benefits after the other, then the provisions of subsection 5.a. above shall not apply.
6. When the above rules do not establish an order, the plan that has covered the person for the longest period of time is the primary payer.
7. When the above rules do not establish an order, benefits are determined first under the plan that covered the Subscriber for the longest period of time.

A reduction in benefits will be prorated for all covered expenses, which means that each benefit that would be payable in the absence of this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan during a Calendar Year.

Practitioner. A Provider licensed by the state in which he or she practices as a (1) Doctor of Medicine or Surgery, (2) Doctor of Osteopathy, (3) Doctor of Podiatry, (4) Chiropractor, or (5) Dentist (DDS or DMD). The term also includes a Psychologist licensed by the state to practice psychology.

Right to Receive and Release Needed Information

PacifiCare and other plans may exchange information needed to coordinate benefits with consent of the Member. Members must furnish needed information.

Facility of Payment

If PacifiCare reimburses other plans for payments that should have been made under this Plan, those payments will be treated as benefits paid under this Plan.

Right of Recovery

Whenever payments have been made by PacifiCare with respect to Allowable Expenses in total amount, at any time, in excess of the maximum amount of payment necessary at the time to satisfy the intent of this provision, PacifiCare shall have the right to recover such payments, to the extent of such excess, from one or more of the following, and PacifiCare shall determine any persons to, or for, or with respect to whom such payments were made, any other insurers, any service plans, or any organizations or other plans.

Important Rules for Medicare and Medicare Eligible Members

The plan will provide its benefits primary to Medicare for both Subscribers and enrolled Dependents when required to do so by federal law. When this plan is primary to Medicare, its benefits are provided as if the Member did not have Medicare. When this plan is secondary to Medicare, PacifiCare will review Medicare's payment and reduce Plan benefits as described in the "Coordination of Benefits" section of this *Evidence of Coverage*.

A Member who has Medicare has the right to reject this payment arrangement and have Medicare for his or her only coverage. But, if a Member chooses to do this, federal law requires that his or her coverage under this Plan be canceled on the date that his Plan ceases to be primary. When an Subscriber rejects this Plan as primary over Medicare, coverage under this Plan for all of the Subscriber's Dependents must also be canceled. However, the Dependents may be eligible to extend coverage for a time if the Group offers continued coverage as described in "Continuation of Group Medical Benefits (COBRA)" in this *Evidence of Coverage*.

If the Member does not have end-stage renal disease (ESRD), and the Group is an employer group of twenty (20) or more employees, either through his or her own current employment or the employment of a spouse, the benefits of this Plan are primary to Medicare.



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Payment Responsibility

Similarly, if the Member does not have end-stage renal disease (ESRD), but has Medicare based on disability and the Group has one hundred (100) or more employees (or is part of a multiple employer plan that includes an employer one hundred or more employees) or through a spouse's employer group coverage, the benefits of this Plan are primary.

If the Member has or develops ESRD while covered under this Plan, the benefits of this Plan are primary for the first thirty (30) months after becoming eligible for Medicare based on ESRD. Medicare is the primary payer after this coordination period. (However, if this Plan was secondary to Medicare when the Member developed ESRD because it was not based on current employment as described above, Medicare continues to be primary payer.)

Any sums collected by or on behalf of the Member or covered Dependents by legal action, settlement, or otherwise, on account of benefits provided under such plan, shall be payable to PacifiCare only after and to such extent that such sums exceed the amount required to fully compensate the Member for the Member's loss.

Subrogation (Third Party Claims)

If the Member receives services for any condition or injury for which a third party is liable, PacifiCare may have the right to recover the money paid for benefits under this Plan. This means PacifiCare is not obligated to pay for services necessary because of an injury or condition for which the Member may have other recovery rights unless or until the Member, or someone legally qualified and authorized to act for the Member, promises in writing to:

- include those amounts in any claim the Member or Member's representative makes for the injury or condition; and
- repay PacifiCare those amounts to the extent that the proceeds of the Member's recovery by reason of such an injury or condition exceeds the total loss, prorating any attorneys' fees incurred in the recovery; and
- cooperate fully with PacifiCare in asserting its rights, supply PacifiCare with any and all information and execute any and all documents PacifiCare reasonably needs for that purpose.



Member Eligibility

- Membership Requirements
- Adding Family Members
- Out-of-Area Child/Student Benefit
- Out-of-Area Subscriber Benefit
- Late Enrollment
- Updating Your Enrollment Information
- Termination of Enrollment
- Coverage Options Following Termination

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

Who Is a PacifiCare Member

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

The following Family Members are eligible to enroll in PacifiCare:

- the Subscriber's Legal Spouse;
- the unmarried biological children of the Subscriber or the Subscriber's Spouse (step-children) who are under the Limiting Age established by the employer (for an explanation of "Limiting Age," see Definitions);
- legally placed Foster child of the Subscriber or covered spouse;
- 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 in this section.

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

- was born to a single person or unmarried couple;
- is not claimed as a dependent on a Federal Income Tax Return;
- does not reside with the Subscriber or within the PacifiCare Service Area.

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.

Eligibility

All Members must meet all eligibility requirements established by the Employer Group and PacifiCare. PacifiCare may request evidence to validate eligibility requirements. PacifiCare's eligibility requirements are:

- have a Primary Residence within Washington;
- select a Primary Care Practitioner within a 30-mile radius of his or her Primary Residence or Primary Workplace (except children enrolled as a result of a Qualified Medical Child Support Order, out-of-area student dependents or enrolled out-of-area Members);



SECTION SEVEN

Member Eligibility

- 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. There are circumstances when enrolling is allowed outside the Open Enrollment Period, which is 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 non-standard enrollment form approved by PacifiCare) by the Subscriber on his or her own behalf, or on the behalf of any eligible Family Member. Enrollment is conditional upon acceptance by PacifiCare; the existence of a valid Employer Group Agreement; and the timely payment of applicable Health Plan Premiums. PacifiCare may in its discretion and subject to specific protocols, accept enrollment data through an electronic submission.

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

Open Enrollment

Most Members enroll in PacifiCare during the “Open Enrollment Period” established by the Employer Group. This is the period of time (31 days) 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 Calendar Year.

Adding Family Members to Your Coverage

The Subscriber’s Spouse and eligible children may apply for coverage with PacifiCare during the employer’s Open Enrollment Period. If you are declining enrollment for yourself or your Dependents (including your Spouse) because of other health plan or insurance coverage, you may in the future be able to enroll yourself or your Dependents in PacifiCare, provided that you request

enrollment within 31 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your Dependents, provided that you request enrollment within 31 days after the marriage, and 60 days from the newborn birth, adoption or placement for adoption. (Guardianship is not a qualifying event for other Family Members to enroll). Under the following circumstances, new Family Members may be added outside the Open Enrollment Period.

- **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 Enrollment/Change Form to PacifiCare within 60 days of the birth of the newborn.
- **Biological newborns and adoptive children.** 10-day enrollment period.
- **Adoption or Placement for Adoption.** Coverage for an adopted child from a recognized county or private agency, 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 child. For adopted children, coverage is effective on the date of adoption or placement for adoption. An application must be received within 60 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.

Continuing Coverage for Student and Incapacitated Dependents

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



Member Eligibility

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 a public or private secondary school, a community college, a state-operated vocational school or a four year college or university 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.

Out-of-Area Child/Student Benefit

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, within the USA, may continue as an Eligible Dependent through the Limiting Age established by the employer for full-time students, if proof of such status is provided to PacifiCare on a periodic basis, as requested by us. If the Dependent student resides outside of the Service Area, the student must maintain a permanent address inside the Service Area with the Subscriber. Out-of-Area Child/Student Dependents are not required to select a PCP while outside of the Service Area. The provisions of this Agreement are in force for Out-of-Area Child/Student Dependents except as amended below.

Preauthorization for Surgeries and Inpatient Stays

Before a hospitalization or outpatient surgery the Out-of-Area Child/Student Dependent or the Out-of-Area Child/Student Dependent Provider must notify PacifiCare in advance. The only exceptions are for Emergencies. PacifiCare asks that the Member or the Member's Provider notify PacifiCare at least ten (10) days before the surgery or admission to the medical facility. If PacifiCare is not notified at least twelve (12) hours before the surgery or admission, the services will not be covered. To notify PacifiCare, call 1-800-932-3004 and give the following information:

- the patient's name;
- the Provider's name;
- the diagnosis and procedure;
- the name of the medical facility;
- for inpatient care, the scheduled admission date and the expected length of stay;
- for outpatient surgeries, the scheduled date of service.

Behavioral Health Benefits

All services, except Emergencies, require Preauthorization to be covered. To obtain Preauthorization, call the PacifiCare Behavioral Health Line, a 24-hour, toll-free number at 1-800-577-7244 or 1-800-221-2832 (TTY). Preauthorization does NOT entitle you to additional coverage if you have reached your Behavioral Health Maximum. Please refer to the *Schedule of Benefits* for coverage specifications including dollar and day/visit limitations.

Out-of-Area Child/Student Dependents are not required to use PacifiCare Behavioral Health Plan Providers; however, Out-of-Area Child/Student Dependents are still required to Preauthorize care.

Pharmacy

If the employer has purchased the "Supplemental Outpatient Prescription Drug Benefit" then PacifiCare has a well-established network of pharmacies. An Out-of-Area Child/Student Dependent should have prescriptions filled at a contracted Pharmacy. The Member must show a PacifiCare identification card and pay the appropriate Copayment or Coinsurance amount for each prescription filled.

If a participating Pharmacy is not available and the Member utilizes a Non-Participating Pharmacy, the prescription must be paid in full at the time of the services and the Member will need to submit a claim to PacifiCare for reimbursement. PacifiCare will need a complete prescription drug claim form.

Emergency Care

Emergency care is covered. Medical or Hospital Services provided or recommended by an Out-of-Plan Provider, which do not qualify as Emergency Services, will not be covered unless precertified. This includes non-emergent services received in a Hospital emergency room and stabilization care received after an Emergency.

Explanation of Benefits

Behavioral Health. Mental Health and Chemical Dependency services require Preauthorization through the PacifiCare Behavioral Health line, which is available 24 hours a day at 1-800-577-7244 or 1-800-221-2832 (TTY).

Supplemental Benefits. If the Subscriber's Health Plan includes Supplemental Benefits (except prescription drugs), those benefits are available to a Member enrolled in this Out-of-Area Child/Student Benefit.



SECTION SEVEN

Member Eligibility

The Out-of-Area Child/Student member must follow the provisions of the Supplemental Benefit for coverage to apply (i.e. Contracting Providers must be utilized, if so indicated).

Supplemental Prescription Drug Benefits. If the Subscriber's Health Plan includes a Supplemental Prescription Drug Benefit, then the Out-of-Area Child/Student Member will have the same level of benefit coverage as the Subscriber. If a Participating Pharmacy is not available, they may purchase the Prescription at any pharmacy and send the bill to PacifiCare for reimbursement. All Supplemental Benefit exclusions and limitations apply.

When Coverage Begins

When can you join (enroll)? Out-of-Area Child/Student Dependents can change to Out-of-Area status at anytime, which will become effective the first of the following month. Out-of-Area Students must enroll within 30 days of starting classes.

How do you enroll? Call the PacifiCare Customer Service department. They will assist you in filling out an Enrollment/Change Form.

Can an Out-of-Area Child/Student Dependent return to standard coverage? Yes. If a child or student moves back into the PacifiCare Geographic Service Area, he/she can change their coverage back to the standard provisions of this Agreement. Please call the PacifiCare Customer Service department for assistance. If a student chooses to do this on a break from school, the student must re-enroll as an Out-of-Area child/Student Dependent within 30 days of beginning their studies for the Out-of-Area Child/Student Dependent Coverage to resume.

When does your coverage begin (Effective Date)? Coverage for Out-of-Area Child/Student Dependent begins the first day of the month after they request the change in coverage. Coverage for Out-of-Area Child/Student Dependents begins the first day of the month in which the academic institution in which they are enrolled commences classes, or when the Out-of-Area Child/Student Dependent moves back to college. If Out of Area coverage is changed back to standard coverage, standard coverage is effective the first day of the month after the change is requested.

Payment for Services

Copayments and Coinsurance. The Copayment and Coinsurance levels are those listed on the Subscriber's *Schedule of Benefits*. Copayments or Coinsurance may be due to the Provider at the time of service or the Provider may choose to bill after services are provided.

What to Do if You Receive a Bill

PacifiCare may not contract with the Providers an Out-of-Area Child/Student selects in those instances, therefore, Out-of-Area Child/Student may receive a bill each time a service is provided. These bills should be submitted to PacifiCare within one year of the date the service was provided.

Once PacifiCare receives a bill, PacifiCare will pay you or the Provider the Usual, Customary and Reasonable charges. The Copayment or Coinsurance plus any unpaid balance are the responsibility of the Out-of-Area Child/Student.

When Coverage Ends

Why Coverage Ends

Voluntary Termination for a Change in Primary Residence does not apply to Out-of-Area Child/Student Dependents.

Loss of Eligibility

1. *Limiting Age of Student Dependents.* Eligibility for a Student Dependent will terminate on the last day of the month in which a Student Dependent reaches the Limiting Age.
2. *Academic Disenrollment of Student Dependents.* Eligibility for Student Dependents will continue through scheduled breaks between academic sessions, provided the Student Dependent intends to return to an Academic Institution. If the Student Dependent did not return to an Academic Institution, the Eligibility of the Student Dependent will be terminated retroactively to the end of the month in which they were last enrolled in a qualified institution.

Continuing Coverage for Certain Incapacitated 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:



Member Eligibility

1. The unmarried Dependent is incapable of self-sustaining employment by reason of mental retardation or physical handicap;
2. The unmarried Dependent is chiefly dependent upon the Subscriber for support and maintenance; and
3. The mental or physical condition existed continuously prior to reaching the Limiting Age.

In order to continue coverage under this Section for qualifying incapacitated Dependents, proof of such disability and dependency must be provided to PacifiCare by the Member upon 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 Practitioner to the effect that such disabled Dependent is incapable of self-sustaining employment by reason of mental retardation or physical handicap.

Out-of-Area Subscriber Benefit

The Plan will provide benefits as stated below for Out-of-Area Subscribers and their Dependents enrolled through a group plan only. Conversion or Package plan Members are not eligible for these benefits. Out-of-Area Subscribers live in the United States of America, but neither work nor reside within PacifiCare's Service Area. Out-of-Area Subscriber are not required to select a Primary Care Practitioner.

The Out-of-Area Subscriber must satisfy a separate Deductible and Copayment/Coinsurance Maximum amount. Once the Deductible is met for the Year, covered benefits are paid at 80 percent of the Eligible Charges until the Copayment/Coinsurance Maximum is reached.

The Out-of-Area Subscriber must pay the Deductible amount shown in the *Schedule of Benefits* for covered expenses incurred in each Year that are payable under the Out-of-Area Subscriber benefits. Any Deductible amounts satisfied during the fourth quarter of a Year (October, November, and December) will be carried over and applied toward the Deductible for the next year. The Deductible and charges above Eligible Charges do not apply to the Out-of-Pocket Maximum.

- Individual Deductible – Each Out-of-Area Subscriber must satisfy the Out-of-Area Deductible shown in the *Schedule of Benefits*.
- Family Deductible – The Family Deductible is equivalent to three (3) times the Individual Deductible amount. Covered expense apply to the Family Deductible for each covered Family Member up to the Individual Deductible amount.

Copayment/Coinsurance Maximum

The Plan limits the amount of Copayment or Coinsurance expenses paid by the Out-of-Area Subscribers in each Year for Copayments and Coinsurance of Covered Services. This amount is called the Copayment/Coinsurance Maximum. See the *Schedule of Benefits* for specific amounts.

Once the Member reaches the Copayment/Coinsurance Maximum amount, any required Copayments and Coinsurance for benefits subject to the Copayment/Coinsurance Maximum amount are waived for the rest of the Year. The Out-of-Area Subscriber Deductible does not apply to the Copayment/Coinsurance Maximum. Copayments and Coinsurance for Supplemental Benefits do not count toward the Copayment/Coinsurance Maximum. You must continue to pay Copayments or Coinsurance for Supplemental Benefits even after the Copayment/Coinsurance Maximum has been reached.

Preauthorization for Surgeries and Inpatient Stays

Before a hospitalization or outpatient surgery the Out-of-Area Subscriber or the Out-of-Area Subscribers Provider must notify PacifiCare in advance. The only exceptions are for Emergencies. PacifiCare asks that the Member or the Member's Provider notify PacifiCare at least ten (10) days before the surgery or admission to the medical facility. **If PacifiCare is not notified at least twelve (12) hours before the surgery or admission, the services will not be covered.** To notify PacifiCare, call 1-800-932-3004 and give the following information:

- the patient's name;
- the Provider's name;
- the diagnosis and procedure;
- the name of the medical facility;
- for inpatient care, the scheduled admission date and the expected length of stay;
- for outpatient surgeries, the scheduled date of service.



SECTION SEVEN

Member Eligibility

Behavioral Health Benefits

All services, except Emergencies, require Preauthorization to be covered. To obtain Preauthorization, call the PacifiCare Behavioral Health Line, a 24-hour, toll-free number at 1-800-577-7244 or TTY 1-800-221-2832.

Preauthorization does NOT entitle you to additional coverage if you have reached your Behavioral Health Maximum. Please refer to the *Schedule of Benefits* for coverage specifications including dollar and day/visit limitations.

Out-of-Area Subscribers are not required to use PacifiCare Behavioral Health Plan Providers; however, Out-of-Area Subscribers are still required to Preauthorize care.

Pharmacy

If the employer has purchased the “Supplemental Outpatient Prescription Drug Benefit” then PacifiCare has a well-established network of pharmacies for the Members to access. An Out-of-Area Subscriber should have prescriptions filled at a contracted Pharmacy. The Member must show a PacifiCare identification card and pay the appropriate Copayment or Coinsurance amount for each prescription filled.

If a participating Pharmacy is not available and the Member utilizes a Non-Participating Pharmacy, the prescription must be paid in full at the time of the services and the Member will need to submit a claim to PacifiCare for reimbursement. PacifiCare will need a complete prescription drug claim form.

Emergency Care

Emergency Care is covered. Medical or Hospital Services provided or recommended by an Out-of-Plan Provider, which do not qualify as Emergency Services, will not be covered unless precertified. This includes non-emergent services received in a Hospital emergency room and stabilization care received after an Emergency.

Explanation of Benefits

Behavioral Health. Mental Health and Chemical Dependency services require Preauthorization through the PacifiCare Behavioral Health line, which is available 24 hours a day at 1-800-577-7244 or 1-800-221-2832 (TTY).

Supplemental Benefits. If the Subscriber’s Health Plan includes Supplemental Benefits (except prescription drugs), those benefits are available to a Member enrolled in this Out-of-Area Subscriber Benefit. The Out-of-Area Child/Student Member must follow

the provisions of the Supplemental Benefit for coverage to apply (i.e. Contracting Providers must be utilized, if so indicated).

Supplemental Prescription Drug Benefits. If the Subscriber’s Health Plan includes a Supplemental Prescription Drug Benefit, then the Out-of-Area Subscriber Member will have the same level of benefit coverage as the Subscriber. If a Participating Pharmacy is not available, they may purchase the Prescription at any pharmacy and send the bill to PacifiCare for reimbursement. All Supplemental Benefit exclusions and limitations apply.

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

An employee who declines to enroll as a Subscriber when newly eligible may be eligible for enrollment if the employee adds a new Dependent as a result of marriage, birth, adoption or placement for adoption. The employee must request enrollment as the Subscriber and for any Dependents within thirty-one (31) days of the marriage, birth, adoption or placement for adoption.

2. The other health care coverage is no longer available due to:
 - i. The employee or eligible Family Member has exhausted COBRA continuation coverage under another group health plan; or
 - ii. The termination of employment or reduction in work hours of a person through whom the employee or eligible Family Member was covered; or
 - iii. The termination of the other health plan coverage; or
 - iv. The cessation of an employer’s contribution toward the employee or eligible Family Member coverage; or



Member Eligibility

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

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.

When Coverage Begins

The date coverage under this Plan begins is called the “effective date.” The effective dates for an eligible Subscriber and Dependents who enroll during the required enrollment period stated in “Enrollment” are as follows:

- For new Subscribers and enrolled Dependents, the effective date is the date described in the Agreement. This date is also shown on the Member’s PacifiCare ID card.
- For a Dependent who becomes eligible after the Subscriber’s effective date, the effective date is the date the Dependent first became eligible shown in “Enrollment.”
- For Subscribers and Dependents who be ineligible for other health plan coverage offered through the Group because of a move out of the Service Area of the other health plan, the effective date is the date of the move.
- For Subscribers and Dependents who become eligible for special enrollment, the effective date of coverage is as follows:
 - Due to the Subscriber’s marriage, on the first day of the month following the date the completed request for enrollment is received.
 - Due to the birth of a Dependent, the effective date is the date of birth.
 - Due to the adoption or placement for adoption of a Dependent with the Subscriber, on the date of the adoption or placement for adoption.

Newborn Coverage. Washington law requires the Plan to provide coverage to newborns under the Mother’s coverage for the first three weeks of life. The mandatory coverage provision does not necessary qualify the newborn for enrollment under the Plan. When the eligibility requirements stated in “Who Is Eligible” are met, the newborn will be eligible for enrollment under the Plan effective as of the date of birth. Continuation coverage options under the Plan are available only to Members who meet eligibility requirements and are enrolled in the Plan. If the Newborn’s coverage requires additional premium, coverage will continue beyond 21 days after the date of birth, only upon submission or notification to PacifiCare within 60 days from the date of birth. If a newborn is hospitalized on the date coverage would otherwise terminate (after 21 days), the newborn will only continue to be eligible for Covered Services through discharge if the mother is covered by this contract, the newborn meets the eligibility requirements of the plan, **and** is enrolled.

Notifying You of Changes in Your Plan

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

Updating Your Enrollment Information

Please notify your employer 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 Practitioner or Participating Medical Group, you may contact PacifiCare’s Customer Service department at 1-800-932-3004 or 1-800-786-7387(TDHI). Please notify PacifiCare’s Customer Service if you have an address or phone number change so we can keep in touch with you.



Renewal and Reinstatement

Your Employer Group's Group Agreement with PacifiCare renews automatically, on a yearly basis, subject to all terms of the Group Agreement. If the Group Agreement is terminated by PacifiCare, reinstatement is subject to all terms and conditions of the Group Agreement.

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. Coverage can be terminated, however, because of other circumstances as well, which are described below.

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

When the Group Agreement between the Employer Group and PacifiCare is terminated, all Members covered under the Group Agreement become ineligible for coverage on the date of termination. If the Group Agreement is terminated by PacifiCare for nonpayment of Premiums, coverage for all Members covered under the Group Agreement will be terminated effective the last day for which premiums were received. According to the terms of the Group Agreement, the Employer Group is responsible for notifying you if and when the Group Agreement is terminated 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.

Termination for Cause

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

- **Failure to Pay.** Your coverage may be terminated if you fail to pay any required Copayments, Coinsurance, or charges owed to the Contracting Medical Group or PacifiCare.
- **Fraud or Misrepresentation.** Your coverage may be terminated if you knowingly provide false information (or misrepresent a meaningful fact) on your enrollment form, claim form or related document that affects the Members eligibility for coverage or benefits or fraudulently or deceptively use services or facilities of PacifiCare, its Contracting Medical Group or other health care Practitioners (or knowingly allow

another person to do the same), including altering a prescription. Claims benefits for which no care, service, or supply was received or obtains Covered Services or supplies by means of false or misleading statements.

Termination because of Failure to Pay may, at PacifiCare's sole discretion, cause the Member's coverage to be terminated retroactively either to the date the event occurred or to the Member's effective date. In such cases, premiums, less any claim payments, will be refunded. Termination due to fraud or misrepresentation will be the end of the month following thirty (30) days after the date of PacifiCare's notice of termination to the Member. If coverage is terminated for either 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.

If a Member's coverage is terminated retroactively to its effective date, PacifiCare treats the Member as if the Member had never been covered under this Plan. The Member is not eligible for any continuation of coverage or conversion to an individual plan described in this *Combined Evidence of Coverage and Disclosure Form*. If the Member disagrees with PacifiCare's decision to cancel coverage, the Member has the right to appeal as described in "How to Appeal" in this *Combined Evidence of Coverage and Disclosure Form*.

Upon termination, the Member will be issued a Certificate of Group Health Plan Coverage, either by PacifiCare or the Member's employer. This certificate may be used to provide evidence of prior health plan coverage, if needed by the Member's new health plan. The Member may use the information on the Certificate of Group Health Plan Coverage to reduce or eliminate a pre-existing exclusion period with another insurance carrier.

Self-Payment During Labor Dispute

If the Member's compensation is suspended directly or indirectly as a result of a strike, lockout or other labor dispute, the Member may pay premium for themselves and eligible Dependents directly to the Group for up to six (6) months. See "Conversion Plan Coverage" for continued health care coverage when the six-month period ends.

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



Member Eligibility

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. 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.

Coverage Options Following Termination

If your coverage through this *EOC* 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.

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 the termination of your employment (for reasons other than gross misconduct on your part) or the reduction of hours of employment to less than the number of hours required for eligibility.

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 for any of the following four reasons:

1. The death of your Spouse;
2. A termination of your Spouse's employment (for reasons other than gross misconduct) or reduction in your Spouse's hours of employment to less than the number of hours required for eligibility;
3. Divorce or legal separation from your Spouse; or
4. Your Spouse becomes entitled to Medicare.

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 for any of the following five reasons:

1. The death of the Subscriber;
2. A termination of the Subscriber's employment (for reasons other than gross misconduct) or reduction in the Subscriber's hours of employment to less than the number of hours required for eligibility;
3. The Subscriber's divorce or legal separation;
4. The Subscriber becomes entitled to Medicare; or
5. The Dependent child ceases to be a Dependent eligible for coverage under this Health Plan.

Under COBRA, the Subscriber or enrolled Family Member has the responsibility to inform the Employer Group (or, if applicable, its COBRA administrator) of a divorce, legal separation, or a child losing dependent status under the Health Plan within 60 days of the date of the event. Your Employer Group has the responsibility to notify its COBRA administrator of the Subscriber's death, termination, reduction in hours of employment or Medicare entitlement. Similar rights may apply to certain retirees, spouses and dependent children if your employer commences a bankruptcy proceeding and these individuals lose coverage.

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



SECTION SEVEN

Member Eligibility

If you do not choose continuation coverage on a timely basis, your group health insurance coverage under this Health Plan will end.

If you choose continuation coverage, your Employer Group is required to give you coverage which, as of the time coverage is being provided, is identical to the coverage provided under the plan to similarly situated employees or family members. COBRA permits you to maintain continuation coverage for 36 months, unless you lost group health coverage because of a termination of employment or reduction in hours. In that case, the required continuation coverage period is 18 months. This initial 18-month period may be extended for affected individuals up to 36 months from termination of employment if other events (such as a death, divorce, legal separation or Medicare entitlement) occur during that initial 18-month period. In addition, the initial 18-month period may be extended up to 29 months if you are determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage. Please contact your Employer Group or its COBRA administrator for more information regarding the applicable length of COBRA continuation coverage available.

A child who is born to or placed for adoption with the Subscriber during a period of COBRA continuation coverage will be eligible to enroll as a COBRA-qualified beneficiary. These COBRA-qualified beneficiaries can be added to COBRA continuation coverage upon proper notification to the Employer Group or COBRA administrator of the birth or adoption.

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

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.

Under the law, you may have to pay all of the premium for your continuation coverage. Premiums for COBRA continuation coverage is generally 102% of the applicable Health Plan Premium. However, if you are on a disability extension, your cost will be 150% of the applicable Premium. You are responsible for the timely submission of the COBRA premium to the Employer Group or COBRA administrator. Your Employer Group or COBRA administrator is responsible for the timely submission of Premium to PacifiCare. At the end of the 18-month, 29-month or 36-month continuation coverage period, qualified beneficiaries 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 any questions about COBRA, please contact your Employer Group.

Extending Your Coverage: Converting to an Individual Conversion Plan

If you have been enrolled in this Health Plan 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;
3. You knowingly furnished incorrect information or otherwise improperly obtained benefits of the Health Plan;



Member Eligibility

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. No physical exam, statement of health, or other proof of insurability is needed.

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 and applicable premium payment for all conversions must be received by PacifiCare within 31 days of the loss of group coverage. If you elect our conversion plan it may affect your future ability to purchase an individual plan. For more details, please contact our Customer Service department.

Certificate of Creditable Coverage

According to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), a Certificate of Creditable Coverage will be provided to the Subscriber by either PacifiCare or the Employer Group when the Subscriber or a Dependent ceases to be eligible for benefits under the employer's health benefit plan. A Certificate of Creditable Coverage may be used to reduce or eliminate a preexisting 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. Please contact the PacifiCare Customer Service department if you need a duplicate Certificate of Creditable Coverage.

Uniformed Services Employment and Reemployment Rights Act

Continuation of Benefits Under USERRA.

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

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

The Health Plan Premium for USERRA Continuation of benefits is the same as the Health Plan Premium for other PacifiCare Members enrolled through your employer plus a 2% additional surcharge or administrative fee, not to exceed 102% 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.

**Qualified Medical Child Support Order**

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

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

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



Overseeing Your Health Care

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

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

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

How PacifiCare Makes Important Health Care Decisions

Authorization, Modification and Denial of Health Care Services

PacifiCare and our Participating Medical Groups have established processes to review, approve, modify or deny requests by Practitioners for authorization of the provision of health care services to Members based on Medical Necessity. PacifiCare and our Participating Medical Groups may use criteria or guidelines based on Medical Necessity to reach a determination. Any criteria or guidelines used to modify or deny requested health care services in specific types of cases will be disclosed to the Member, the Practitioner 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 Practitioners or other appropriately licensed health care professionals. At a minimum, PacifiCare and our Participating Medical Groups make these decisions within 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 Member's condition. Decisions will be made within a time frame that does not exceed 5 business days from either PacifiCare's or the Participating Medical Group's receipt of any reasonably necessary and requested information.
 - 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 to the Member's life or health or jeopardize his or her ability to regain maximum function), the decision will be made in a timely fashion appropriate for the Member's condition. Decisions will be made within a time frame that does not exceed 72 hours from either PacifiCare's or the Participating Medical Group's receipt of any reasonably necessary and requested information.
- PacifiCare or the Participating Medical Group will notify the Practitioner and the Member in writing when a decision cannot be made within the required time frame for any of the following reasons:
- PacifiCare or the Participating Medical Group is not in receipt of all of the information reasonably necessary and requested;
 - PacifiCare or the Participating Medical Group requires consultation by an expert reviewer; or
 - PacifiCare or the Participating Medical Group has asked an additional examination or test, provided the examination or test is reasonable and consistent with good medical practice.
- The notification will specify the information requested but not received, or the additional examinations or tests required. It will also include the anticipated date by which a decision will be rendered. Upon receipt of all information reasonably necessary and requested by PacifiCare or the Participating Medical Group, either PacifiCare or the Participating Medical Group will approve, modify or deny the request for authorization within the applicable time frame specified above.
- At a minimum, PacifiCare and our Participating Medical Groups notify requesting Practitioners of a decision to approve, modify or deny a request for the authorization of health care services within 24 hours of the decision. Members are notified of decisions to deny, delay or modify requested health care services in writing within 2 business days of the decision. This notification will include a description of the reasons for the decision,



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Overseeing Your Health Care

the criteria or guidelines used, the clinical reasons for decisions regarding Medical Necessity, and information about how to file an appeal of the decision with PacifiCare. PacifiCare's Appeals Process is outlined later in this section.

A copy of PacifiCare's policies and procedures may be requested, as well as a description of the processes used for the authorization, modification or denial of health care services. Copies of PacifiCare's criteria or guidelines are also available. Please contact the Customer Service department at 1-800-932-3004.

PacifiCare's Utilization Management Policy

PacifiCare distributes its policy on financial incentives to all its Participating Practitioners, Members and employees. PacifiCare also requires that Participating Practitioners and staff who make utilization decisions, and those who supervise them, sign a document acknowledging receipt of this policy. The policy affirms that a utilization management decision is based solely on the appropriateness of a given treatment and service, as well as the existence of coverage. PacifiCare does not specifically reward Participating Practitioners 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.

Utilization Criteria

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

- InterQual® Criteria (Nationally published criteria for utilization management.)
- HCIA-Sachs Length of Stay® Guidelines (Average length of hospital stays by medical or surgical diagnoses);
- PacifiCare Technology Assessment Guidelines (TAG) and Benefit Interpretation Policies (BIP);

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

Denial, delay or modification of health care services based on Medical Necessity must be made by a licensed Practitioner or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the Practitioner.

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

Preauthorization determinations are made once the Member's Participating Medical Group Medical Director or designee receives all reasonably necessary medical information. PacifiCare makes timely and appropriate initial determinations based on the nature of the Member's medical condition in compliance with State and Federal Requirements. Member agree that their Provider will be their "authorized representative" (pursuant to ERISA) regarding receipt of approvals or request for health care services for purposes of medical management.

Assessment of New Technologies

PacifiCare regularly reviews new procedures, devices and drugs to determine whether or not they are safe and effective for our Members. The Technology Assessment and Guideline Committee – consisting of PacifiCare Medical Directors, Primary Care Practitioners, pharmacists and specialists – conducts careful reviews of case studies, clinical literature, and opinions of review organizations, such as ECRI (formerly the Emergency Care Research Institute), the Health Technology Assessment Information Service, the HAYES New Technology Summaries, the Agency for Health Care Policy and Research, Medicare, and Federal Drug Administration decisions.

What to Do if You Have a Problem

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

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



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If you feel that we haven't assisted you or that your situation requires additional action, you may also request a formal Appeal or Quality Review. To learn more about this, read the following section, "Appealing a Health Care Decision."

Appealing a Health Care Decision (How to Appeal)

Pre-Service Determination

If PacifiCare makes a pre-service adverse determination the Member or Member representative can appeal the determination in writing. PacifiCare will reconsider the adverse determination and notify the Member in writing fourteen (14) calendar days of receipt of the appeal unless PacifiCare notifies the Member that an extension is necessary to complete the appeal. The extension can not delay the decision beyond thirty (30) days of the request for appeal, without the written consent of the Member.

Post-Service Determination

The Member has the right to appeal any decision of PacifiCare to deny all or part of a claim for services. Requests for an appeal must be submitted in writing within one hundred eighty (180) days from the date the Member is notified of the denial by PacifiCare. PacifiCare will notify the Member of its decision within thirty (30) days of receiving the written complaint or request for review. PacifiCare's written response will include the reasons for its decision. If PacifiCare upholds a prior decision to deny the claim, PacifiCare will also tell the Member the Plan provisions on which the decision is based.

The written request must contain: the Member's name, social security number, the issue to be reviewed, and any data, documents or comments supporting the Member's argument. The request should be submitted to:

PacifiCare of Washington
Customer Service Center
P.O. Box 6092
Cypress, CA 90630
Fax number 1-800-617-2039

You may appoint someone to file an appeal on your behalf. The Member's request must include the name of the person the Member designates to act for the Member, the Member's name (printed), signature and the date. The written request must also clearly describe

the complaint on which the individual will act for the Member. Once PacifiCare has received the written request for appeal, the Member or the appointed representative may review pertinent documents at PacifiCare's office during normal work hours. The Member may also submit issues and comments. For expedited appeals, PacifiCare will accept requests both verbally or in writing.

Voluntary Second Level Appeal for Pre-Service and Post-Service Claims

If the Member does not agree with PacifiCare's reconsideration decision, the Member may write and ask for a hearing before a panel from PacifiCare's Appeals and Grievance Committee. This panel will not include any reviewers who made the initial decision. The Member and appointed representative have the right to present the case to the panel in person. The Member must request the in-person review at the time of the written request for a second level review.

At any point, the Member has the right to send the complaint to the State Insurance Commissioner's Office. Include a copy of PacifiCare's decision. None of these steps stops the Member from taking the case to a civil court. If the Member is not satisfied with the outcome of the review at any level.

Quality of Care Review

All quality of care complaints requiring clinical review are reviewed by PacifiCare's Medical Management department. Complaints affecting your immediate condition are reviewed immediately. PacifiCare conducts this review by investigating the complaint and consulting with your Participating Medical Group, treating Practitioners, and other PacifiCare departments. We also review medical records as necessary, and you may need to sign an authorization to release your medical records.

We will notify you in writing regarding your quality of care review. The results of the quality of care review are confidential and protected from legal discovery in accordance with Washington law.

The Appeals Process

Complaints that are not related to quality of care are handled through our appeals process. PacifiCare's clinical review personnel generally conduct the first review of appeals. Our initial appeal determination is sent to you within 30 days of PacifiCare's receipt of an



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appeal and will include an explanation of the reasons for our decision. Other information is included in the following circumstances:

- For appeals involving the delay, denial or modification of health care services based on a finding that the services are not Medically Necessary in whole or in part, PacifiCare's written response will describe the criteria or guidelines used and the clinical reasons for our determination, including all criteria and clinical reasons related to Medical Necessity.
- For appeals involving the delay, denial or modification of health care services based on a finding that the requested services are not Covered Services, PacifiCare's written response will specify the provisions in the *Combined Evidence of Coverage and Disclosure Form* or supplemental materials that exclude coverage.

Expedited Review Process

Appeals involving an imminent and serious threat to your health, including, but not limited to, severe pain or the potential loss of life, limb or major bodily function will be immediately referred to PacifiCare's clinical review personnel. If your case does not meet the criteria for an expedited review, it will be reviewed under the standard appeal process. If your appeal requires expedited review, PacifiCare will immediately inform you in writing of your review status and your right to notify. When PacifiCare makes an adverse determination for Preauthorized services or Experimental and Investigational services and the Member or the Member's treating Provider determines that a delay would jeopardize the Member's life or materially jeopardize the Member's health, PacifiCare will expedite and process either a written or an oral appeal and issue a decision no later than seventy-two (72) hours after a receipt of the appeal.

Appeals of pre-service denials and experimental and investigational services shall be evaluated by health care Practitioners who were not involved in the initial decision and who have appropriate expertise in the field of medicine that encompasses the covered Member's condition or disease.

All appeals must include a review of all relevant information submitted by the covered Member or a Practitioner acting on behalf of the covered Member.

PacifiCare shall issue to affected parties and to any Practitioner acting on behalf of the covered Member a written notification of the adverse determination that

includes the actual reasons for the determination, the instructions for obtaining an appeal of PacifiCare's decision, a written statement of the clinical rationale for the decision, and instructions for obtaining the clinical review criteria used to make the determination.

Non-Binding Arbitration

The Member has the right to submit to arbitration under the commercial mediation rules of the Judicial Arbitration and Mediation Systems. There is no charge to the Member for this service, however, the decision is not binding to either party.

You may submit your request to:

PacifiCare Appeal and Grievance Unit
P.O. Box 6092
Cypress, CA 90630
1-800-932-3004

Experimental or Investigational Treatment

If PacifiCare makes an adverse determination for Experimental and Investigational services the Member or Member representative may appeal the determination. PacifiCare will reconsider the adverse determination and notify the Member in writing within twenty (20) working days of receipt of the appeal unless PacifiCare notifies the Member that an extension is necessary to complete the appeal. The 20-day period may be extended, but only with the Member's written consent. PacifiCare's notice will explain the basis for the denial and how the Member can send PacifiCare a request to review its decision.

External Independent Review

PacifiCare offers an external independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge for PacifiCare Members after exhausting the carrier's grievance process and receiving a decision that is unfavorable or if PacifiCare fails to respond to the grievance within the time lines stated above in the appeals section.

You may request an external review of PacifiCare's denial of the requested service or procedure or denial of payment for the service or procedure. If you request an external review, the denial will be reviewed by an independent Practitioner or practitioner who is not



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affiliated with PacifiCare. You will have an opportunity to submit whatever information you believe is relevant to your request. However, neither you nor PacifiCare will have an opportunity to meet with the reviewer or otherwise participate in the reviewer's decision.

All requests for an external review must be made within one hundred eighty (180) calendar days of the date you receive PacifiCare's denial. You, your practitioner, or your designated representative may request an external review by PacifiCare's Customer Service department at 1-800-932-3004 or by sending a written request to:

PacifiCare of Washington
Customer Service Center
P.O. Box 6092
Cypress, CA 90630-0092

An External Independent Review (EIR) Coordinator will be designated to address any questions you might have and to assist you with the external independent review process.

The external review will be performed by an independent Practitioner or Provider who is qualified to decide whether the requested service or procedure is or is not Medically Necessary, as defined in the *EOC*. The Independent Review Organization (IRO) has been contracted by the State of Washington Department of Health, and has no material affiliation or interest with PacifiCare. Neither you nor PacifiCare will choose or control the choice of reviewer. In certain cases, the external review will be performed by a panel of Practitioners or practitioners, as deemed appropriate by the IRO.

Within three (3) business days of PacifiCare's receipt of your request for external review, PacifiCare will forward the request to the IRO, together with (i) all relevant medical records; (ii) all other documents relied upon by PacifiCare in making a decision on your case; and (iii) all other information or evidence that you or your practitioner have already submitted to PacifiCare. If there is any information or evidence you or your practitioner wish to submit in support of your request for coverage of the service or procedure that has not previously been provided to PacifiCare, you may include this information with your request to PacifiCare for an

external review, and PacifiCare will include it with the documents forwarded to the IRO. A decision will be made within twenty-five (25) calendar days. If the reviewer needs additional information to make a decision, this time period may be extended.

The external review process will also be expedited if you meet all of the criteria for external review and your practitioner certifies that the requested service or procedure would be significantly less effective if not promptly initiated. A decision will be made within eight (8) business days of the request for expedited review. If the reviewer needs additional information to make a decision, this time period may be extended.

The reviewer's decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and PacifiCare with the reviewer's decision, a description of the qualifications of the reviewer, and any other information deemed appropriate by the organization.

If the final external decision is to approve payment or referral, PacifiCare will accept the decision and provide coverage for such service or procedure in accordance with the terms and conditions of your PacifiCare Health Plan.

If the final external review decision is that payment or referral will not be made, PacifiCare will not be obligated to provide coverage for the service or procedure.

Members or Practitioners who want additional information about PacifiCare's external, independent review process may call PacifiCare's Customer Service department.

Complaints Against Participating Medical Groups, Practitioners, Practitioners and Hospitals

Claims against a Participating Medical Group, the group's Practitioners, or Practitioners, Practitioners 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.



SECTION EIGHT

Overseeing Your Health Care

In the event of a dispute between you and a Participating Medical Group (or one of its Participating Practitioners) 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 non-binding arbitration except upon agreement between the parties. Should the parties fail to resolve the grievance, you or the Participating Medical Group (or its Participating Practitioner) may seek any appropriate legal action deemed necessary. Member claims against PacifiCare will be handled as discussed above under “Appealing a Health Care Decision.”



General Information

- How to Replace Your Card
- Translation Assistance
- Speech and Hearing Impaired Assistance
- Coverage in Extraordinary Situations
- Compensation for Practitioners
- Organ and Tissue Donation
- Public Policy Participation

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

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

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

Does PacifiCare offer a translation service?

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

Does PacifiCare offer hearing and speech impaired telephone lines?

PacifiCare has a dedicated telephone number for the hearing and speech impaired. This phone number is 1-800-786-7387.

How is my coverage provided under extraordinary circumstances?

There are circumstances not reasonably within the control of PacifiCare, such as major disasters, epidemics, complete or partial destruction of facilities, wars, riots or civil insurrection, which results in the unavailability of PacifiCare, its personnel, facilities, or the Participating Medical Group. In such situations, PacifiCare, the Participating Medical Group and facilities shall provide or attempt to arrange for medical and hospital services insofar as practical, according to their best judgment, within the limitation of such facilities and personnel. Neither PacifiCare nor any Participating Medical Group shall have any liability or obligation for delay or failure to provide or arrange for medical and hospital services

if such delay or failure is the result of any of the circumstances described above.

How does PacifiCare compensate its Participating Practitioners?

PacifiCare itself is not a practitioner of health care. PacifiCare typically contracts with independent medical groups to provide medical services to its Members, and with hospitals to provide hospital services. Once they are contracted, they become PacifiCare Participating Practitioners.

Participating Medical Groups in turn employ or contract with individual Practitioners. None of the Participating Medical Groups or Participating Hospitals, or their Practitioners or employees, are employees or agents of PacifiCare. Likewise, neither PacifiCare nor any employee of PacifiCare is an employee or agent of any Participating Medical Group, Participating Hospital or any other Participating Practitioner.

Most of our Participating Medical Groups receive an agreed-upon monthly payment from PacifiCare to provide services to our Members. This monthly payment may be either a fixed dollar amount for each Member or a percentage of the monthly premium received by PacifiCare. The monthly payment typically covers professional services directly provided, or referred and authorized, by the Participating Medical Group.

Some of PacifiCare's Participating Hospitals receive similar monthly payments in return for providing Hospital Services for Members. Other Participating Hospitals are paid on a discounted fee-for-service or fixed charge per day of hospitalization. Most acute care, Subacute and Transitional Care, and Skilled Nursing Facilities are paid on a fixed charge per day basis for inpatient care.

At the beginning of each year, PacifiCare and its Participating Medical Groups agree on a budget for the cost of services for all PacifiCare Members assigned to the Participating Medical Group. At the end of the year, the actual cost of services for the year is compared to the agreed-upon budget. If the actual cost of services is less than the agreed-upon budget, the Participating Medical Group shares in the savings.

The Participating Hospital and Participating Medical Group typically participate in programs for hospital services similar to what is described above.



SECTION NINE

General Information

Stop-loss insurance protects Participating Medical Groups and Participating Hospitals from large financial expenses for health care services. PacifiCare provides stop-loss protection to our Participating Medical Groups and Participating Hospitals that receive the monthly payments described above. If any Participating Hospital or Participating Medical Group does not obtain stop-loss protection from PacifiCare, it must obtain stop-loss insurance acceptable to PacifiCare.

PacifiCare arranges with additional Practitioners or their representatives for the provision of Covered Services that cannot be performed by your assigned Participating Medical Group or Participating Hospital. Such services include authorized Covered Services that require a specialist not available through your Participating Medical Group or Participating Hospital, or Emergency and Urgently Needed Services. PacifiCare or your Participating Medical Group pays these Practitioners at the lesser of the Practitioner's reasonable charges or agreed to rates. Your responsibility for Covered Services received from these Practitioners is limited to payment of applicable Copayments. (For more about Copayments, see "Section Six: Payment Responsibility.")

How do I become an organ and tissue donor?

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

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

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

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

How can I learn more about being an organ and tissue donor?

To get your donor card and information on organ and tissue donation call 1-800-355-SHARE or 1-800-633-6562. You can also request donor information from your local Department of Motor Vehicles (DMV).

On the Internet, contact:

- All About Transplantation and Donation (www.transweb.org)
- Dept. of Health and Human Services (www.organdonor.gov)
- Once you get a donor card, be sure to sign it in your family's presence. Have your family sign as witnesses and pledge to carry out your wishes, then keep the card with you at all times where it can be easily found.

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



Definitions

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

Adverse Determination and Noncertification A decision by a health carrier to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits, including the admission to or continued stay in a facility. Such term does not include a decision affecting payment or coverage after the service or benefit has been provided.

Alternative Practitioner A practitioner licensed by the state of Washington under Title 18, to practice health care consistent with state law who has contracted with the Plan to provide services which are within the Alternative Practitioners' permitted scope of practice. Alternative Providers include, but are not limited to Podiatrists, Chiropractors, Naturopaths, Acupuncturists, Massage Therapists, Physicians Assistants, ARNP's and Registered Nurses.

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.

Certificate of Health Coverage A Certificate of Coverage that provides evidence of prior health plan coverage, under the Health Insurance Portability and Accountability Act. All Members terminating coverage under the Plan are entitled to receive a Certificate of Health Coverage.

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.

Clinical Review Criteria The written screening procedures, decision abstracts, clinical protocols, health care service management computer software, and practice guidelines used by PacifiCare to determine the necessity and appropriateness of health care services.

Coinsurance Some benefits of this Plan are not payable at 100 percent. For these benefits, "Coinsurance" is the percentage of the Eligible Charge that is the Member's responsibility. For example, if the Plan provides benefits for ambulance transport at 80 percent of the Eligible Charge, the other 20 percent is the Member's Coinsurance.

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

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

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

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

Custodial or Convalescent Care Care and services that assist an individual in the activities of daily living. Inpatient care that serves mainly to support self-care and provide room and board is convalescent care. 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 does not require the continuing attention of trained medical or paramedical personnel.



SECTION TEN

Definitions

Deductible The maximum dollar amount a Member and/or family is responsible for paying before benefits are payable under the Agreement. The Deductible amounts can be found on the *Schedule of Benefits*.

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.

Eligible Charge The amount of a Covered Service or supply on which the Plan bases its benefit payments. For a Plan Practitioner, the Eligible Charge is the amount that the practitioner has contracted to accept from PacifiCare as payment in full for Covered Services and supplies. For all other Practitioners, the Eligible Charge is the Usual, Customary, or Reasonable charge (UCR).

Emergency Medical Condition A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected by the Member to result in any of the following:

- placing the Member's health in serious jeopardy;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part;
- active labor, meaning labor at a time that either of the following would occur:
 1. there is inadequate time to effect safe transfer to another hospital prior to delivery or
 2. a transfer poses a threat to the health and safety of the Member or unborn child.

Emergency Services The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a Prudent Layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

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

ERISA The Employee Retirement Income Security Act (ERISA) of 1974 is 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.

Experimental or Investigational Defined in the "Exclusions and Limitations of Benefits" section of this *Combined Evidence of Coverage and Disclosure Form*.

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

Grievance Is a written or oral complaint submitted by or on behalf of a covered person regarding: (a) Denial of health care services or payment for health care services; (b) issues other than health care services or payment for health care services including dissatisfaction with health care services, delays in obtaining health care services, conflicts with carrier staff or practitioners; and dissatisfaction with carrier practices or actions unrelated to health care services.

Group Agreement The Medical and Hospital Group Subscriber Agreement entered into between PacifiCare and the employer, labor union, trust, organization, association or other entity through which you enroll for coverage. Documents detailing the arrangement include the *Group Subscriber Agreement*, *Schedule of Benefits*, *Evidence of Coverage and Disclosure Form*, application, any endorsement approved by the Plan and any supplemental benefits selected by the Group.

Health Care Services Services offered or provided by health care facilities and health care practitioners relating to the prevention, cure, or treatment of illness, injury or disease.

Health Plan Your benefit plan as described in this *Combined Evidence of Coverage and Disclosure Form*, *Schedule of Benefits*, and supplemental benefit materials.



Definitions

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 care giver and family of the Member receiving Hospice services.

Hospital An institution that is licensed by the state and, for compensation on behalf of its patients and on an inpatient basis, is primarily engaged in providing diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of the injured or ill by or under the supervision of a staff of Practitioners. Such institution also continuously provides 24-hour-a-day nursing service by or under the supervision of registered nurses; or is any other licensed institution with which PacifiCare has an agreement to render Hospital services.

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

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 Practitioner who is a Participating Practitioner as a cause of infertility.

Intermittent Services See definition for “Part Time or Intermittent Services.”

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

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

Medically Necessary (or Medical Necessity) refers to an intervention, if, as recommended by the treating Practitioner and determined by the Medical Director of PacifiCare or the Participating Medical Group, it is all of the following:

- a. A health intervention for the purpose of treating a medical condition;

- b. The most appropriate supply or level of service, considering potential benefits and harms to the Member;
- c. Known to be effective in improving health outcomes. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. For new interventions, effectiveness is determined by scientific evidence; and
- d. If more than one health intervention meets the requirements of (a) through (c) above, furnished in the most cost-effective manner that may be provided safely and effectively to the Member. “Cost-effective” does not necessarily mean lowest price.

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

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

- i. *Treating Practitioner* means a Practitioner who has personally evaluated the patient.
- ii. A *health intervention* is an item or service delivered or undertaken primarily to treat (that is, prevent, diagnose, detect, treat, or palliate) a medical condition or to maintain or restore functional ability. A medical condition is a disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation. A health intervention is defined not only by the intervention itself, but also by the medical condition and the patient indications for which it is being applied.
- iii. *Effective* means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
- iv. *Health outcomes* are outcomes that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person’s life.



- v. *Scientific evidence* consists primarily of controlled clinical trials that either directly or indirectly demonstrates the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential Experimental biases. For existing interventions, the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of Medical Necessity. If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the definition of Medical Necessity in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.
- vi. A *new intervention* is one that is not yet in widespread use for the medical condition and patient indications being considered. New interventions for which clinical trials have not been conducted because of epidemiological reasons (i.e. rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care. If professional standards of care do not exist, or are outdated or contradictory, decisions about such new interventions should be based on convincing expert opinion.
- vii. An intervention is considered *cost-effective* if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

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

Medicare Eligible Those Members that 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.

Non-Participating Practitioners A hospital or other health care entity, a Practitioner 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.

Out-of-Area Dependent A Dependent who is a full-time student at a school outside the Service Area and lives outside the Service Area and more than thirty (30) miles away from the nearest Primary Care Practitioner while at school.

Out-of-Area Member A Member who resides in the United States but outside the Service Area and more than thirty (30) miles away from the nearest available Primary Care Practitioner.

Out-of-Pocket Maximum The maximum amount of Copayments and/or Coinsurance a Member is required to pay for certain Covered Services in a Calendar Year. (Please refer to your *Schedule of Benefits*.)

PacifiCare PacifiCare of Washington, Incorporated, a company registered in Washington State as a health care service contractor.

Part-Time or Intermittent Services Skilled Rehabilitation Care, Skilled Nursing Care and home health aide services furnished any number of days per week as long as the cumulative total is less than 8 hours each day, and 28 or fewer hours each week.

Participating Hospital Any general acute care hospital licensed by the state of Washington that has entered into a written agreement with PacifiCare to provide Hospital Services to PacifiCare's Members.



Definitions

Participating Medical Group An independent practice association (IPA) or medical group of Practitioners that has entered into a written agreement with PacifiCare to provide Practitioner services to PacifiCare's Members. An IPA contracts with independent contractor Practitioners who work at different office sites. A medical group employs Practitioners who typically all work at one or several physical locations. Members using a Plan Medical Group for Covered Services and supplies will be billed only for any Deductible, Coinsurance and Copayment amounts required by the Plan.

Under certain circumstances, PacifiCare may also serve as the Member's Participating Medical Group. This includes, but is not limited to, when the Member's Primary Care Practitioner contracts directly with PacifiCare and there is no Participating Medical Group.

Participating Practitioner A hospital or other health care entity, a Practitioner or other health care professional, or a health care vendor that has entered into a written agreement to provide Covered Services to PacifiCare's Members. A Participating Practitioner may contract directly with PacifiCare, with a Participating Medical Group, or with another Participating Practitioner.

Practitioner A Provider licensed by the State in which he or she practices as a (1) Doctor of Medicine or Surgery, (2) Doctor of Osteopathy, (3) Doctor of Podiatry, (4) Chiropractor, or (5) Dentist (DDS or DMD). The term also includes a Psychologist licensed by the state to practice psychology.

Preauthorization Authorization for medical care that is given before the Member receives the care.

Preferred Transplant Network A network of transplant facilities that are:

- licensed in the state of Washington;
- certified by Medicare as a transplant facility for a specific organ transplant;
- designated by PacifiCare as a transplant facility for a specific organ program;
- able to meet the reasonable access standards for organ transplantation based on the Regional Organ Procurement Agency statistics within the transplant facility's geographic location. A Regional Organ Procurement Agency is a geographic area designated by a state-licensed organ procurement organization for transplants in the state of Washington.

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.

Prescription Drug Any medical substance which, under the Federal Food, Drug and Cosmetic Act, as amended, is required to be labeled with the legend "Caution: Federal Law prohibits dispensing without a prescription."

Drugs that meet the other coverage requirements of this Plan shall not be excluded for uses other than that stated in the drug's Federal Food and Drug Administration labeling if the drug is recognized as effective for such use by any of the following: (1) Medicare; (2) The American Hospital Formulary Service – *Drug Information*, The American Medical Association *Drug Evaluation*, U.S. Pharmacopoeia – *Drug Information*, or any other authoritative standard reference compendia that may be identified by Medicare or the Washington State Insurance Commissioner; or (3) by the majority of relevant peer-reviewed medical literature. Available benefits shall also be provided for services and supplies used by a covered Practitioner to administer such drugs.

Prevailing Rates As determined by PacifiCare, the Usual, Customary and Reasonable rates for a particular health care service in the Service Area.

Primary Care Practitioner (PCP) A Participating Practitioner who is a Practitioner trained in internal medicine, general practice, family practice, pediatrics or obstetrics/gynecology, and who has accepted primary responsibility for coordinating a Member's health care services.

Primary Hospital The Plan Hospital with which the Member's Primary Care Practitioner is affiliated. The Primary Care Practitioner has agreed with PacifiCare to refer Members to this Hospital whenever possible.

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

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



SECTION TEN

Definitions

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

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

Rehabilitation Services The combined and coordinated use of medical, social, educational and vocational measures for training or retraining individuals disabled by disease or injury.

Schedule of Benefits An important part of your *Combined Evidence of Coverage and Disclosure Form* that provides benefit information specific to your Health Plan, including Copayment and Coinsurance information.

Service Area The geographic area in the state of Washington in which PacifiCare is authorized by the Washington State Insurance Commissioner to arrange for Covered Services through its agreements with Plan Practitioners. PacifiCare is continually changing its Service Area. Please call Customer Service for current information.

Skilled Nursing Care (1) A skilled nursing service is a service that must be provided by a registered nurse, or a licensed practitioner (vocational) nurse under the supervision of a registered nurse, to be safe and effective. In determining whether a service requires the skill of a nurse, consider the complexity of the service, the condition of the patient, and accepted standards of medical and nursing practice. Some services may be classified as a skilled nursing service on the basis of complexity alone, e.g., intravenous and intramuscular injections or insertion of catheters, and if reasonable and necessary to the treatment of the patient's illness or injury, would be covered on that basis. However, in some cases the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse, (2) a service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a licensed nurse. Where a service can be safely and effectively performed (or self-administered) by the average nonmedical person without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although

a nurse actually provides the service. Similarly, the unavailability of a competent person to provide a non-skilled service, notwithstanding the importance of the service to the patient, does not make it a skilled service when a nurse provides the service.

Skilled Nursing Facility A facility that provides inpatient skilled nursing care, rehabilitation services or other related health services and is accredited as an extended care facility or certified by Medicare. This does not include a convalescent nursing home, rest facility, residential care facility or facility for the aged that primarily provides custodial care, including training in the routines of daily living.

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 Washington.

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

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

Totally Disabled or Total Disability For Subscribers, the persistent inability to reliably engage in any substantially gainful activity by reason of any medically determinable physical or mental impairment resulting from an injury or illness. For Dependents, Totally Disabled (incapacitated) is an unmarried child who is not able to maintain self-sustaining employment because of a developmental disability or a physical handicap that commenced prior to reaching the maximum age of this Plan and remains chiefly dependent upon the Subscriber for support and maintenance. Determination of Total Disability will be made by a Participating Medical Group Practitioner 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 6 months.



Definitions

Transitional Care See “Subacute Care.”

Urgently Needed Services An unforeseen illness or injury that is severe or painful enough to require treatment within twenty-four (24) hours. A delay beyond twenty-four (24) hours may lead to deterioration of the Member’s health and/or well being with a potential for an adverse clinical outcome.

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

Women’s Health Care Provider A Plan Doctor of Medicine or Osteopathy who is a Family or General Practitioner, Practitioners Assistant, Obstetrician, Gynecologist, ARNP, Certified Nurse Midwife who provides Women’s Health Care Services.

Women’s Health Care Services Maternity care, reproductive health services, gynecological care, general examinations, and preventive care as medically appropriate, and medically appropriate follow-up visits for the above services.

Year The period that begins at 12:01 a.m. on each January 1st and ends at midnight on each December 31st.

NOTE: THIS COMBINED EVIDENCE OF COVERAGE AND DISCLOSURE FORM CONSTITUTES ONLY A SUMMARY OF THE PACIFICARE HEALTH PLAN. THE GROUP AGREEMENT BETWEEN PACIFICARE AND THE EMPLOYER GROUP MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. A COPY OF THE GROUP AGREEMENT WILL BE FURNISHED UPON REQUEST AND IS AVAILABLE AT PACIFICARE AND YOUR EMPLOYER GROUP’S PERSONNEL OFFICE.

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