Some benefits are subject to limitations. These limitations may include length of treatment, frequency of treatment and/or maximum amount PacifiCare of Colorado will pay. See Chapter Three of this Evidence of Coverage for details on your benefits.

Following is a list of benefits and where to find information regarding the corresponding copayments. Please call PacifiCare Customer Service at 1-800-877-9777, if you would like additional information.

### Office Visits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Copayment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP Office Visit</td>
<td>see ID card</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>see ID card</td>
</tr>
<tr>
<td>Allergy Testing</td>
<td>PCP or Specialist office visit copayment</td>
</tr>
<tr>
<td>Allergy Injections</td>
<td>see ID card</td>
</tr>
<tr>
<td>Cardiac Rehabilitation</td>
<td>no copayment</td>
</tr>
<tr>
<td>Eye Refraction</td>
<td>see ID card</td>
</tr>
<tr>
<td>Short-Term Physical/Occupational Therapy</td>
<td>PCP office visit copayment</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>PCP office visit copayment</td>
</tr>
</tbody>
</table>

### Hospital Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Copayment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Care</td>
<td>see ID card</td>
</tr>
<tr>
<td>Outpatient Surgery/Observation Room</td>
<td>see ID card</td>
</tr>
</tbody>
</table>

### Emergency Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Copayment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room Setting - Inside and Outside Service Area</td>
<td>see ID card</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>see ID card</td>
</tr>
<tr>
<td>• after normal hours in a physician’s office</td>
<td></td>
</tr>
<tr>
<td>• urgent care center inside service area</td>
<td></td>
</tr>
<tr>
<td>Urgent Care/Follow-Up - Outside Service Area</td>
<td>see ID card</td>
</tr>
<tr>
<td>• emergency room</td>
<td></td>
</tr>
<tr>
<td>• physician’s office or urgent care center</td>
<td></td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>see ID card</td>
</tr>
</tbody>
</table>

### Other

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Copayment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care</td>
<td>call Customer Service</td>
</tr>
<tr>
<td>Injectables for Home Use</td>
<td>see ID card</td>
</tr>
<tr>
<td>Infertility Evaluation</td>
<td>50% copayment</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>no copayment*</td>
</tr>
</tbody>
</table>

*Prosthetic Arms and Legs may require a 20% copayment.

### Preventive Care

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Copayment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Exam</td>
<td>PCP or Specialist office visit copayment</td>
</tr>
<tr>
<td>Well-Woman Exam</td>
<td>PCP office visit copayment</td>
</tr>
<tr>
<td>Well-Baby Care</td>
<td>PCP or Specialist office visit copayment</td>
</tr>
<tr>
<td>Maternity Care</td>
<td>PCP office visit copayment</td>
</tr>
</tbody>
</table>

### Mental Health Care

A referral from your PCP is not required; however, you must call your Mental Health Provider (see Chapter Eight, How To Get Help) to access mental health services.

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Copayment Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>see ID card</td>
</tr>
<tr>
<td>Inpatient for schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive order, specific obsessive-compulsive disorder and panic disorder</td>
<td>Inpatient hospital copayment</td>
</tr>
<tr>
<td>Outpatient</td>
<td>see ID card</td>
</tr>
<tr>
<td>Outpatient for schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive order, specific obsessive-compulsive disorder and panic disorder</td>
<td>see ID card</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>call Customer Service</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>call Customer Service</td>
</tr>
</tbody>
</table>

### Radiological Services

(MRI, CT, SPECT, and PET scans) see ID card**

**Some plans do not have a copayment for these services, please see ID card to verify applicable copayment for these services.

### Important Additional Information

- Your group may select different copayments for certain benefits. If the copayment listed on your ID card or in your enrollment brochure differs from the copayment shown, the copayment on your ID card applies.
- Some plans have a different copayment for PCP office visits and specialist office visits. Please see your ID card or contact PacifiCare Customer Service for information on your office visit copayment.
- Outpatient prescription drugs and eyewear are optional benefits that may have been selected by your employer. Refer to your ID card to see if you are eligible for these benefits and applicable copayments.
- Certain groups restrict or exclude coverage of sterilizations, family planning and/or abortions. Be sure to check with your employer or PacifiCare Customer Service for more information.
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CHAPTER ONE
HOW TO USE YOUR
PACIFICARE OF COLORADO HEALTH PLAN

Welcome to PacifiCare of Colorado

Your health is important to us. To help you make the best use of your PacifiCare of Colorado health care benefits, we have provided this manual. It contains valuable information that will enable you to use PacifiCare of Colorado efficiently and effectively. This manual supersedes all previous Evidences of Coverage. Because benefits and/or procedures may change from year to year, it is important that you use the most recent Evidence of Coverage as your reference.

When you enrolled, you received a packet of information including details about the plan your employer has selected and rosters of contract providers. This Evidence of Coverage (EOC) contains additional information about PacifiCare of Colorado services and benefits that you need to know to best use your PacifiCare of Colorado coverage. Please keep it with your enrollment packet so you have all PacifiCare of Colorado information in one place. If you do not have an enrollment packet, or need updated materials, contact Customer Service (see Chapter Eight, How to Get Help).

Evidence of Coverage (EOC) Organization

The following is a brief explanation of the information in each chapter in your EOC and how you can use it.

Chapter One
How to Use Your PacifiCare of Colorado Health Plan

The information in this chapter is designed to help you understand and use your PacifiCare of Colorado coverage efficiently and effectively. It explains the rules for using your PacifiCare of Colorado plan and how to get the services you need, and tells you how to select and work with your Primary Care Physician (PCP).

Chapter Two
Your Rights and Responsibilities

This outlines the general provisions of the Agreement you have with PacifiCare of Colorado, including specific legal requirements that you and PacifiCare of Colorado must observe.

Look in this chapter when you want to know the rules about such subjects as who is eligible, when coverage begins, and other general information about what you are entitled to and what you are required to do under the provisions of your legal agreement with PacifiCare of Colorado.

Chapter Three
What is Covered: Your Schedule of Benefits

This chapter details the services that are covered under your plan, as well as those services excluded from coverage under your plan.

In this chapter, you can see what is included for any benefit. If you do not find a listing for the type of health care coverage you are looking for, check Section Z., General Exclusions.
Chapter Four
This chapter summarizes the benefits mandated by the State of Colorado. The chapter is provided for information purposes only, and is not to be relied upon as the level of benefits available through your PacifiCare of Colorado coverage. The benefits available through your PacifiCare of Colorado coverage meet or exceed the State of Colorado mandates. For detailed coverage available through this Plan, please refer to Chapter Three, What is Covered: Your Schedule of Benefits.

Chapter Five
Outpatient Prescription Drugs
This chapter explains the PacifiCare of Colorado optional outpatient prescription drugs benefit. This benefit is covered only if it has been selected by your employer as part of the subscribing group’s plan. Check your enrollment packet, with your employer, or with Customer Service to find out if your plan includes this benefit.

Chapter Six
Optional Benefits
This chapter explains the PacifiCare of Colorado optional benefits, each of which may or may not be part of your group plan depending on which optional benefits your employer has selected. Check your enrollment packet, with your employer, or with Customer Service to find out if your plan includes these benefits.

Chapter Seven
Definition of Terms
This chapter lists and defines terms that are used in a particular way in this EOC. Use this chapter any time there are terms that are unclear to you, or to clarify the exact legal meaning of a term.

Chapter Eight
How to Get Help
This chapter explains who to contact for information and questions.
You can reference this chapter when you need the Customer Service phone number or hours.

Other PacifiCare of Colorado Materials
This EOC is your primary resource for information about PacifiCare of Colorado and your benefits. But the following materials also provide valuable information that you will need to use PacifiCare of Colorado effectively.

Enrollment Packet
This is the folder you received when you enrolled in PacifiCare of Colorado. It contains the following:

- Health Plan Description Form or Summary of Benefits
  This summarizes the major features of your plan. It is not intended to replace this EOC, which contains the complete provisions of your plan.

- Service Area Map
  Found in the Provider Directory, the Service Area Map illustrates the PacifiCare of Colorado service area for your HMO coverage.

- Provider Directory
  Lists by city all of the participating Primary Care Physicians and hospitals associated with PacifiCare of Colorado.
• Optional Benefits Descriptions
  Each of these, which may or may not be in your packet, depending on your plan, summarizes optional
  benefits your employer has selected to be included in your plan. These summaries are not intended to
  replace the Evidence of Coverage and Owner's Manual, which contain the complete provisions of your
  optional benefits, if any.

• Enrollment Application
  Your copy of the PacifiCare of Colorado enrollment application has important information on the back
  about your membership conditions.

Materials are updated periodically. Contact Customer Service for replacement or updated copies (see
Chapter Eight, How to Get Help).

PacifiCare of Colorado Benefits You

PacifiCare of Colorado is a State licensed Health Maintenance Organization (HMO) offering Federally
qualified and non-Federally qualified products. PacifiCare of Colorado has a working relationship
between its members and a network of more than 4,300 health care physicians, including PCPs (who are
internists, pediatricians, and family practitioners) and specialists. As an HMO, PacifiCare of Colorado's
obligation to its members is to furnish benefits in the form of medical services through its contract
providers. Therefore, it is important to you that you follow PacifiCare of Colorado procedures and use the
providers that have contracts with PacifiCare of Colorado.

NOTE:
PacifiCare of Colorado contract providers are independent contractors and are not agents or employees of
PacifiCare of Colorado.

How to Determine Benefits

The terms and provisions of this EOC control the type and scope of benefits available to a member. The
EOC must be read as a whole to accurately determine benefits. When reading a coverage section, you
must also read what is not covered, any limitations and read the separate general exclusions and general
limits sections (Sections Z. and AA., in Chapter Three, What is Covered) to determine what, if any,
services are excluded or limited. It is important that you read this EOC in its entirety to accurately
determine what is covered and what services are excluded, and/or limited.

How to Use Your Plan

We look forward to working with you to help you stay healthy. You should feel secure knowing your
PacifiCare of Colorado health plan provides thorough coverage. Now you need to know how to use these
resources wisely. Here are some important things you should remember:

• Carry and use your ID card.
• Select your PCP right away and call him/her first when you need care.
• Know the covered benefits under your plan.

Your ID Card: Passport to Health Care

Keep your PacifiCare of Colorado ID card with you at all times. It is your passport to quality medical and
emergency care. Each covered member of your family will receive an ID card. At the time of services, the
card must be shown to identify yourself or your family member as a PacifiCare of Colorado member. If
you fail to do so, or misrepresent your membership status, claims payment may be denied.

Your PCP: Key to Your Health Care

The relationship between our members and their PCPs is the cornerstone of our success at PacifiCare of
Colorado. We believe that having one good doctor to look over your health care needs is better than
having several doctors who know very little about you. This relationship is designed to make you more
comfortable and secure in the quality of services you need for your best health.
Think of your PCP as your partner in your personal health care management, providing most of your care and coordinating any other care as necessary. Your PCP will develop a central collection point for your detailed health-history records. This provides a more thorough understanding of your needs and your dependents' needs. Your PCP will also handle the paperwork and billing directly with PacifiCare of Colorado. If you do receive a bill for covered services, please mail it to PacifiCare of Colorado with your membership number (usually the subscriber's Social Security number) from your ID card.

Covered medical services, except true emergency care, must be provided or referred by your PCP. Having a PCP is essential to using the advantages of your PacifiCare of Colorado coverage.

Please keep in mind that PacifiCare of Colorado is not responsible for charges incurred when a member misses an appointment or cancels a scheduled service.

Selecting Your PCP
You need to choose a PCP in order to receive PacifiCare of Colorado covered benefits, except true emergency services. Each family member may select a different PCP. If you have not yet chosen a PCP, please do so right away by calling our Customer Service Department (see Chapter Eight, How to Get Help). If you do not choose a PCP at the time you enroll, PacifiCare will assign a PCP for you and, if applicable, your dependents in order to process your application.

Working With Your PCP
When you need medical care, call your PCP and he/she will make the necessary arrangements for treatment. Remember that your PCP must arrange a referral before you see a specialist, or PacifiCare of Colorado is not responsible for any charges. This rule affords you access to care and provides you with professional guidance to the right kind of care.

Your PCP cannot authorize a referral after the fact.

If you choose to see a doctor who does not participate in the PacifiCare of Colorado system or if you see a specialist without a referral from your PCP, you will be responsible for all of the charges for all services, including hospital care. PacifiCare of Colorado has no obligation to pay these charges, which can accumulate much more rapidly than you anticipate. The covered benefits you receive under the terms of this Agreement will not be denied or restricted solely because you may choose to receive non-covered care from a provider who does not participate in the PacifiCare of Colorado network. Note that in a case of a life or limb threatening emergency, you may go to any physician or facility, and special procedures apply. See the Emergency or Urgent Care Services section in this chapter.

Changing Your PCP
When you want to change your PCP, call Customer Service immediately. The change will take effect the first day of the following month. To transfer your records, contact your former PCP and follow his/her procedures.

Remember that any specialist physician referrals must be reissued by your new PCP. You must contact him/her before you receive further specialist care. Also see Specialty Care Referrals below.

Access to Care: Physician Network
Many of PacifiCare's participating physicians are organized into groups of primary care physicians (PCPs) and specialists who have joined together to provide services to PacifiCare members. This unique arrangement has benefits for patients and doctors alike. For those physicians affiliated in this manner primary care physicians belong to just one group, but some specialists may have more than one affiliation. When you need specialty care, your PCP may refer you to a specialist with whom he or she is affiliated. PCPs typically have established relationships with other doctors to whom they will most likely refer patients when specialized care is needed. Primary care physicians work closely with the specialty physicians they know and trust – to ensure that each member receives the care he or she needs.

This system of referring creates a framework for effective coordinated care and communications regarding patient health, supported by trusting physician relationships – all important elements of a quality health care system. Referring to a specialist with whom your PCP is familiar makes it easy for your PCP to communicate with both you and your specialist and coordinate your care. PacifiCare of Colorado's policy is to encourage PCPs to consider patients' input in care decisions. This arrangement benefits patients and doctors alike.
An Access Plan detailing the managed care network is available upon request. Please contact Customer Service at 1-800-877-9777. See Chapter Eight How to Get Help for further assistance.

**Medical Management**

PacifiCare of Colorado may determine medical necessity by using precertification programs and criteria as deemed appropriate by PacifiCare of Colorado. Such programs and criteria are reviewed and updated from time to time. See Chapter Seven, Definition of Terms, PacifiCare of Colorado Criteria for further information. Through the precertification process, PacifiCare of Colorado may encourage that certain services be directed to, and performed at, the most cost effective setting.

If a member is hospitalized in a non-preferred or non-participating facility, for services to be covered PacifiCare of Colorado may elect to transfer the member to a preferred or participating facility as soon as it is medically appropriate, based on the cost-effectiveness of the services performed. If the member chooses to remain in a non-preferred or non-participating facility after being notified of the intent to transfer the member to a preferred or participating facility, further services will not be covered.

**Second Opinions**

Second opinions are covered when they are medically appropriate. In order to obtain a second opinion, you must obtain the necessary referrals from your PCP.

**Your Plan: The Benefits of PacifiCare of Colorado**

You can have the confidence of knowing that you will receive quality care and service with your PacifiCare of Colorado coverage. The quality of your care is monitored under our Quality Assurance Program.

**Copayments**

It is important for you to be familiar with your copayments. Copayments are intended to remind members that they share the responsibility for health care costs with their doctors, hospitals and PacifiCare of Colorado. Copayments should always be made to the provider at the time you receive service.

You may require medically necessary services that are not covered under your group plan. Therefore, it is essential that you understand which benefits and copayment obligations apply to you. To find out, check the following:

- Chapter Three, What is Covered: Your Schedule of Benefits, in this EOC
- Materials (usually a Comparison of Benefits) provided by your employer
- Your PacifiCare of Colorado ID card
- Your employer's benefit or personnel office

When in doubt, call PacifiCare of Colorado. Your PCP or specialty care physician is the authority on the management of your health. PacifiCare of Colorado administration is the best source of information about your health care plan Agreement. Each has a different responsibility to you. For more information, see Chapter Eight, How to Get Help.

**What to do if you get a bill**

As a member of a Health Maintenance Organization, you are not required to submit claim forms – your provider and PacifiCare take care of the paperwork for you. If you receive a bill, look for the box that reads “You Owe” or “Pay This Amount.” If there is a balance due, and you have already made your copayment, please contact the provider’s billing office to make sure their records are updated with your current insurance information. Contracted providers will bill PacifiCare directly if you provide them with your updated insurance information. Remember, in certain instances you may incur the entire cost of services. These instances include (but are not limited to) receiving a service that is not a covered benefit of your health plan, seeing a specialist without a valid referral from your PCP, or receiving unauthorized care from a non-participating medical provider (except for emergency or urgently needed services). If your questions are not resolved regarding your bill please contact Customer Service (see Chapter Eight, How to Get Help) for assistance.
Advance Directives

Your right to make medical care decisions includes the giving of “advance directives,” which are written instructions concerning your wishes about your medical treatment. These instructions are used in the event you become unable to make health care decisions for yourself.

Please understand that you are not required to have any advance directives in order to receive care and treatment. You must only be informed about them. Whether or not you have advance directives, you will receive the medical care and treatment appropriate for your condition and consistent with your consent.

You should prepare advance medical directives before you get too sick to think or communicate clearly. The kinds of advance medical directives recognized in Colorado are the “living will” (which applies in cases of terminal illness), the “medical durable power of attorney” (which allows your named agent to make decisions for you if you become unable to make them) and “the CPR directive” (which allows you to reject cardiopulmonary resuscitation). These documents do not take away your right to decide what you want, if you are able to do so.

Should a PacifiCare of Colorado member execute an advance directive, your physician or any other medical provider, including Medicare- and Medicaid-certified hospitals, skilled nursing facilities, home health agencies, hospice programs, and ambulance personnel, should be informed in order to include a notation in your medical record accordingly. A copy of your executed advance directive should be sent to your primary care physician, not PacifiCare of Colorado.

Your decision to execute an advance directive has no effect on your PacifiCare of Colorado benefits or eligibility. PacifiCare of Colorado will not discriminate against a member based on whether he or she has or has not executed an advance directive.

Special Health Care Needs

Specialty Care Referrals

PacifiCare of Colorado's referral system for specialty care is designed to ensure that you get quality care. Having your PCP involved in working with specialists is like having a built-in second opinion from someone you know and trust.

Should your PCP decide that you need to see a physician specialist, he/she will arrange for a referral to a participating specialist for a one-time visit, a specific period of time or for a specified treatment or course of treatment. When you receive a copy of the referral, be sure to note the limits. PacifiCare of Colorado will not cover services beyond the specified limits. Your PCP cannot authorize or extend a referral after the fact.

Without a referral, PacifiCare of Colorado cannot cover any of the expenses of the physician specialist or related hospital care and charges. If you change your PCP, all specialist referrals become invalid. In order for continuing visits to your specialist(s) to be covered, a new referral must be obtained from your new PCP.

Obstetrician/Gynecologist Care

PacifiCare of Colorado coverage includes general and specialized obstetrician/gynecologist (OB/GYN) services for our female members (within the limitations as described in the What is Covered: Your Schedule of Benefits chapter in this EOC). It is PacifiCare’s desire that you establish a partnership with your PCP that includes joint decision making because of his/her familiarity with your overall health. In support of that partnership, PacifiCare recommends that your PCP participate in the evaluation as to whether services by an OB/GYN are needed. However, a female member may make an appointment directly with a participating OB/GYN for services related to that specialty.

The only exception to the OB/GYN direct access process is OB/GYN specialists whose practices primarily consist of sub-specialty care such as infertility or genetics. Such specialists can be accessed only by referral from the member’s PCP.
It is also important to note that your participating OB/GYN is a specialist provider under your PacifiCare of Colorado plan. As a specialist provider, the OB/GYN cannot make referrals to other providers for you. If, following a discussion with your OB/GYN and your PCP, it is determined that additional specialty care may be needed, any such care must be directed by your PCP.

**Behavioral Health Services**

As a PacifiCare member, you have 24-hour a day access to behavioral health benefits. All mental health and chemical dependency services require pre-authorization for services to be covered. Emergency services are allowed without prior approval.

To obtain information about behavioral health benefits, participating behavioral health practitioners, referrals for subspecialty care, or if you require care outside your behavioral health practitioner’s normal business hours, please contact PacifiCare Customer Service (see Chapter Eight, How to Get Help). You do not need a referral from your primary care physician to seek covered mental health services. To access mental health services please refer to the Guide to Accessing Mental Health and Substance Abuse Benefits in Chapter Eight, How to Get Help.

Members whose participating primary care physician is affiliated with the Colorado Pediatric Partners pediatrician group must contact Physician Health Partners Mental Health to access mental health services. Contact the pediatrician or PacifiCare Customer Service to determine if he or she is affiliated with Colorado Pediatric Partners. Additionally, if your PCP is affiliated with Primary Physician Partners or Medwest Medical Group, your mental health and substance abuse benefits provider is PRO Behavioral Health. Please identify yourself as a PacifiCare member when contacting PacifiCare Behavioral Health, PRO Behavioral Health or Physician Health Partners Mental Health. Also, be sure to present your PacifiCare ID card each time you visit your mental health professional.

For behavioral health services, if you are outside the service area, you will be covered for emergency services only. Please see the Emergency or Urgent Care Services section below for more specific information. PacifiCare Behavioral Health (PBH), PRO Behavioral Health and Physician Health Partners Mental Health will coordinate all follow-up behavioral health services to emergency treatment on your behalf. This may include a transfer to a participating provider designated by your mental health provider when you are stable and the transfer would not create an unreasonable risk to your health.

All authorized services prescribed by PBH will be billed directly to PacifiCare Behavioral Health. However if you get emergency treatment form a non-participating practitioner, you may receive a bill. Send PBH a copy of the bill or claim within ninety (90) days of the date of service, or as soon as possible. PBH will not pay for claims submitted after one hundred twenty (120) days of the date of service. Mail bills to: PacifiCare Behavioral Health of California, Claims Department, 23046 Avenida de la Carlota, Suite 700, Laguna Hills, CA 92653. If your plan includes a copayment, you are responsible to pay these directly to the provider.

**Receiving Care After-Hours**

If you need to talk to or see your PCP after his or her office has closed for the day, call the physician office phone number located on the front of your ID card. The physician on call will return your call and advise you on how to proceed.

**Emergency or Urgent Care Services**

**Emergency Care Inside the PacifiCare of Colorado Service Area**

If a medical emergency exists, go to the nearest hospital emergency room or other facility for treatment. In the case of a life- or limb-threatening emergency you have the option of calling the emergency telephone access number 911 or its local equivalent. Make sure your PCP is notified by the following business day so that he/she can coordinate whatever care you need and schedule any follow-up treatment.

**Urgent Care Inside the PacifiCare of Colorado Service Area**

When you need urgent care, call your PCP first. Ask your PCP about after-hours and "on-call" procedures now, before you need these services. Your physician can assess the situation and decide if emergency care is needed. Many times the situation may be distressing but not actually life or limb threatening.
Emergency Care and Urgent Care Outside the PacifiCare of Colorado Service Area

If a medical emergency exists or urgent care is necessary, go to the nearest hospital emergency room, physician’s office or other facility. PacifiCare of Colorado must be notified within forty-eight (48) hours, or as soon as practical, after a hospital admission outside the service area.

PacifiCare of Colorado will pay for any treatment that is a covered benefit resulting from an unforeseen medical emergency when received from a licensed medical practitioner anywhere in the world.

Emergency Follow-up Care Outside the PacifiCare of Colorado Service Area

In addition to our standard coverage for emergency services and urgently needed services, follow-up care to emergency services received outside the service area is covered to a maximum PacifiCare of Colorado payment of $400 per person per contract year. Ask the out-of-area provider to send the bill directly to PacifiCare of Colorado Customer Service Department at P. O. Box 6770, Englewood, CO 80155. If the provider demands payment at the time of service, PacifiCare of Colorado will reimburse you, less copayments, for covered services up to $400 over the copayment amount.

Copayments

There are two copayment levels for emergency services. The higher copayment applies when services are obtained in a hospital emergency room; the lower copayment applies when the emergency services are obtained in a physician office outside normal business hours or an urgent care facility. Thus, it is to your advantage to visit your PCP’s office or other medical facility when you have a choice.

If a member is admitted as an inpatient to a hospital directly from urgent care or the emergency room, the urgent or emergency copayment is waived.

StopSmoking Program

Program Description

PacifiCare of Colorado supports the Colorado Department of Health Tobacco Cessation Program. This program, The Colorado Quitline, is a self-directed, self-paced program that includes telephonic support for the person choosing to quit tobacco use. The program is designed to be customized to each individual's needs and readiness to quit. The components of the intervention build the participant's self confidence in their ability to quit smoking or to quit using other tobacco products through goal oriented lifestyle modification. PacifiCare members who are enrolled in the program may be eligible for Nicotine replacement therapy aids (NRT).

For More Information

For more information, or to enroll in the Tobacco Cessation program, please call 1-800-639-QUIT. There is no charge for this program.

Capitation

At PacifiCare of Colorado two of our greatest concerns are also two of yours. We both want to maintain quality care, yet keep costs down. We believe our Provider Capitation Program is a great way to achieve these goals.

What Is Capitation?

Capitation is a system for reimbursing providers for medical services they provide to our members. Under the Capitation Program, a provider is paid a monthly fee based on the forecasted patient services the provider is expected to provide to his/her PacifiCare of Colorado patients. The cost of actual services are “Charged” against, and covered by, the monthly fee.

How Is The Capitation Program A Benefit To Me?

Capitation encourages an appropriate level of care for our members, and helps strengthen the partnership between our members and their providers. Patients are referred to a specialist when necessary, but receive the majority of their treatment from their PCPs, who are familiar with their medical histories.

Capitation is a benefit to employers as well, because it allows for better management of the health care dollar. Through capitation we can more accurately estimate and manage the cost of our member’s health care.
Is This Program Also Beneficial To The Provider?

The Capitation Program offers PacifiCare of Colorado providers the advantage of stabilized cash flow and revenue. The Capitation Program also supports providers in rendering cost-effective, quality care, and promotes good health care management.

How Is The Quality Of My Care Ensured?

At PacifiCare of Colorado we've implemented several mechanisms to ensure quality of care for our members. These include physician office chart audits, precertification and review for appropriateness of procedures, on-going membership surveys, case management and physician peer comparisons. If you have any questions regarding the providers listed in the directory, or if you wish to obtain the professional qualifications of primary care and specialist practitioners – such as medical school, residency completed and board certification status – please contact Customer Service (see Chapter Eight, How to Get Help).

PacifiCare of Colorado Service Area

The PacifiCare of Colorado service area includes the following Colorado counties:

Your Rights and Responsibilities

We're committed to developing and maintaining a good working partnership with you. As a member, we want you to know that you can expect certain rights from PacifiCare of Colorado and that you have certain responsibilities. And, we want to know if we're not meeting your expectations. This chapter, and Chapter Two, Your Rights and Responsibilities, explain PacifiCare of Colorado's responsibility to you and your obligations to PacifiCare of Colorado.

Member satisfaction is important to PacifiCare of Colorado. PacifiCare of Colorado strives to see that members are treated fairly in the services they receive through their plan. Unfortunately, there may be occasions when this is not the case. For this reason, there is a process available to provide the opportunity to express concerns or request reconsideration of a decision or decisions that have been made. Please see Section J., Member Complaint and Appeal Process – Benefit Denials, in Chapter Two, Your Rights and Responsibilities, for further information.
Following are some of the additional rights and responsibilities.

*As a PacifiCare member, you have the right to:*

**Timely, Quality Care**
- Choose and seek care through a qualified Contracting Primary Care Physician and Contracting Hospital. PacifiCare can advise you if a specific contracted Primary Care Physician is not accepting new patients at a particular time. Your Contracting Primary Care Physician will discuss with you the Contracting Hospital that best fits your needs in the event you need hospital services.
- Access in a timely manner, to your Contracting Primary Care Physician, and referrals to specialists when Medically Necessary.
- Receive emergency services when you, as a prudent layperson acting reasonably, believe that an emergency medical condition exists. Payment will not be withheld in cases where you have acted as a prudent layperson with an average knowledge of health and medicine in seeking emergency services.
- Receive urgently needed services when traveling outside the Plan’s service area or in the Plan’s service area when unusual or extenuating circumstances prevent you from obtaining care from your Contracting Primary Care Physician.
- Discuss the full range of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Participate actively in decision-making regarding your health with your Contracting Medical Provider.
- Receive reasonable continuity of care, including information about continuing health care requirements following discharge from inpatient or outpatient facilities. Also to know in advance, the time and location of an appointment, as well as the physician providing care.
- Receive information about your medications – what they are, how to take them and possible side effects.
- Be advised if a physician proposes to engage in experimental or investigational procedures affecting your care or treatment. You have the right to refuse to participate in such research projects.

**Treatment with Dignity and Respect**
- Be treated with dignity and respect and have your right to privacy recognized.
- Exercise these rights regardless of your race, physical or mental disability, ethnicity, gender, sexual orientation, creed, age, religion, national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for your health care. Expect these rights to be upheld by PacifiCare and Contracting Medical Providers.
- Refuse any treatment or leave a medical facility, even against the advice of a physician. Your refusal in no way limits or otherwise precludes you from receiving other Medically Necessary covered services for which you consent.
- Complete an advance directive, living will or other directive and give it to your Contracting Primary Care Physician or medical provider to include in your medical record.

**Information About PacifiCare and Their Contracting Medical Providers**
- Receive information about PacifiCare and the covered services under your Plan.
- Receive information about and know the names and qualifications of your Contracting Primary Care Physician, health care professionals, and Contracting Medical Providers involved in your medical treatment.
- Receive information regarding how medical treatment decisions are made by your Contracting Primary Care Physician, medical group or PacifiCare, including payment structure.
- Receive and examine a billing explanation for non-covered services, regardless of payment source.
- Request information about PacifiCare’s Quality Improvement Program, its goals, processes and/or outcomes.

**Timely Problem Resolution**
- Make complaints and request appeals, without discrimination, about PacifiCare or care provided to you.
- Expect problems to be fairly examined and appropriately addressed within the timeframes set by the Plan.
- Choose to have a service or treatment decision, if it meets certain criteria, reviewed by a physician or panel of physicians who are not affiliated with PacifiCare. This process is called an independent external review.
Protection of Privacy in All Settings

• Know that PacifiCare protects the privacy and security of personal health information in all settings from unauthorized or inappropriate use via its policies and procedures and agreements with Contracting Medical Providers.

• Know that when you or your legal representative sign your application/Individual election form, you give routine consent to PacifiCare. Routine consent covers the use of your personal health information that is needed for Plan operations, such as: treatment, coordination of care, use of measurement and survey data to improve care and service, utilization review, billing or fraud detection.

• Know that PacifiCare does not disclose medical information related to your mental health, genetic testing results and drug and alcohol abuse treatment records, to third parties without the your special consent/authorization or as required or permitted by law.

• Know that if you are unable to give consent, you may extend your rights to any person who has legal responsibility to make decisions on your behalf, regarding your medical care or the release of personal health information.

• Review your medical records. If you would like to review, correct or copy your medical records, you should contact your Contracting Primary Care Physician or other health care provider who created the medical record directly.

• Know that PacifiCare may accommodate employer requests for information by providing de-identified aggregated data. Only as permitted by law, PacifiCare may release information to self-funded employers where needed to administer payment. If required to supply this information to self-funded employers, they agree to protect the individual’s data from internal disclosure that would affect the individual.

Your responsibilities include:

• Review information regarding covered services, any exclusions, deductibles or copayments and policies and procedures as stated in your member materials or Evidence of Coverage.

• Provide PacifiCare, your physicians other health care professionals and Contracting Medical Providers, to the degree possible, the information needed in order to care for you.

• Follow treatment plans, and care instructions as agreed upon with your Contracting Medical Provider. Actively participate in understanding and improving your own medical and/or behavioral health condition.

• Behave in a manner that supports the care provided to other patients and the general functioning of the facility.

• Accept your financial responsibility for any copayment or coinsurance associated with services received while under the care of a physician or while a patient at a facility.

• Ask your Contracting Primary Care Physician or PacifiCare questions regarding your care. If you would like information about Contracting Medical Providers or have a suggestion, complaint or payment issue, we recommend you call PacifiCare Customer Service department at 1-800-877-9777 or for the hearing impaired TDD 1-800-659-2656. Our Customer Service Representatives are available Monday through Friday 8 a.m. to 6 p.m.

In addition, please be aware of the following:

• Notify Customer Service if you change your address. Otherwise, PacifiCare of Colorado is not responsible if you do not receive updated information.

• Notify Customer Service if you lose your ID card--your ID card is essential for your access to benefits!

• You cannot let any unauthorized individual use your ID card. If you do, PacifiCare of Colorado will not pay for the services so obtained and you risk termination of your coverage and possible legal action.

• You must submit an enrollment change form to PacifiCare of Colorado when you have a change in dependent status. You can get these forms from your employer.
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CHAPTER TWO
YOUR RIGHTS AND RESPONSIBILITIES

A. Agreement

A.1. Agreement Effective Period

A.1.1. This Agreement will be in effect for one year from the date hereof or the dates specified on the Signature Sheet, subject to Section N., Termination of Group Coverage, in this chapter.

A.1.2. This Agreement replaces and supersedes any and all editions of the PacifiCare of Colorado Evidence of Coverage and Owner's Manual (EOC) previously issued to the subscribing group and member.

A.2. Agreement Inclusions

A.2.1. This Agreement, along with the Evidence of Coverage and Owner's Manual Signature Sheet, the application of the subscribing group and the individual applications of the member, and any written amendments, constitutes the entire contract between the parties.

A.2.2. The headings in this Agreement are for reference purposes only and should not be considered in the interpretation of this Agreement or any of its terms or provisions. They are not intended to qualify, modify or explain any such terms or provisions or their effect.

A.3. Amendment/Termination of Agreement

A.3.1. This Agreement may be amended, changed, or terminated as stated in this Agreement or by mutual agreement between PacifiCare of Colorado and the subscribing group, without the consent or agreement of its members or any person having a beneficial interest in it. Any change or amendment will not affect services provided before the date of the change.

A.3.2. The terms and provisions of this Agreement control the type and scope of benefits available to a member. No representative or agent of PacifiCare of Colorado can amend this Agreement by giving oral advice, incomplete or incorrect information, or by contradicting the provisions of this Agreement. PacifiCare of Colorado will not deviate from the provisions of this Agreement.

A.4. PacifiCare of Colorado’s Agreement

A.4.1. PacifiCare of Colorado, Inc. (PacifiCare of Colorado), a Colorado corporation, is a State-licensed health maintenance organization (HMO) offering Federally qualified and non-Federally qualified products. PacifiCare of Colorado and/or its assigns will professionally and consistently administer this Agreement as explained in this EOC. This will be done according to the specific definitions of terms used in this Agreement, as described in Chapter Seven of this EOC, Definition of Terms, and according to applicable State and Federal laws and regulations.

A.4.2. In compliance with federal and state law, PacifiCare of Colorado shall not discriminate on the basis of age, sex, color, race, disability, marital status, religious affiliation or public assistance status in the administration of this Agreement.

A.5. Member’s Agreement

A.5.1. By choosing the coverage specified in this Agreement, paying the premium, or accepting benefits under this Agreement, all members or their legal representatives expressly agree to all terms, conditions and provisions of this Agreement, whether or not the member has signed the application of the subscriber.

A.5.2. The member must pay the copayments applicable to the plan under which he/she is enrolled. Copayments should be paid to the provider at the time of service.
A.6. **Subscribing Group's Agreement**

A.6.1. If the subscribing group pays the premium on behalf of any eligible member (as described in Section F., Eligibility, in this chapter), or if any eligible member in the subscribing group chooses the coverage specified in this Agreement or accepts benefits under this Agreement, the subscribing group expressly agrees to all terms, conditions and provisions of this Agreement, whether or not any employee or representative of the group has signed the Group Health Application and/or the Signature Sheet.

A.7. **Assignment**

A.7.1. The rights and privileges of any subscribing group or member pursuant to this Agreement may not be assigned or delegated. PacifiCare of Colorado shall have the right to assign this Agreement.

A.8. **Administrative Rules**

A.8.1. PacifiCare of Colorado may adopt reasonable policies, procedures, rules and interpretations that govern this Agreement.

A.9. **Conformity with Statutes**

A.9.1. Any provision of this Agreement which, on its effective dates, is in conflict with the applicable statutes of the jurisdiction in which it is delivered, is hereby amended to conform with the minimum requirements of such statutes.

A.9.2. PacifiCare of Colorado will modify enrollment and eligibility criteria applicable under this Agreement to allow the Subscribing Group to meet the legal requirements of the Family and Medical Leave Act (29 U.S.C. Section 2601, et. seq.) and the Omnibus Reconciliation Act of 1993 (OBRA '93) as it relates to Qualified Medical Child Support Orders.

B. **Continuation of Coverage**

B.1. **Availability**

B.1.1. Colorado law, Section 10-16-108 C.R.S., and Federal law, Title X, Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as amended, require continuation coverage be made available to subscribers and their dependents when the subscriber is terminated or some other qualifying event occurs that would cause the subscriber or member to lose coverage. Continuation coverage means you have the right to continue your PacifiCare of Colorado group coverage at your own expense, even if you are no longer eligible for coverage paid by your employer. It is PacifiCare of Colorado's opinion that the Federal law, COBRA, will take precedence over the Colorado law except for groups of fewer than twenty (20) employees, church groups, or any subscribers terminated for gross misconduct.

B.1.2. To the extent required by either Federal or State law, continuation coverage will be made available under this Agreement.

B.1.3. Continuation coverage is *not* automatic. The subscriber or dependent *must* be eligible, *must* elect to take the coverage, *must* complete an enrollment application, and *must* pay the necessary premiums.

B.1.4. There are certain events that will terminate the continuation coverage before the end of the continuation period. These events are outlined in the State and Federal legislation.

B.2. **Continuation of Coverage Rules**

B.2.1. This section summarizes the various provisions of the law. It is a general notice of the member's rights and should not be regarded as a complete discussion of the applicable provisions.

B.2.2. Continuation of health plan coverage is available to subscribers and their qualified beneficiaries, which include spouse and dependent children. This coverage is based on certain qualifying events.
B.2.3. If a qualifying event occurs, the subscribing group/plan administrator will supply members with individual notice and a form to elect continuation coverage. For groups with twenty (20) or more employees plan members must make their election within sixty (60) days of the later of the following:

- The date of termination of coverage under this Agreement
- The date the member receives notice of the right to continuation of coverage

B.2.3.1. For groups with fewer than twenty (20) employees, plan members must make their election within thirty (30) days from the date of termination of employment.

B.2.4. For dissolution of marriage, legal separation, or changes in dependent status, the member must notify the subscribing group/plan administrator within sixty (60) days of the event if the subscribing group has twenty (20) or more employees. For members in groups with less than twenty (20) employees, notification is required within thirty (30) days of the event.

B.2.5. Qualified beneficiaries who relocate outside the PacifiCare of Colorado service area are entitled to retain their PacifiCare of Colorado coverage subject to the conditions of this Agreement. With the exception of benefits listed in Section E., Emergencies and Urgent Care Outside the PacifiCare of Colorado Service Area, in Chapter Three, What is Covered, all covered services must be obtained within the PacifiCare of Colorado service area through a participating Primary Care Physician (PCP).

B.3. Groups of Fewer than Twenty (20) Employees

B.3.1. For groups with fewer than twenty (20) employees, church groups, or any employees terminated for gross misconduct, the continuation period is eighteen (18) months from termination of employment.

B.3.2. For groups with fewer than twenty (20) employees, church groups, or any subscribers terminated for gross misconduct, a terminated subscriber may elect to receive continuation coverage for the subscriber and/or dependents if:

- The group contract has not been terminated in its entirety by the subscribing group.
- Any premium or contribution required from or on behalf of the subscriber has been paid in full to the termination date.
- The subscriber has been continuously covered under the group service contract or its predecessor contract for a minimum of six (6) months.
- The subscriber is not entitled to Medicare or Medicaid coverage.
- The subscriber elects within thirty (30) days from the date of termination of employment (sixty (60) days if the subscribing group fails to provide proper notice) to accept continuation coverage and pays 100% of the required monthly premium for the requested coverage.

B.3.3. Within ten (10) days of the date of termination, the subscribing group will provide the subscriber with written notice of his/her right to elect continuation coverage, the amount of the monthly payment required from the subscriber, the place of payment, and deadline for receiving payment and the fact that loss of coverage will result if payment is not received by the deadline.

B.4. Groups of Twenty (20) or More Employees

B.4.1. For groups with twenty (20) or more employees, the premium may be up to 102% of the premium being paid before the qualifying event occurred with one exception. For a disabled beneficiary, the premium may be increased from 102% to 150% for months 19-29 of continuation coverage.

B.4.2. A qualified beneficiary must pay current premiums for continuation coverage no later than forty-five (45) days after the beneficiary's election to continue coverage.
B.5. **Continuation of Coverage Table**

B.5.1. The length of continuation of coverage, the qualifying events, and qualified beneficiaries are summarized in this table:

<table>
<thead>
<tr>
<th>Qualifying Events</th>
<th>Continuation Period (20 or more employees)</th>
<th>Continuation Period (fewer than 20 employees)</th>
<th>Qualified Beneficiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Termination of employment (except for gross misconduct of a subscriber in a group of 20 or more)</td>
<td>18 months*</td>
<td>18 months</td>
<td>Subscriber, spouse, and/or other dependents</td>
</tr>
<tr>
<td>2. Reduction of working hours of subscriber</td>
<td>18 months*</td>
<td>N/A</td>
<td>Subscriber, spouse, and/or other dependents</td>
</tr>
<tr>
<td>3. Death of subscriber</td>
<td>36 months</td>
<td>18 months</td>
<td>Spouse and/or other dependents</td>
</tr>
<tr>
<td>4. Dissolution of marriage or legal separation of subscriber from subscriber’s spouse</td>
<td>36 months</td>
<td>18 months</td>
<td>Spouse and/or other dependents</td>
</tr>
<tr>
<td>5. Subscriber becomes entitled to Medicare</td>
<td>36 months</td>
<td>N/A</td>
<td>Spouse and/or other dependents</td>
</tr>
<tr>
<td>6. Dependent child ceases to be a dependent child under the requirements of this Agreement</td>
<td>36 months</td>
<td>N/A</td>
<td>Dependent child</td>
</tr>
</tbody>
</table>

*Except for the reason of gross misconduct, this continuation period for the subscriber, spouse and/or other dependents may be extended by an additional eleven (11) months if a qualified beneficiary receives a determination of disability under the Social Security Act. The determination of disability must be made prior to termination or within the initial sixty (60) days of COBRA coverage.

B.6. **Conversion to Nongroup Coverage**

B.6.1. At the end of the continuation period, the subscriber or qualified beneficiary has the option to convert to nongroup coverage generally available under this Agreement. See Section C., Conversion, in this chapter.

C. **Conversion**

C.1. **Availability**

C.1.1. Any member who is no longer eligible for coverage as part of a subscribing group may convert to individual conversion membership without regard to health status or requirement for health care services. The member cannot elect conversion coverage if he/she is eligible for continuation or COBRA coverage (See Subsection C.2, Limitations, below for additional information).

C.1.2. Any member who has reached the end of continuation coverage may convert to conversion coverage without regard to health status or requirement for health care services. Notification of conversion rights will be given during the 180 days preceding the expiration of the continuation coverage.

C.1.3. The subscriber must convert his/her membership according to the policies that PacifiCare of Colorado has in effect at the time of application for conversion.

C.1.4. Conversion coverage plans offered are the Basic and Standard Health Benefit plans mandated by the State of Colorado.
C.2. **Limitations**

C.2.1. Notwithstanding Subsections C.1-C.3 in this section, a subscriber and/or dependents will have no conversion rights if the subscriber is no longer eligible to continue as a member of the subscribing group for any of the following reasons:

- Termination of entire group if the group has fifty-one (51) or more employees, or as required by small group health insurance laws
- Termination for nonpayment of applicable premiums or copayments
- Termination due to failure to comply with recommended procedures or treatments
- Gross abuse of PacifiCare of Colorado's plan rules and regulations
- Falsifying membership information

C.3. **Election**

C.3.1. The member must convert his/her membership within thirty-one (31) days of the date he/she becomes ineligible for coverage under the subscribing group. The conversion is effective retroactive to the date of ineligibility.

C.4. **Out-of-Area**

C.4.1. PacifiCare of Colorado may designate an insurance carrier to provide conversion benefits to those persons who cease to be eligible for coverage because they no longer maintain residence within the service area. Benefits, terms, and premiums of the conversion contract will be determined by the designated insurance carrier.

D. **Coordination of Benefits and Subrogation**

D.1. **Coordination of Benefits**

D.1.1. **General**

D.1.1.1. PacifiCare of Colorado will follow coordination of benefits guidelines promulgated by the Colorado Division of Insurance to establish the order of carrier responsibility in coordinating benefits with other Plans in force for members, including members covered by more than one policy with PacifiCare of Colorado. "Plan" is defined below.

D.1.1.2. The benefits available to members under any other Plan will be coordinated pursuant to the provisions of this section to avoid duplicate payment to members for the same or similar benefits or services.

D.1.1.3. In the event that the order of benefit determination rules set forth in this Section D. differ from those permitted by Colorado Insurance Regulation 4-6-2, or any successor regulation, then the order of benefit determination rules set forth herein will be construed as if their terms conformed to the minimum requirements of that regulation.

D.1.2. **Applicability**

D.1.2.1. This Coordination of Benefits ("COB") provision applies to this Plan when a subscriber or the subscriber's covered dependent has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.

D.1.2.2. If this COB provision applies, the order of benefit determination rules should be looked at first. The order of benefit determination rules are stated in Subsection D.1.4, Order of Benefit Determination Rules. Those rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:

- Will not be reduced when, under the order of benefit determination rules, This Plan determines its benefits before another Plan; but
- May be reduced when, under the order of benefits determination rules, another Plan determines its benefits first. The above reduction is described in Subsection D.1.5, Effect on the Benefits of This Plan.
D.1.3. Definitions

The following definitions will apply to this section:

D.1.3.1. "Plan" is any of the following which provides benefits, indemnification or services for, or because of, medical or dental care or treatment covered by This Plan:

- Group insurance or group-type coverage (including other PacifiCare of Colorado coverage), whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes coverage other than school accident-type coverage.
- Coverage under a governmental Plan, or coverage required or provided by law. This does not include a state Plan under Medicaid (Grants to States for Medical Assistance Programs, Title XIX of the United States Social Security Act, as amended from time to time).
- Individual automobile "no-fault" or traditional "fault" type contracts.
- Hospital indemnity benefits in excess of $100 per day.

Each contract or other arrangement for coverage under any bulleted item above is a separate Plan. Also, if an arrangement has two parts and COB rules apply only to one of the two, each of the parts is a separate Plan.

D.1.3.2. "This Plan" refers to the covered benefits for health care services of the Evidence of Coverage of which this section is a part.

D.1.3.3. "Primary Plan/Secondary Plan" The order of benefit determination rules state whether this Plan is a Primary Plan or a Secondary Plan as to another Plan covering the person.

When This Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the individual, This Plan may be a Primary Plan as to one or more other Plans, and may be a Secondary Plan as to a different Plan or Plans.

D.1.3.4. "Allowable Expense" means a necessary, reasonable and customary item of expense for health care; when the item of expense is covered at least in part by one or more Plans covering the individual for whom the claim is made.

The difference between the cost of a private hospital room and cost of semi-private hospital room is not considered an Allowable Expense under the above definition unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice or as specifically defined in the Plan.

When a Plan provides benefits in the form of services, the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

When benefits are reduced under a Primary Plan because a covered individual does not comply with the Plan provisions, the amount of such reduction will not be considered an Allowable Expense. Examples of such provisions are those related to second surgical opinions, precertification of admissions or services and preferred provider arrangements.

D.1.3.5 "Claim Determination Period" means the period of time, which must not be less than twelve consecutive months, over which allowable expenses are compared with total benefits payable in the absence of COB, to determine:

- whether overinsurance exists; and
- how much each plan will pay or provide

It usually is a calendar year, but a plan may use some other period of time that fits the coverage of the group contract. A person may be covered by a plan during a portion of a claim determination period if that person's coverage starts or ends during the claim determination period.
As each claim is submitted, each plan is to determine its liability and pay or provide benefits based upon allowable expenses incurred to that point in the claim determination period. But that determination is subject to adjustment as later allowable expenses are incurred in the same claim determination period.

However, it does not include any part of a year during which an individual has no coverage under This Plan, or any part of a year before the date this COB provision or a similar provision takes effect.

D.1.4. Order of Benefit Determination Rules

D.1.4.1. General. When there is a basis for a claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan unless:

- The other Plan has rules coordinating its benefits with those of This Plan, and both those rules and This Plan's rules, D.1.4.2 below, require that This Plan's benefits be determined before those of the other Plan; or
- The other Plan is a governmental Plan or coverage required or provided by law, and This Plan is required by law or regulation to be the Primary Plan. A basis for a claim under a governmental Plan can exist when a member is covered or eligible for coverage under that Plan, whether or not the member applies for or receives benefits thereunder. The conditions shown are current examples (subject to change) of some of the areas in which this Plan is required to be the Primary Plan:
  - The member is covered under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).
  - The member is covered under Medicaid.
  - The member is actively at work and is age 65 or older, and is enrolled as a subscriber or as a dependent of a subscriber (of any age) in the group coverage of a subscribing group with twenty (20) or more employees.
  - The member is entitled to Medicare benefits on the basis of End Stage Renal Disease, in which case This Plan will be primary for the first thirty (30) months (or such period of time as Medicare regulations may require) of treatment; after the initial period, the benefits under This Plan will be reduced to the extent that they duplicate any benefits provided or available under Medicare, if the member is covered or eligible to be covered under Medicare.

D.1.4.2. Rules. This Plan determines its order of benefits using the first of the following rules which applies:

**Rule a:** Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, member or subscriber (that is, other than as a dependent) are determined before those of the Plan which covers the individual as a dependent.

**Rule b:** Dependent Child/Parents not Separated or Divorced. Except as stated in **Rule c** below, when This Plan and another Plan cover the same child as a dependent of different persons, called "parents":

- The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but
- If both parents have the same birthday, the benefits of the plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other plan does not have the rule described in the first bulleted item immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule of the other Plan will determine the order of benefits.
Rule c: Dependent Child/Separated or Divorced. If two or more plans cover an individual as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

- First, the Plan of the parent with custody of the child;
- Then, the Plan of the spouse of the parent with the custody of the child; and
- Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent will be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

Rule d: Joint Custody. If the specific terms of a court decree state that the parents will share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the Plans covering the child will follow the order of benefit determination rules outlined in Rule b.

Rule e: Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, then Rule e is ignored.

Rule f: Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, member or subscriber longer are determined before those of the Plan which covered that individual for the shorter term.

Rule g: Disputed Order of Benefits. If the plans can not agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment except that no plan shall be required to pay more than it would have paid had it been primary.

D.1.5. Effect on the Benefits of This Plan

D.1.5.1. When This Section Applies. This Subsection D.1.5 applies when, in accordance with Subsection D.1.4, Order of Benefit Determination Rules, This Plan is a Secondary Plan as to one or more other Plans. In that event the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in D.1.5.2 immediately below.

D.1.5.2. Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:

- The benefits that would be payable for the Allowable Expense under This Plan in the absence of this COB provision; and
- The benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

D.1.5.3. Only the amount of benefit actually paid by This Plan may be charged against any applicable limit under This Plan.
D.1.6. Right to Receive and Release Needed Information
D.1.6.1. Certain facts are needed to apply these COB rules. PacifiCare of Colorado has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or individual. PacifiCare of Colorado need not tell, or get the consent of, or provide notice to, any individual to do this. Each individual claiming benefits under This Plan must give PacifiCare of Colorado any facts it needs to pay the claim.

D.1.7. Facility of Payment
D.1.7.1. A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, PacifiCare of Colorado may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under This Plan. PacifiCare of Colorado will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

D.1.8. Right of Recovery
D.1.8.1. If the amount of the payments made by PacifiCare of Colorado is more than it should have paid under the COB provision, it may recover the excess from one or more of:
- The individuals it has paid or for whom it has paid;
- Insurance companies; or
- Other organizations.

D.1.8.2. The "amount of payments made" includes the reasonable cash value of any benefits provided in the form of services.

D.2. Motor Vehicle No-Fault Insurance
D.2.1. Under Colorado law, if a member owns and operates a motor vehicle on the public highways, the member is required to have no-fault insurance, which covers certain medical and rehabilitation expenses incurred if a member or others are injured in an automobile accident.

D.2.2. PacifiCare of Colorado is required by law to coordinate its coverage with a member's no-fault insurance. This means that if a member is injured in an automobile accident, the automobile no-fault insurance will pay first, and PacifiCare of Colorado will provide coverage only if the amount of no-fault coverage is insufficient to pay for all of the medical expenses.

D.2.2.1. PacifiCare of Colorado's coverage under this Agreement includes the amount of the deductible under the no-fault coverage.

D.2.3. If there is an automobile policy in effect, and the member waives or fails to assert his/her rights to the no-fault benefits, PacifiCare of Colorado will not pay the benefits that would have been available under the no-fault policy.

D.2.4. If the no-fault insurance policy provides coverage in excess of the minimum required by law, PacifiCare of Colorado will coordinate benefits with the amount of coverage provided.

D.2.5. PacifiCare of Colorado reserves the right to require proof that the automobile policy has paid all benefits required by law before PacifiCare of Colorado pays any benefits.

D.2.6. If there is more than one automobile policy in force, PacifiCare of Colorado will coordinate with complying no-fault policies as required by the state of Colorado.

D.2.7. After benefits under the no-fault policy have been exhausted, coverage under the terms of this Agreement will be available only if the member obtains all medical care for covered benefits in compliance with this Agreement from or through a participating PCP.
D.3. Workers’ Compensation

D.3.1. PacifiCare of Colorado will not provide benefit services or supplies required as a result of a work-related illness or injury. This applies to illness or injury resulting from occupational accidents or sickness covered under any of the following:

- Occupational disease laws
- Employer's liability
- Federal, State, or municipal law
- The Workers' Compensation Act

D.3.2. To recover benefits for a work-related illness or injury, the member must pursue his/her rights under the Workers’ Compensation Act or any of the above provisions that may apply to the illness or injury. This includes filing an appeal with the Industrial Commission, if necessary.

D.3.2.1. When a legitimate dispute exists as to whether an injury or illness is work-related, PacifiCare of Colorado will provide benefits during the appeal process if the member signs an agreement to reimburse PacifiCare of Colorado for 100% of the benefits provided.

D.3.3. PacifiCare of Colorado will not provide benefit services for a work-related illness or injury even under the following circumstances:

D.3.3.1. The member fails to file a claim within the filing period allowed by law.

D.3.3.2. The member obtains care that is not authorized by Workers' Compensation.

D.3.3.3. The member fails to comply with any other provisions of the law.

D.3.3.4. The member has a choice of providers, which includes a PacifiCare of Colorado provider, elects to use a non-participating provider and the claim is subsequently denied by Workers’ Compensation.

D.3.4. Benefits will not be denied to a subscriber whose employer has not complied with the laws and regulations governing Worker's Compensation Insurance, provided that such subscriber has sought and received services under the provisions of this Agreement.

D.4. Subrogation

D.4.1. PacifiCare of Colorado will not cover any services or supplies for which a third party is liable or has agreed to make payment. In such cases, all of the following will apply:

D.4.1.1. The member shall promptly notify PacifiCare of Colorado of any claim against the third parties.

D.4.1.2. The member shall cooperate in every necessary way to help PacifiCare of Colorado enforce its right to pursue and collect from the third party.

D.4.1.3. The member shall hold recovery proceeds in trust for PacifiCare of Colorado.

D.4.1.4. PacifiCare of Colorado shall be subrogated and shall succeed to any member's right of recovery from a third party for the amount of actual expenses paid by PacifiCare of Colorado, as well as future medical expenses not yet incurred, which are related directly to the injury or illness and are the responsibility of a third party.

D.4.1.5. The member shall reimburse PacifiCare of Colorado as explained in Subsections D.4.1.6-D.4.1.9 below.

D.4.1.6. When the member has received payment from the third party, as a result of judgement, settlement, or otherwise, the member must first reimburse PacifiCare of Colorado for the amount of actual expenses paid. An agreement pertaining to a fair present value payment or trust account to cover future medical expenses will be established by PacifiCare of Colorado and the member in the event of a lump sum award or settlement of a claim for future medical expenses. In the absence of such an agreement, PacifiCare of Colorado will exclude coverage for future medical expenses related to the injury or illness up to the amount of the award.
D.4.1.7. The right of reimbursement of PacifiCare of Colorado comes first even if a member is not paid for all of his claim for damages against the other person or organization or if the payment he receives is for, or is described as for, his damages (such as for personal injuries) for other health care expenses or if the member recovering money is a minor.

D.4.1.8. PacifiCare of Colorado will be reimbursed subject to reduction equal to PacifiCare of Colorado's pro rata share of the attorney's fees and costs incurred by the member in obtaining the recovery. In no event will PacifiCare of Colorado pay more than thirty-three percent (33%) of PacifiCare of Colorado's recovery in attorney's fees.

D.4.1.9. Should a member refuse or fail, for any reason, to pursue his rights, then PacifiCare of Colorado will have the right to initiate an action as subrogee in the member's name or in PacifiCare of Colorado's name, at PacifiCare of Colorado's election, to recover benefits provided under this Agreement and the member will cooperate fully in the pursuit of any such action.

D.4.1.10. The member will, on request, execute and deliver whatever documents or whatever else PacifiCare of Colorado determines is necessary to carry out the provisions of this subsection.

D.4.1.11. The provisions of this section are binding on all members by virtue of Subsection A.5, Member's Agreement. However, PacifiCare of Colorado may condition the payment of benefits on the member's (or his/her personal representative's) express written acceptance of the provisions of this section.

E. **Effective Date of Coverage**

E.1. **Effective Date**

E.1.1. Subject to the terms of Sections F., Eligibility, and G., Enrollment, in this chapter, when an individual submits a written application for him/herself or for him/herself and eligible dependents on or before he/she is eligible to enroll, coverage will become effective on the first day of the month after he/she becomes eligible or as indicated on the Signature Sheet.

E.2. **Addition of Dependents**

E.2.1. To enroll a new dependent acquired through marriage or birth, the subscriber must submit written application for dependent coverage within thirty-one (31) days after the marriage or birth. Coverage will be effective retroactively to the date of the marriage or birth.

E.2.2. To enroll a new dependent acquired through legal adoption, the subscriber must submit written application for dependent coverage within thirty-one (31) days of when the child is placed with the subscriber for adoption. The subscriber also must submit a copy of the adoption papers. Coverage will be retroactively effective to the date of placement.

E.2.3. Newborns are covered for the first thirty-one (31) days of life, regardless of whether the subscriber applies for continued coverage beyond the first thirty-one (31) days PROVIDED that all medical care for covered benefits for the newborn is obtained in compliance with this Agreement from or through a participating provider. For continuing coverage beyond the first thirty-one (31) days of life, the subscriber must make written application for dependent coverage within the required thirty-one (31) days.

E.2.4. Any applicable changes in monthly premium amounts due to the addition of a dependent(s) will take effect as specified under Payment Arrangements on the Signature Sheet.

E.2.5. If, following acquisition of a new dependent(s), the subscriber fails to submit a written application for dependent coverage as required in this section, the new dependent(s) cannot be enrolled prior to the next group open enrollment period except as described in Section G.3.
E.3. Previous Confinement

E.3.1. If an eligible new member or a subscriber (as defined in Chapter Seven, Definition of Terms) is confined to a hospital or institution on the proposed effective date of coverage under this Agreement, coverage under this Agreement will become effective upon that date subject to reduction for benefits under the prior carrier’s period of extension or accrued liability, PROVIDED he/she obtains all medical care for covered benefits in compliance with this Agreement and from or through a participating Primary Care Physician (PCP). The member must notify PacifiCare of Colorado of the confinement within forty-eight (48) hours, or as soon as practical, after the proposed effective date. This subsection shall be applied in a manner necessary to conform to the requirements of Colorado law.

F. Eligibility

F.1. Subscriber

F.1.1. To be eligible to enroll as a subscriber, an individual must be an employee with the subscribing group. The subscribing group must give PacifiCare of Colorado a definition of “eligible employee” when it submits the group application.

F.1.2. All eligible employees and their eligible dependents must reside inside the PacifiCare of Colorado service area. For legally required exceptions to this provision, see Section B., Continuation of Coverage, in this chapter.

F.2. Dependents

NOTE: The dependent eligibility conditions included in the HMO Evidence of Coverage and Owner's Manual Signature Sheet supersede the eligibility conditions referenced in this section, if different from those conditions stated here. Your employer group may establish different criteria regarding the following dependent eligibility. Check with your employer or Customer Service for information regarding the dependent age limit(s) or other dependent eligibility information applicable to your employer group.

F.2.1. A subscriber's spouse is eligible to enroll as a dependent.

F.2.2. Common law spouses will be considered eligible dependents if evidence satisfactory to PacifiCare of Colorado is furnished upon request.

F.2.3. Legal separation does not constitute ineligibility. The Subscribing Group may elect, however, to deny eligibility to legally separated spouses. Legal separation is a qualifying event for COBRA (see Section B., Continuation of Coverage, in this chapter).

F.2.4. A subscriber's children are eligible to enroll as dependents through the month in which they reach the age of 19, or 24 if enrolled as a full-time student at a high school, college, university, vocational, or secondary school, provided they meet the following criteria:

F.2.4.1. They are unmarried natural, legally adopted, or step-children,

OR

They are unmarried children for whom the subscriber has assumed permanent legal guardianship. Legal evidence of the adoption, guardianship and custody, such as a certified copy of a court order, must be furnished to PacifiCare of Colorado on request.

F.2.4.2. They must be principally dependent upon the subscriber for maintenance and support.

F.2.4.3. They must reside inside the PacifiCare of Colorado service area, or be enrolled as a full-time student at an elementary school, middle school, high school, college, university, vocational, or secondary school. Verification of academic enrollment must be provided to PacifiCare of Colorado on request.

F.2.5. Newborns of the subscriber are covered from the date of birth. This does not include an adopted child before the child is placed with the subscriber for adoption as explained in Section E., Effective Date of Coverage, in this chapter.
F.2.6. Regardless of age, any natural, adopted, or step-child(ren), of the subscriber, or child(ren) for whom the subscriber has assumed permanent legal guardianship, as described above, are eligible if they are medically certified as disabled and incapable of self-support. Proof of such incapacity and dependency must be furnished at least annually as requested by PacifiCare of Colorado, and as required by the subscribing group. Such dependents are the only exception to the age limitation described above.

F.3. Active Military Duty and Military Reservists

F.3.1. Unless otherwise specified in the Signature Sheet, subscribers or covered dependents who are called to active military duty will no longer be considered eligible under PacifiCare of Colorado, but may elect continuation of coverage under COBRA or USERRA (Uniformed Services Employment and Reemployment Rights Act). The waiting period will be waived for those returning from active duty if application is made within thirty-one (31) days following the date of re-employment.

F.3.1.1. Continuation coverage under this Health Plan shall be available to Members through Group under the Uniform Services Employment and Reemployment Rights Act of 1994, as amended (“USERRA”). The continuation coverage under this section shall be equal to, and subject to the same limitations as, the benefits provided to other Members regularly enrolled in this Health Plan and shall be made available to eligible Members absent from employment with Group by reason of service in the United States uniformed services (“USERRA Continuation Members”). Such coverage, including, but not limited to, the maximum period of USERRA coverage, will be provided to USERRA Continuation Members pursuant to the requirements set forth in USERRA.

For HMO 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.

F.3.1.2. Group shall provide written notice to each Member eligible for USERRA continuation coverage of the continuation coverage available to such Member under USERRA.

F.3.1.3. The Health Plan Premium for USERRA Continuation Members shall be equal to the Health Plan Premium for similarly situated regular Group Members plus any additional surcharge or administrative fee that can be charged to the USERRA Continuation Member as allowed by law. Group shall be solely responsible for collecting Health Plan Premiums from USERRA Continuation Members and shall transmit such Health Plan Premiums to PacifiCare along with the Group’s Health Plan Premiums otherwise due under this Agreement. Group shall maintain accurate records regarding USERRA Continuation Member Health Plan Premium, qualifying events, terminating events and other information necessary to administer this continuation benefit.

F.3.2. Military Reservists returning to work from active duty in the Armed Forces may have coverage reinstated, for themselves and any eligible dependent provided:

F.3.2.1. such individual was eligible under the plan on the day employment with his or her employer ended due to being called to active duty in the Armed Forces; and

F.3.2.2. such individual becomes re-employed with his/her employer within ninety (90) days of his/her discharge, or within one (1) year if such individual was hospitalized on the date of his/her discharge; and

F.3.2.3. the individual applies for coverage subject to the enrollment requirements outlined in this Agreement.

F.3.3. The coverage provided under this provision will be the benefits currently provided by PacifiCare of Colorado. If an individual returns to active employment within the same contract year, eligible charges accumulated toward the satisfaction of provisions such as full payment provisions or contract year maximums will be taken into consideration when determining benefits available for the remainder of the contract year.

F.4. Proof of Eligibility

F.4.1. All members and applicants for coverage under this Agreement must complete and submit to PacifiCare of Colorado all applications or other forms or statements that PacifiCare of Colorado may reasonably request to determine eligibility.
G. **Enrollment**

**NOTE:**

The dependent eligibility conditions included in the HMO Evidence of Coverage and Owner's Manual Signature Sheet supersede the eligibility conditions referenced in this section, if different from those conditions stated here. Your employer group may establish different criteria regarding the following dependent eligibility. Check with your employer or Customer Service for information regarding the dependent age limit(s) or other dependent eligibility information applicable to your employer group.

G.1. **Initial Enrollment**

G.1.1. Subscribers and dependents will be enrolled under this Agreement when they first become eligible or as described in Subsection G.2.2 below. They must submit completed enrollment application forms to the subscribing group or as otherwise directed by PacifiCare of Colorado within thirty-one (31) days of the eligibility date. Promptly after receiving the form, the subscribing group will forward it to PacifiCare of Colorado.

G.1.1.1. All members and applicants for coverage under this Agreement must complete and submit to PacifiCare of Colorado all applications or other forms or statements that PacifiCare of Colorado may reasonably request to determine eligibility.

G.2. **Group Open Enrollment**

G.2.1. The subscribing group will offer coverage as described in this Agreement to all eligible individuals under conditions no less favorable than those for any other alternate health care plan it makes available.

G.2.2. There will be a group enrollment period annually, during which the subscribing group will offer to all eligible individuals the choice of enrollment, for themselves and their dependents, in PacifiCare of Colorado or any other alternate health care plans available through the subscribing group.

G.3. **Other Enrollment**

G.3.1. Eligible individuals may enroll in PacifiCare of Colorado outside the group enrollment period when newly eligible in the following situations:

G.3.1.1. An individual involuntarily loses coverage under another creditable coverage in which he/she was enrolled at the time of initial eligibility or open enrollment.

G.3.1.2. A court has ordered that coverage be provided for a dependent under a covered employee's health benefit plan.

G.3.1.3. A court has ordered that coverage be provided under an eligible, but not enrolled, employee’s health benefit plan. The employee is required to enroll at the same time as the dependent.

G.3.1.4. The spouse of a subscriber has coverage through his/her employment, and dependents of the subscriber are covered under the spouse's insurance. Then the spouse involuntarily loses this coverage. At this time, the spouse, if alive, and any dependents of the subscriber previously covered by the spouse's insurance may enroll in PacifiCare of Colorado as dependents, with the consent of the subscribing group.

G.3.1.5. An individual employed by a PacifiCare of Colorado subscribing group was covered under his/her spouse's coverage through the spouse's employment. Then the spouse involuntarily loses this coverage. At this time, the individual, his/her spouse, and any dependents of the individual may enroll in PacifiCare of Colorado, with the consent of the subscribing group.

G.3.1.6. For the situations described in G.3.1.4 and G.3.1.5 above, PacifiCare of Colorado reserves the right to make it a condition of enrollment that PacifiCare of Colorado receives written proof of loss of coverage due to one of the following circumstances:

- Termination of job or reduction in hours
- Insurance carrier termination of coverage for the spouse's employer
- Death of the spouse, leaving other dependents without coverage
G.3.1.7. An individual who is employed by a PacifiCare of Colorado subscribing group and who previously declined enrollment is entitled to enroll if the employee has a new dependent by birth, marriage, adoption, or placement for adoption. The election to enroll must be made within thirty (30) days following the birth, marriage, adoption, or placement for adoption.

G.3.2. To be eligible to enroll with PacifiCare of Colorado, the individuals must submit a change form to PacifiCare of Colorado through the subscribing group within thirty-one (31) days from the date of the loss of creditable coverage. Coverage with PacifiCare of Colorado becomes effective the first day following termination of previous coverage.

G.4. Limit of Enrollment

G.4.1. If it becomes necessary for PacifiCare of Colorado to limit enrollment of additional members in order to maintain a suitable level of medical and hospital care, PacifiCare of Colorado can limit enrollment in a manner that may suspend the eligibility or enrollment provisions of this Agreement.

H. Limitations

H.1. Acts Beyond PacifiCare of Colorado’s Control

H.1.1. In the event of circumstances not reasonably within the control of PacifiCare of Colorado, such as any major disaster, epidemic, complete or partial destruction of facility, act of nature, war, riot, or civil insurrection, which results in the unavailability of any participating physicians, hospitals or contract providers, PacifiCare of Colorado shall attempt to arrange for medical and hospital services for members insofar as practical, according to its best judgment. During this period, PacifiCare of Colorado will have the right to authorize and direct where medical and hospital services will be performed. Neither PacifiCare of Colorado, nor any participating physicians, hospitals or contract providers 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.

H.2. Contract Providers

H.2.1. The specific contract providers associated with PacifiCare of Colorado, both individuals, organizations, and institutions, may be subject to change. A member may contact PacifiCare of Colorado for the latest update to the Provider Directory.

H.2.2. PacifiCare of Colorado does not guarantee the continuing participation of any primary care physician or other participating provider or institution during the term of this Agreement. In the event of any termination of a member's primary care physician or his/her inability to perform, the member will be required to select a new primary care physician immediately.

I. Member Complaint and Appeal Process for Claims Involving Utilization Review

NOTE:
“Utilization review” means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review. Utilization review shall also include reviews for the purpose of determining coverage based on whether or not a procedure or treatment is considered experimental or investigational in a given circumstance, and reviews of a member’s medical circumstances when necessary to determine if an exclusion applies in a given situation.

I.1. Complaints

I.1.1. If the member is not satisfied with services or benefits received from the PacifiCare of Colorado, PacifiCare Behavioral Health or any participating provider, the member is asked to contact the Customer Service Department initially and an attempt will be made to resolve concerns. A complaint form will be provided to the member if the member wishes to register a written complaint.
I.2. **Appeal Process**

I.2.1. If the member is not satisfied with the resolution and wishes to pursue the issue further, the member or the member’s designated representative may either submit a verbal or written request to initiate the appeal process. Written requests should be directed to the PacifiCare of Colorado’s Member Appeals Team. Verbal requests should be directed to Customer Service. An appeal must be initiated within twenty-four (24) months of the date of the initial denial.

I.2.2. **Department Review**

I.2.2.1. The Member Appeals Team will attempt to resolve such requests through research by the appropriate department to determine if criteria and processes have been administered correctly. The appeal will be evaluated by a physician who shall consult with clinical peers in the specialty as would typically manage the case being reviewed. The clinical peers shall not have been involved in the initial adverse determination. The member and the ordering provider will be notified of the resolution no later than twenty (20) days after PacifiCare of Colorado receives the request. If the member or ordering provider is not satisfied with the decision, a written or verbal request must be submitted within ninety (90) days of the review determination to initiate the next level of the appeal process. If the next step of the process is not initiated by the member or ordering provider as explained above, the action or claim denial will be final.

I.2.2.1.1. **Expedited Review**

In cases where the time frame set forth in the Department Review would seriously jeopardize the life or health of the member, or would jeopardize the member’s ability to regain maximum function, PacifiCare of Colorado will conduct an Expedited Review. This review shall be provided to all requests concerning an admission, availability of care, continued stay or health care service for a member who has received emergency services but has not been discharged from a facility. In an expedited review, PacifiCare of Colorado shall make a decision and notify the member or ordering provider as expeditiously as the member’s medical condition requires, but no later than seventy-two (72) hours after the review is commenced. If the Expedited Review is conducted during the member’s hospital stay or course of treatment, the service shall be continued without liability to the member until the member has been notified of the decision. PacifiCare of Colorado will provide written confirmation of its decision within two (2) working days of providing notification of the decision, if the initial notification was not in writing.

I.2.3. **Plan Internal Review Committee (PIRC)**

I.2.3.1. In the case where the Department Review process, including an Expedited Review, does not resolve a difference of opinion between PacifiCare of Colorado and the member or ordering provider, the member may submit a written or verbal request for review by the PIRC. This committee shall include a minimum of three people, and will be composed of employees of PacifiCare who have appropriate professional expertise. A majority of the PIRC shall be comprised of persons who were not previously involved in the appeal. However, a person who was previously involved with the appeal may be a member of the PIRC or appear before the PIRC to present information or answer questions. The PIRC will make a decision within thirty (30) days of the member’s request.

I.2.4. **Standard Independent External Review**

I.2.4.1. If the member is not satisfied with the decision of the PIRC, the member or the member’s designated representative may request an independent external review. The Independent External Review process is available to PacifiCare of Colorado members who have completed each of the internal appeals review levels offered by PacifiCare of Colorado or have completed an expedited review of a denial of a benefit pursuant to state regulation.
I.2.5. Expedited Independent External Review

I.2.5.1. A member or the member’s designated representative may make a request for an expedited external review if the member has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the member, would jeopardize the member’s ability to regain maximum function or, for members with a disability, create an imminent and substantial limitation of their existing ability to live independently.

I.2.5.2. The member or the designated representative’s request for an expedited review must include a physician’s certification that the member’s medical condition meets the criteria.

I.2.6. Review Time Frames

I.2.6.1. All requests for an independent external review must be made within sixty (60) calendar days of the date the member receives the PIRC denial. The member, the member’s physician, or the member’s designated representative may submit a written request for an independent external review. PacifiCare of Colorado, upon receipt of a completed request for an independent external review will deliver a copy of the request to the Division of Insurance (DOI) within two (2) working days, or within one (1) working day for an expedited independent external review. Within two (2) working days (or one [1] working day for an expedited review) from the time a request for external review is received from PacifiCare of Colorado, the DOI will assign an approved Independent External Review Entity (the “review entity”) to conduct the external review, and shall notify PacifiCare of Colorado of such entity. Within two (2) working days (or within one [1] working day for an expedited review) of receiving notice of the review entity from the DOI, PacifiCare of Colorado shall notify the member or the designated representative, electronically, by facsimile, or by telephone, followed by a written confirmation.

I.2.6.2. Within two (2) working days of receipt of notice from PacifiCare of Colorado, the member or the designated representative may provide the DOI with documentation regarding a potential conflict of interest of the review entity, electronically, by facsimile, or by telephone, followed by a written confirmation.

I.2.6.3. If the DOI determines that the review entity presents a conflict of interest, the DOI shall assign, within one (1) working day, another review entity to conduct the external review. The DOI shall notify the member and PacifiCare of Colorado of the name and address of the new review entity to which the appeal should be sent.

I.2.6.4. Within six (6) working days (or within three [3] working days for an expedited review) of the date the DOI notifies PacifiCare of Colorado of the review entity, PacifiCare of Colorado shall deliver to the assigned review entity the documents and information considered in making the determination. Within two (2) working days (or within one [1] working day for an expedited review) of receipt of the materials, the review entity shall deliver to the member or the designated representative, the index of all materials that PacifiCare of Colorado has submitted to the review entity. PacifiCare of Colorado shall provide to the member or designated representative, upon request, all relevant information supplied to the review entity that is not confidential or privileged under state or federal law concerning the case under review.

I.2.6.5. The review entity shall notify the member or the designated representative, the health care professional, and PacifiCare of Colorado of any additional medical information required to conduct the review. Within five (5) working days (or within two [2] working days for an expedited review) of such a request, the member or the designated representative or the health care professional shall submit the additional information, or an explanation of why the additional information is not being submitted to the review entity and PacifiCare of Colorado. If the member or designated representative or the health care professional fails to provide the additional information or the explanation of why additional information is not being submitted within the timeframe specified, the assigned review entity shall make a decision based on the information submitted by PacifiCare of Colorado.
I.2.6.6. The reviewer’s decision will be in writing and will include the reasons why the service or procedure is or is not medically necessary, or is or is not experimental or investigational, as applicable. The determinations of the reviewer shall be binding on the health coverage plan. Where a determination is made in favor of the covered individual requesting an independent external review, coverage for the treatment and services required shall be provided subject to the terms and conditions applicable to benefits under PacifiCare of Colorado’s health coverage plan.

I.2.6.7. Within thirty (30) working days (or within seven [7] working days for an expedited review) after the date of receipt of the request for external review, the review entity shall provide written notice of its decision to uphold or reverse PacifiCare of Colorado’s final adverse determination to the member or the member’s designated representative, PacifiCare of Colorado, the physician or other health care professional and the DOI. The reviewer may request that the DOI extend the deadline for the written notice of the review entity up to ten (10) working days (or five [5] working days for an expedited review) for the consideration of additional information.

I.2.6.8. Upon PacifiCare of Colorado’s receipt of the independent external review entity’s notice of a decision reversing PacifiCare of Colorado’s final adverse determination, PacifiCare of Colorado shall approve the coverage that was the subject of the final adverse determination. For concurrent and prospective reviews, and for expedited reviews, PacifiCare of Colorado shall approve the coverage with one (1) working day. For retrospective reviews, PacifiCare of Colorado shall approve the coverage within five (5) working days of the receipt of the Independent External Review entity’s decision. For all reviews, PacifiCare of Colorado shall provide written notice of the approval to the member or the designated representative within one (1) working day of PacifiCare of Colorado’s approval of coverage. The coverage shall be provided subject to the terms and conditions applicable to benefits under the health coverage plan.

I.2.6.9. If the member is not satisfied with the decision of the Standard or Expedited Independent External Review Panel, the member may, within twenty-four (24) months of the decision from the Independent External Review Panel, submit the claim to binding arbitration, as described in I.3 below. If a written request is not submitted as stated, then the action or claim denial will be final.

I.3. Arbitration

I.3.1. If a member is not satisfied with the resolution of a legal claim after exhausting all levels of the appeals process applicable to the claim, PacifiCare of Colorado and the member agree that they shall submit the claim to binding arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association unless both PacifiCare of Colorado and the member agree in writing to use another form of alternative dispute resolution (e.g., mediation). The results of the binding arbitration shall be final, with no further recourse in a court of law or otherwise available to either PacifiCare of Colorado or the member. Judgement upon the award rendered by the arbitrator(s) shall be entered in any court having jurisdiction. PacifiCare of Colorado and the member shall equally share the costs of arbitration; however, each party shall be individually responsible for the expenses related to its attorney, experts and evidence.

J. Member Complaint and Appeal Process - Benefit Denials

NOTE: This section is applicable to complaints and appeals not related to claims involving Utilization Review as described above in Section I., Member Complaint and Appeal Process for Claims Involving Utilization Review.

J.1. Member Complaints

J.1.1. If the member is not satisfied with services or benefits received from PacifiCare of Colorado, PacifiCare Behavioral Health, or any participating provider, the member is asked to contact the Customer Service Department initially and an attempt will be made to resolve concerns. A complaint form will be provided to the member if the member wishes to register a written complaint.
J.2. **Member Appeal Process**

J.2.1. If the member is not satisfied with the resolution and wishes to pursue the issue further, the member must submit a written or verbal request to initiate the member appeal process. Written requests should be directed to the PacifiCare of Colorado Member Appeals Team. Verbal requests should be directed to Customer Service. An appeal must be initiated within twenty-four (24) months of the date of the initial denial.

J.2.2. **Department Review**

J.2.2.1. The PacifiCare of Colorado Member Appeals Team will attempt to resolve such written and verbal requests through research by the appropriate department to determine if criteria and processes have been administered correctly. The member will be notified of the resolution usually no later than thirty-one (31) days after PacifiCare of Colorado receives the request. If the member is not satisfied with the decision, a written request must be submitted within ninety (90) days of the review determination to initiate the next level of the Member Appeal Process. If the next step of the process is not initiated by the member as explained above, the action or claim denial will be final.

J.2.3. **Member Relations Committee Review**

J.2.3.1. The Member Relations Committee will provide a formal review and respond to the member usually within thirty-one (31) days of receiving the request.

J.2.3.2. If the member is not satisfied with the decision of the Member Relations Committee, the member may, within twenty-four (24) months of the decision from the Member Relations Committee, submit the claim to binding arbitration, as described below. If a written request is not submitted as stated, then the action or claim denial will be final.

J.3. **Arbitration**

J.3.1. If a member is not satisfied with the resolution of a legal claim after exhausting all levels of the member appeals process applicable to the claim, PacifiCare of Colorado and the member agree that they shall submit the claim to binding arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association unless both PacifiCare of Colorado and the member agree in writing to use another form of alternative dispute resolution (e.g., mediation). The results of the binding arbitration shall be final, with no further recourse in a court of law or otherwise available to either PacifiCare of Colorado or the member. Judgment upon the award rendered by the arbitrator(s) shall be entered in any court having jurisdiction. PacifiCare of Colorado and the member shall equally share the costs of arbitration; however, each party shall be individually responsible for the expenses related to its attorney, experts and evidence.

K. **Premiums**

K.1. **Payments**

K.1.1. The subscribing group must remit to PacifiCare of Colorado, for each member, the monthly premiums specified on the Signature Sheet.

K.1.2. Changes in monthly premium amounts due to addition or deletion of dependents will take effect as specified under Payment Arrangements on the Signature Sheet.

K.1.3. The monthly premiums must be prepaid for each month of coverage; they are due on or before the first day of the month for which covered benefits are to be prepaid and provided.

K.1.4. Only members for whom the stipulated premium is actually received will be entitled to benefits hereunder, and then only for the period for which such premium is received.

K.1.5. If the addition of a new dependent, as explained in Section E., Effective Date of Coverage, in this chapter, results in a change to the premium rate, the new rate will become effective as of the new dependent's effective date.

K.1.6. The premium rates set forth on the Signature Sheet may be modified by PacifiCare of Colorado in its sole discretion upon thirty (30) days written notice to the subscribing group. Any such modification shall take effect beginning the first full month following the expiration of the thirty (30) day notice period.
K.2. **Late Charges**

K.2.1. Premium payments due on the first of the month but not paid may be subject to a one and one-half percent per month late charge.

K.3. **Nonpayment**

K.3.1. If any required premium is not received by PacifiCare of Colorado, claims for members whose premiums have not been received will be held and will not be paid until premiums are current. (See Subsection N.1, Nonpayment, in this chapter for additional information.)

K.4. **Clerical Errors**

K.4.1. Clerical error shall not deprive the member of coverage under this Agreement. Failure to report the termination of coverage shall not continue such coverage beyond the date it is scheduled to terminate according to the terms of this Agreement. Upon discovery of a clerical error, an appropriate adjustment in the premium(s) shall be made. However, no such adjustment in premium(s) or coverage shall be granted by PacifiCare of Colorado to the subscribing group for more than sixty-two (62) days of coverage prior to the date PacifiCare of Colorado was notified of such clerical error.

L. **Records**

L.1. **Confidentiality**

L.1.1. Privileged information from medical records of members, including mental health records, and information about the physician-patient relationship will be confidential. PacifiCare of Colorado will not voluntarily disclose this information without prior written consent of the member except for use of the medical records necessary to administer this Agreement; use of the medical records for medical research and education; bona fide peer review during records review or utilization review programs established to promote quality medical care; provision of statistical utilization data to the subscribing group; use of the medical records for a bona fide medical emergency; and any other exceptions provided by law. Where the release of names or identifying demographic information is not necessary to the function being performed, such information will not be released.

L.2. **Release of Information**

L.2.1. Members may be required to release privileged or confidential information necessary to determine benefits on claims. If this information is not released, PacifiCare of Colorado may withhold payment for the claims.

L.2.2. To help determine claims payment, members automatically authorize all contract providers to give PacifiCare of Colorado any medically related information about their treatment.

L.3. **Access to Records**

L.3.1. Either the subscribing group or PacifiCare of Colorado will keep member eligibility records. Upon request, the subscribing group will submit to PacifiCare of Colorado or give PacifiCare of Colorado reasonable access to these records.

L.3.2. The subscribing group shall furnish PacifiCare of Colorado with all information, authorization, and supporting documentation which PacifiCare of Colorado may reasonably require with regard to any matters pertaining to this Agreement. All documents furnished to the subscribing group by the member in connection with coverage under this Agreement, and the subscribing group's payroll and any other records pertinent to the coverage under this Agreement shall be open for inspection by PacifiCare of Colorado at any reasonable time.

M. **Relationship Between Parties**

M.1. **Description**

M.1.1. PacifiCare of Colorado's contract providers are independent contractors; they are neither agents nor employees of PacifiCare of Colorado. Also, neither PacifiCare of Colorado nor PacifiCare of Colorado employees are employees of the contract providers.
M.1.2. The subscribing group and the member agree and understand that PacifiCare of Colorado does not engage in the practice of medicine. PacifiCare of Colorado is a health maintenance organization and not a health care provider. The provider-patient relationship between the provider and member is maintained by each provider of health care services, whether or not the provider is a PacifiCare of Colorado participating provider. Each provider is responsible to the member for the diagnosis, treatment or other services rendered to the member by the provider.

M.2. Liability

M.2.1. PacifiCare of Colorado is not responsible for any loss, injury or professional negligence of any participating provider or other providers which provide medical and/or hospital care to the member.

M.2.2. The subscribing group and its members are not agents or representatives of PacifiCare of Colorado, and they are not liable for any acts or omissions by PacifiCare of Colorado or its agents or employees, or those of current or future contract providers associated with PacifiCare of Colorado.

M.3. PacifiCare of Colorado’s Responsibility

M.3.1. PacifiCare of Colorado agrees to indemnify and hold harmless the subscribing group, its directors, officers, employees, and any member from all damages, claims, lawsuits, settlements, judgments, costs, penalties, and related expenses, including attorney's fees for damages to any member resulting from the wrongful failure of PacifiCare of Colorado to make payment for services pursuant to the terms of this Agreement, so long as PacifiCare of Colorado is notified promptly in writing of any such claims and given the authority, information, and assistance (at PacifiCare of Colorado's expense) for the defense of same.

M.4. Subscribing Group’s Responsibility

M.4.1. The subscribing group agrees to engage PacifiCare of Colorado, as described in this Agreement, to provide for necessary medical and hospital services to members who voluntarily enroll under this Agreement; the employer agrees to pay a predetermined monthly premium as explained in this Agreement.

M.4.2. The subscribing group agrees to indemnify and hold harmless PacifiCare of Colorado for covered benefits rendered to or on behalf of terminated subscribers and/or ineligible dependents, beyond the date of subscriber and/or dependent termination of coverage if the subscribing group or subscriber is delinquent in notifying PacifiCare of Colorado of the change in status. Notification will be considered delinquent if not received by PacifiCare of Colorado within thirty-one (31) days of change in status.

M.4.3. Notice given by PacifiCare of Colorado to an authorized representative of the subscribing group shall be deemed notice to all affected enrollees and their enrolled family dependents in the administration of this Agreement, including the termination of this Agreement or the termination of individual coverage. In the event that this agreement is terminated, PacifiCare of Colorado will provide conversion notification as described in Section C., Conversion, in this chapter.

M.4.4. Within thirty-one (31) days following receipt of notification, the subscribing group shall apprise PacifiCare of Colorado of enrollments, terminations or other changes. No adjustment in premium(s) or coverage shall be granted by PacifiCare of Colorado to the subscribing group for more than thirty-one (31) days of coverage prior to the date PacifiCare of Colorado was notified of the change.

M.5. ERISA

M.5.1. If this health plan is an employee welfare benefit plan of the employer under the Employee Retirement Income Security Act of 1974 (ERISA), the employer shall be the Plan Administrator. PacifiCare of Colorado will exercise discretion in the determination and administration of benefits under this plan. PacifiCare of Colorado will administer all health care claims under this plan and will provide the employer with health plan information to assist the employer in meeting ERISA reporting requirements.
N. **Termination of Group Coverage**

N.1. **Nonpayment**

N.1.1. If a subscribing group defaults on payment of the monthly premium, PacifiCare of Colorado will terminate this Agreement for all members after giving the subscribing group written notice. Termination will be effective at the end of the period for which monthly premium has been paid. The subscribing group will be responsible for all premiums incurred up to the date of termination. Upon termination of the group plan for non-payment of premium, members in groups with fifty (50) or fewer employees, or as required by small group health insurance laws, are entitled to conversion coverage as described in Section C., Conversion, in this chapter. Members in groups with more than fifty (50) employees are not entitled to conversion coverage upon termination of the group plan.

N.2. **Misstatements/Omissions**

N.2.1. PacifiCare of Colorado shall have the right to rescind this agreement, as of the date of inception, for any material misstatement or omission of facts in the subscribing group application or any supporting documents.

N.2.2. Any claims that have been paid will be deducted from premiums received.

N.2.3. Claims paid in excess of premiums received will be the responsibility of the subscribing group.

N.3. **Written Notice**

N.3.1. The subscribing group may terminate this Agreement on the anniversary of the effective date of coverage for the subscribing group with at least thirty-one (31) days written notice prior to the anniversary or as specified on the Signature Sheet.

N.3.2. The subscribing group may terminate this Agreement at any other time with ninety (90) days prior written notice or as specified on the Signature Sheet.

N.3.3. PacifiCare of Colorado may terminate this Agreement if any one of the following events occurs: i) fraud or intentional misrepresentation of material fact; ii) failure to comply with contribution or participation rules; iii) movement outside of the service area by all members of the subscribing group; iv) cessation of membership of a sub-group in an association; v) failure to comply with the requirements set forth in this Agreement; or vi) as otherwise specified in this Agreement.

N.3.4. This Agreement will be terminated if required at any time by order of the Colorado Commissioner of Insurance.

N.4. **Refunds**

N.4.1. If PacifiCare of Colorado terminates coverage for the entire subscribing group, any prepayment of premium for the period(s) after termination will be prorated to the termination date, unless benefits have been paid for that period.

N.5. **Confinement at Termination**

N.5.1. If a member is confined to a hospital or inpatient facility on the member’s termination date, coverage will be extended until the member is discharged from the hospital or inpatient facility, unless the termination was due to nonpayment of premium or fraud.

N.6. **Continuation of Coverage**

N.6.1. When coverage for the subscribing group terminates for reasons other than replacement with another group policy or fraud or abuse in procuring and utilizing coverage, members in groups with fifty (50) or fewer employees are entitled to conversion coverage as described in Section C., Conversion, in this chapter. Members in groups with more than fifty (50) employees are not entitled to conversion coverage upon termination of the subscribing group.
N.7. Termination of Benefits

N.7.1. Except as provided in Subsection N.5, Confinement at Termination, in this chapter, no benefits will be payable under this Agreement for any service provided to members after the date of termination of the entire subscribing group.

N.7.2. PacifiCare of Colorado reserves the right to recover from members any costs incurred by PacifiCare of Colorado for services provided after the termination date.

O. Termination of Individual Coverage

O.1. Termination Date

O.1.1. Coverage of any member will end on the earliest one of the following dates:

- The date specified on the Signature Sheet
- The last day of the month in which the subscriber terminates employment
- The last day of the month that the required monthly premium has been paid
- The last day of the month in which the member requests in writing, cancellation of coverage
- The last day of the month in which the subscribing group's coverage is involuntarily terminated (see Subsection N.6, Continuation of Coverage above and Section C., Conversion, in this chapter for information on conversion coverage)
- On a termination date as explained in Section N., Termination of Group Coverage, in this chapter
- Immediately upon notice of termination of a member by PacifiCare of Colorado as explained later in this section

O.2. Voluntary Termination of Dependent Coverage

O.2.1. Subscribers may voluntarily terminate an enrolled dependent's coverage at any time by submitting an enrollment change form.

O.2.1.1. The termination is effective on the last day of the month in which PacifiCare of Colorado receives the enrollment change form.

O.3. Required Termination of Dependent Coverage

O.3.1. Subscribers must terminate dependent's coverage because of the dependent's death, divorce, marriage, induction into active military service, or failure to maintain the eligibility conditions described in Section F., Eligibility, in this chapter. The subscriber must submit an enrollment change form to PacifiCare of Colorado within thirty-one (31) days of the change in status.

O.3.1.1. The termination is effective on the last day of the month in which the change in status occurred, regardless of whether the subscribing group gives PacifiCare of Colorado timely notice of the change.

O.3.2. The subscriber shall be responsible for any services provided to a dependent during any period the dependent does not meet the eligibility requirements stated in this chapter. The subscribing group agrees to assist PacifiCare of Colorado in obtaining reimbursement for any amounts paid when a subscriber's dependent is not eligible.

O.3.3. All dependents coverage terminates on the day the subscriber becomes ineligible for coverage as explained in this section and Section F., Eligibility, in this chapter, except the provision explained in Subsection O.12, Reduced Working Hours, in this chapter.

NOTE:
Availability of continuation coverage under COBRA legislation and State law is explained in Section B., Continuation of Coverage, in this chapter.
O.4. **Refunds for Dependent Coverage**

O.4.1. PacifiCare of Colorado will refund a maximum of one month's premium, if paid in advance for a dependent whose coverage is terminated, if the following are true:

O.4.1.1. Notification of the change is received by PacifiCare of Colorado within thirty-one (31) days of the change.

O.4.1.2. PacifiCare of Colorado has not paid any claims for the dependent within the thirty-one (31) days.

O.4.1.3. Termination of the dependent results in a change to the premium rate.

O.5. **Nonpayment of Copayments**

O.5.1. If a member does not pay a required copayment or does not make satisfactory arrangements to pay the copayment, PacifiCare of Colorado may terminate the subscriber and any of his/her dependents with not less than ten (10) days written notice from PacifiCare of Colorado to the member and the subscribing group.

O.5.1.1. If termination of a member results from failing to pay a required copayment, the subscriber and any of his/her dependents will not be eligible to re-enroll, in any PacifiCare of Colorado plan, in any capacity, until the copayment has been paid in full. Nor will they be eligible to re-enroll prior to the first group open enrollment period following termination.

O.6. **Refusal of Compliance**

O.6.1. If a member refuses to accept or comply with recommended procedures and/or treatment incident to a provider/patient or hospital/patient relationship, including leaving an inpatient facility against medical advice, and in the judgement of two or more participating physicians, no professionally acceptable covered treatment alternatives exist, then the member will be so advised.

O.6.2. If the member still refuses to accept the recommended procedure and/or treatment, then the contract provider, hospital, and PacifiCare of Colorado will have no further liability or responsibility to provide care for the condition under treatment and/or the subscriber, the member and/or any dependents may be terminated after not less than ten (10) days written notice from PacifiCare of Colorado to the member and the subscribing group.

O.6.2.1. If termination of a member results from refusal of compliance, the subscriber and any of his/her dependents will not be eligible to re-enroll, in any PacifiCare of Colorado plan, in any capacity, until the first open enrollment period following termination.

O.7. **Failure to Establish PCP Relationship**

O.7.1. If a member is unable to establish and maintain a satisfactory physician-patient relationship with a participating physician, then the rights of the member under this Agreement may be terminated with not less than ten (10) days written notice from PacifiCare of Colorado to the member and the subscribing group.

O.7.1.1. If termination of a member results from failure to establish a PCP relationship, the subscriber and any of his/her dependents will not be eligible to re-enroll, in any PacifiCare of Colorado Plan, in any capacity, until the first open enrollment period following termination.
O.8. **Inappropriate Behavior**

O.8.1. If the member's behavior is disruptive, unruly, abusive, or uncooperative to the extent that continued membership would seriously impair PacifiCare of Colorado's ability to furnish services to the member or other members, PacifiCare of Colorado may terminate coverage for the member after not less than ten (10) days written notice from PacifiCare of Colorado to the member and the subscribing group.

O.8.1.1. If possible, PacifiCare of Colorado will make a good faith effort to resolve the problem, including the use or attempted use of its internal member appeals procedure. PacifiCare of Colorado will consider whether the member's behavior is the result of a reaction to treatment or medication due to mental illness.

O.8.1.2. If termination of a member results from inappropriate behavior, the subscriber and any of his/her dependents will not be eligible to re-enroll, in any PacifiCare of Colorado plan, in any capacity, at any time.

O.9. **False Information**

O.9.1. PacifiCare of Colorado may immediately terminate coverage for the subscriber and/or any member for obtaining or attempting to obtain services or benefits under this Agreement by means of false, misleading, or fraudulent information, acts, or omissions.

O.9.1.1. If termination of a member results from the use of false information, the subscriber and any of his/her dependents will not be eligible to re-enroll, in any PacifiCare of Colorado plan, in any capacity, at any time.

O.10. **Confinement at Termination**

O.10.1. If a member is confined to a hospital or inpatient facility on the member’s termination date, coverage will be extended until the member is discharged from the hospital or inpatient facility, unless the termination was due to nonpayment of premium or fraud.

O.10.2. Prenatal and maternity care are not considered confinement. Therefore, PacifiCare of Colorado will not continue coverage past the termination date for a member receiving prenatal or postnatal care.

O.11. **Misuse of ID Card**

O.11.1. PacifiCare of Colorado ID cards are solely for identification. Possession of a card does not ensure eligibility and/or rights to service or other benefit.

O.11.2. The holder of a PacifiCare of Colorado ID card must be a member for whom all premiums under this Agreement have been paid.

O.11.2.1. If a member permits the use of his/her PacifiCare of Colorado ID card by any other person, the card will be reclaimed by PacifiCare of Colorado and all rights of the member and his/her dependents under this Agreement will be immediately terminated. Notice of termination will be sent to the subscribing group.

O.11.2.2. Payment for services or other benefits received improperly through the use of an ID card are the financial obligation of the individual who used the ID card improperly.

O.11.2.3. If termination of a member results from misuse of the ID card, the subscriber and any of his/her dependents will not be eligible to re-enroll, in any PacifiCare of Colorado plan, in any capacity, at any time.
**O.12. Reduced Working Hours**

O.12.1. If a subscriber's working hours are reduced by his/her employer to less than twenty-four (24) hours per week, the subscribing group may contract with PacifiCare of Colorado to continue coverage for the subscriber and his/her dependents for the same premium and under the same terms of this Agreement if all of the following conditions are true:

O.12.1.1. The subscriber has been continuously employed as a full-time employee of the subscribing group and has been a subscriber covered under this Agreement, or under any former agreement providing similar benefits which this Agreement replaces, for at least six (6) months immediately before the reduction in working hours.

O.12.1.2. The reduction in working hours is due to economic conditions.

O.12.1.3. The employer intends to increase the subscriber's working hours to the full forty (40) hour work schedule as soon as economic conditions improve.

*NOTE:* An employee whose working hours are reduced as described above may be entitled to continuation coverage as explained in Section B., Continuation of Coverage, in this chapter.

**O.13. Relocation**

O.13.1. If a member relocates outside of the PacifiCare of Colorado service area, coverage will terminate on the last day of the month in which he/she leaves the service area. See Section B.2.5., for information regarding COBRA coverage.

O.13.2. If a subscriber has been transferred for employment outside of the service area by the subscribing group employer, but the subscriber's dependents temporarily remain in the service area, coverage may continue for the dependents until the end of the month in which they also leave the service area.

**O.14. General Information**

O.14.1. Except as specifically described in this section, all rights to covered benefits will end on the effective date of termination.

O.14.2. PacifiCare of Colorado reserves the right to recover from the subscriber the reasonable value of any benefits provided by PacifiCare of Colorado and incurred by the subscriber or his/her dependents after termination of their coverage under this Agreement.

O.14.2.1. If the subscriber fails to reimburse PacifiCare of Colorado for any amounts paid following the member's termination, the subscriber, member and any of their dependents will not be eligible to re-enroll, under any PacifiCare of Colorado plan, in any capacity, until such reimbursement to PacifiCare of Colorado has been made.

O.14.3. A member's termination of coverage will not affect any pending claim. A pending claim will include only those services and supplies provided before the termination date.

O.14.4. The provisions of this section are overridden by the provisions of Section B., Continuation of Coverage, and Section C., Conversion, in this chapter, as applicable.

**P. Miscellaneous**

**P.1. Claims**

P.1.1 A claim paid and/or submitted by a member for a covered service must be submitted to PacifiCare of Colorado within twelve (12) months after the date of the service, or reimbursement will not be made. If you are covered by more than one health benefit plan you should file all your claims with each plan.
P.2. **Copayment Limit**

P.2.1. After a subscriber or a subscriber with dependent coverage demonstrates that the total copayments paid during any contract year exceeds $3,500 for an individual or $8,000 for a family, no additional copayments for the subscriber or dependents need be paid for the remainder of the contract year.

P.2.2. Copayments applicable to optional benefits, as described in Chapter Five, Outpatient Prescription Drugs, or Chapter Six, Optional Benefits, of this Agreement, do not apply to the copayment limit described in P.2.1 above.

P.3. **Member Identification**

P.3.1. At the time of service, a member must identify him/herself to a hospital or contract provider as a PacifiCare of Colorado member. If he/she does not do so, or if the member misrepresents his/her membership status, claims payment may be denied.

P.4. **Notice**

P.4.1. Any notice under this Agreement must be deposited in the U. S. mail, postage prepaid; hand-delivered; sent via electronic facsimile transmission; or via overnight courier service and addressed as follows:

- To PacifiCare of Colorado at:
  P. O. Box 6770
  Englewood, Colorado 80155

- To a subscribing group:
  Address as indicated on the Signature Sheet

- To a member at:
  Member’s address of record

*NOTE:*

PacifiCare of Colorado will not be responsible for a member's failure to have a PacifiCare of Colorado ID card or for any inconvenience, misunderstanding, or cost incurred by a PacifiCare of Colorado member when the member does not have his/her current address of record on file.

P.4.2. Except as otherwise specifically provided in this Agreement, all notices will be considered effective on delivery.
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CHAPTER THREE
WHAT IS COVERED:
YOUR SCHEDULE OF BENEFITS

The following services are covered benefits when medically necessary, if provided, or properly arranged for with a participating provider, by the member's participating Primary Care Physician (PCP) unless excluded or limited by any section in this Agreement including, but not limited to Section Z., General Exclusions, or Section AA., General Limits.

PacifiCare of Colorado may determine medical necessity by using precertification programs and criteria as deemed appropriate by PacifiCare of Colorado. Such programs and criteria are reviewed and updated from time to time. See Chapter Seven, Definition of Terms, PacifiCare of Colorado Criteria for further information. Through the precertification process, PacifiCare of Colorado may encourage that certain services be directed to, and performed at, the most cost effective setting. A summary of health care benefits mandated under Colorado law (10-16-104 C.R.S.) is provided in Chapter Four of this Evidence of Coverage (EOC). The summary is provided for your information only. Covered benefits under your PacifiCare of Colorado health plan are determined and interpreted in accordance with (i) the Schedule of Benefits chapter of this Agreement, (ii) the terms and conditions set forth in this Agreement, and (iii) the actual language of the Colorado insurance laws regarding the specific mandated benefits.

A. Clinics

A.1. Pain Clinics

A.1.1. Outpatient services must be requested in writing by the PCP. This request must include supporting second opinions from two participating specialists, one of whom is a licensed mental health provider. Any psychotherapy and/or physical therapy sessions as a part of the program will be counted toward the Pain Clinics limit listed below.

LIMITS:
- Treatment may not be started prior to written authorization from PacifiCare of Colorado
- In no event will PacifiCare of Colorado pay more than $2,000 toward the covered charges to a pain clinic, center, or facility per chronic condition, per member per lifetime

NOT COVERED:
- Convenience items and meals
- Pain centers, facilities, clinics, or centers involved in treatment of pain are not covered for inpatient care

A.2. Lymphedema Clinics

A.2.1. Lymphedema clinics when necessary for the treatment of complications of breast reconstruction following mastectomy

A.3. Clinics Not Covered

A.3.1. Special service clinics, centers, or programs on an inpatient or outpatient basis, except those otherwise listed as covered. This includes, but is not limited to clinics, centers, or programs for:
- Disassociated disorders
- Eating disorders
- Headaches
- Lactation
- Long-term brain injury
- Post-traumatic stress
- Premenstrual syndrome (PMS)
- Senior services
- Stress management
B. Dietary and Diabetes Counseling

B.1. Dietary Counseling

B.1.1. One dietary counseling session when regulation of the diet is a significant part of the treatment program for a pathological state or illness.

LIMIT:
One visit per contract year

NOT COVERED:
Dietary counseling for obesity, including weight reduction programs

B.2. Diabetes Counseling

B.2.1. Dietary counseling, medication management, and self-management skills instruction for members diagnosed with diabetes or those with special management needs.

C. Durable Medical Equipment

C.1. Durable Medical Equipment

C.1.1. The following durable medical equipment is covered based on criteria established by PacifiCare of Colorado. The criteria may include that the equipment must enable a patient who otherwise would have to be treated in an acute care or rehabilitative facility to be cared for outside such an institution.

- Apnea monitors
- Bilirubin lights or blankets
- Bone stimulators
- Continuous passive motion machines (CPM)
- Eye prosthetics
- Feeding pumps
- Glucose meters
- Hospital beds
- Insulin pump supplies (including cartridges, extension tubing, batteries, infusion sets, and customary dressings provided by the pump supplier to secure infusion sets)
- Lymphedema pumps
- Nebulizers
- Oxygen and related equipment
- Positive airway pressure devices (C-PAP) (Bi-PAP)
- Peak flow meters
- Suction machines
- Traction equipment
- Ventilators
- Wheelchairs

LIMITS:
- $1,500 per member per contract year
- One (1) glucose meter per member per lifetime
- One (1) peak flow meter per member per lifetime
- At PacifiCare of Colorado’s discretion, the equipment may be rented or purchased

C.1.2. Preauthorized external extremity prosthetics up to $1,500 applicable to the durable medical equipment maximum only if the prosthesis will restore function of the extremity.

NOTE:
Coverage for prosthetic arms and legs is based on criteria and is not subject to the durable medical equipment maximum of $1500. However, the member is responsible for 20% of the eligible charge for these items.

NOT COVERED:
Penile prostheses and prostheses for cosmetic purposes
C.1.3. Insulin pumps to the extent preauthorized based on criteria established by PacifiCare of Colorado. Insulin pumps are not subject to the durable medical equipment maximum described in C.1.1 above.

C.2. Authorization

C.2.1. Durable medical equipment, including oxygen, must be authorized for a specified period of time in advance in writing by PacifiCare of Colorado. The authorization will specify whether purchase or rental is approved. After the initial authorized period of coverage, continuation is subject to written reauthorization in advance for another specified period.

C.3. Orthopedic Braces

C.3.1. Orthopedic braces when prescribed by a participating physician and obtained through a designated provider and that meet all of the following criteria:
   a) are required to support or correct a defect of form or function or a permanently non-functioning or malfunctioning body part, and
   b) are medically approved and in general use for the specific condition, and
   c) are primarily and customarily used either as an alternative to surgery or to speed recovery of a patient who has had surgery, and
   d) can withstand repeated use, and
   e) are not generally useful to a patient in the absence of an injury or illness.

C.3.2. Fitting and adjustment of covered braces.

C.3.3. Repair or replacement of covered braces unless necessitated by misuse. PacifiCare of Colorado may replace or repair a brace at its discretion.

LIMIT:
$500 per member per contract year. Each $1 paid for orthopedic braces shall reduce by $1 the amount available for podiatric shoe inserts, as listed in C.4. below

NOT COVERED:
Dental braces, braces used as aids in sports and activities, corsets and other non-rigid appliances

C.4. Podiatric Shoe Inserts

C.4.1. Podiatric shoe inserts for persons with diabetes with historical ulcers or presence of pre-ulcerous lesions and documented neuropathy. In addition, for members with persistent plantar facitis, or documented neuropathy who have documented failure of commercial over-the-counter inserts when used as a trial prior to, or in lieu of surgery.

LIMIT:
$500 per member per contract year. Each $1 paid for podiatric shoe inserts shall reduce by $1 the amount available for orthopedic braces, as listed in C.3. above

NOT COVERED:
Orthotic devices for podiatric use and arch support

D. Emergencies Inside the PacifiCare of Colorado Service Area

D.1. Ambulance

D.1.1. Medically necessary air or ground ambulance service when the destination is an acute care facility, for any of the following:
   • Movement from the place where the member was injured in an accident or became ill to a facility for treatment
   • If medically necessary care is not available at a hospital or hospice, movement to the nearest hospital where the medically necessary care may be given
   • When ordered by the member's attending physician, movement from the hospital to another facility or from the member's home for emergency situations

NOT COVERED:
Ambulance service provided due to the absence of another medically appropriate form of transportation or for the member's convenience
D.2. **Medical Emergencies**

D.2.1. Emergency services necessary to screen and stabilize a member in cases where a prudent layperson, acting reasonably, believes that an emergency medical condition exists. The member’s PCP should be notified of the episode by the following business day.

D.2.2. There are two copayment levels for emergency services:

- The higher copayment applies when services are obtained in a hospital emergency room.
- The lower copayment applies when the emergency services are obtained in a physician's office outside normal business hours or an urgent care facility.

If a member is admitted as an inpatient to a hospital directly from the emergency room, the emergency copayment is waived.

D.2.3. Unauthorized use of the emergency facility will be reviewed by PacifiCare of Colorado. Payment of claims may be denied and may be the member's personal responsibility.

D.2.4. In a life or limb threatening emergency the member will have the option of calling the emergency telephone access number 911 or its local equivalent.

D.2.5. If the member is hospitalized in a non-participating facility, the member’s PCP may elect to transfer the member to a participating hospital of the PCP’s choosing as soon as it is medically appropriate. If the member chooses to remain in a non-participating facility after being notified of the intent to transfer the member to a participating facility, further services will not be covered.

**NOT COVERED:**

- Follow-up care in the emergency facility
- Emergency visits made in non-life or limb threatening situations without the member's participating PCP's authorization. In this instance, the member will be liable for the entire charge for the visit and for any unauthorized care resulting from it
- Emergency room services obtained during normal physician office hours, except in the event of a life or limb threatening emergency or when preauthorized by the PCP

E. **Emergencies and Urgent Care Outside the PacifiCare of Colorado Service Area**

E.1. **Ambulance**

E.1.1. Medically necessary air or ground ambulance service under emergency conditions arising from an accident, acute illness or injury and when the destination is an acute care facility.

E.2. **Medical Emergencies**

E.2.1. Emergency services necessary to screen and stabilize a member in cases where a prudent layperson, acting reasonably, believes that an emergency medical condition exists.

E.2.2. If a member receives medically necessary emergency care or urgent care outside the PacifiCare of Colorado service area, the member will be entitled to reimbursement for:

- Reasonable charges for hospital services that are covered benefits
- Reasonable charges for professional services that are covered benefits, including sales tax in states where such tax is allowed by law
- Ambulance service resulting from an accident, acute illness or injury
- Reasonable charges for transportation authorized by PacifiCare of Colorado to return the member to a PacifiCare of Colorado participating hospital, less the cost of the member's normal return trip expense
E.2.3. There are two copayment levels for emergency services:
- The higher copayment applies when services are obtained in a hospital emergency room.
- The lower copayment applies when the emergency services are obtained in a physician's office outside normal business hours or an urgent care facility.

If a member is admitted as an inpatient to a hospital directly from the emergency room, the emergency copayment is waived.

E.2.4. PacifiCare of Colorado must be notified within forty-eight (48) hours, or as soon as practical, after a hospital admission outside the service area.

E.3. Follow-Up Care to Emergency Services

E.3.1. Follow-up care to emergency services received outside the service area or urgently needed non-emergency services (as defined in Chapter Seven, Definition of Terms).

LIMIT:
A maximum PacifiCare of Colorado payment of $400 per person per contract year

E.4. Claims

E.4.1. A claim paid and/or submitted by a member for a covered service must be submitted to PacifiCare of Colorado within twelve (12) months after the date of the service, or reimbursement will not be made.

Claims can be submitted by providing an itemized statement to PacifiCare of Colorado Customer Service at the address listed in Chapter Eight, How to Get Help.

F. Eye Examinations/Eyeglasses

F.1. Preventive Care

F.1.1. Routine visual acuity exams as part of covered periodic health appraisals.

F.2. Routine Examinations

F.2.1. Routine eye examinations, including refractions to determine the prescription for corrective lenses, eyeglasses or contact lenses, at PacifiCare of Colorado designated facilities.

LIMIT:
One routine exam per member per contract year

NOT COVERED:
- Fitting contact lenses
- Vision therapy
- Radial keratotomy, keratomileusis and excimer laser surgery

F.3. Eyeglasses

F.3.1. Eyeglasses when prescribed following cataract surgery with an intra ocular lens implant. Eyeglasses must be obtained through participating providers.

LIMITS:
- $125 per pair of eyeglasses
- One (1) pair of eyeglasses per surgery
- Two (2) pairs of eyeglasses per lifetime

NOT COVERED:
- Eyeglasses or contact lenses other than following cataract surgery as described above, except as covered as a supplemental benefit purchased by the subscribing group
- Special treatment for eyeglasses, including, but not limited to, tinting and scratch resistant coatings
G. **Family Planning**

G.1. **Family Planning**

G.1.1. Voluntary family planning to include:

- Family planning counseling
- Information on birth control
- IUDs and implantable contraceptive devices, including their insertion and removal
- Diaphragms and cervical caps, including their fitting
- Costs related to an elective abortion

**LIMIT:**
Two (2) elective abortions per member per lifetime

- Pre- and post-abortion counseling
- Surgical procedures causing permanent sterilization, including vasectomies and tubal ligations

**NOT COVERED:**
- Pregnancy test kits and ovulation kits
- Reversal of voluntary sterilization and related procedures

G.2. **Infertility**

G.2.1. Limited infertility services to the extent preauthorized based on criteria established by PacifiCare of Colorado, including testing, artificial insemination, appropriate medical advice, and instruction in accordance with accepted medical practice.

**LIMITS:**
- Treatment for infertility is covered only for members who have been diagnosed as biologically infertile in accordance with accepted medical practice
- Twelve (12) artificial inseminations per pregnancy. If after twelve (12) attempts, the member fails to become pregnant, no additional inseminations will be covered
- Certain other limits apply to covered infertility services as defined by criteria established by PacifiCare of Colorado. Contact PacifiCare of Colorado Customer Service for further information. See Chapter Eight, How to Get Help

**NOT COVERED:**
- In vitro fertilization (test tube babies), the Gamete Intrafallopian Transfer (G.I.F.T.) procedure, the Zygote Intrafallopian Transfer (Z.I.F.T.) procedure, Artificial Reproductive Technology (A.R.T.), other ovum transplant procedures, surrogate parentage, drug therapy for infertility, and related costs of each
- Procedures considered to be experimental/investigational
- The cost related to donor sperm and donor ova (collection, preparation, storage, etc.)
- Infertility services for members who have undergone a voluntary sterilization procedure

H. **Hearing Tests**

H.1. **Preventive Care**

H.1.1. Examinations to determine the need, if any, for hearing correction.

**NOT COVERED:**
Hearing aids and evaluation for hearing aids

I. **Home Health Care**

I.1. **Nursing Care Services**

I.1.1. Skilled nursing care at home when prescribed by a participating provider and deemed medically necessary for treatment of a covered illness or injury.
I.1.2. Home health care services are provided only when and as long as the following two conditions are met simultaneously:

- The patient's participating provider prescribes a specific home care plan to be provided and sets forth the length of time deemed medically necessary to complete the treatment plan. This plan must be approved in writing by PacifiCare of Colorado and periodically reviewed and reauthorized by PacifiCare of Colorado or an agent acting on PacifiCare of Colorado's behalf.
- The services are provided by a Medicare certified home health agency selected or approved by PacifiCare of Colorado.

NOT COVERED:
- Custodial and maintenance care
- Homemaker services

I.1.3. Periodic assessment visits by either a physician or a licensed nurse to determine the patient's condition, progress, and level of care needs.

LIMIT:
After the period of time specified in the prescribed treatment plan, continuation of care depends on a reevaluation of the patient's status for medical necessity.

I.2. Therapy (Physical, Occupational, and/or Speech)

I.2.1. These benefits are covered as part of home health care only for treatment of acute conditions that are subject to significant improvement within two (2) months of when treatment begins and the patient is homebound.

I.3. Training for Home Care

I.3.1. One-time training for a family member, household resident, or nonprofessional person employed by the patient or family. This training covers the services necessary to the custodial or maintenance levels of care.

J. Hospice Care

J.1. Services at Home or Hospice Facility

J.1.1. When preauthorized by PacifiCare of Colorado, services covered in home or hospice facility include:

- Nursing care provided by or under the supervision of a registered nurse
- Home health aide services under the supervision of an RN or specialized rehabilitative therapist
- Respiratory therapy and inhalation services
- Nutrition counseling by a nutritionist or dietitian
- Physical therapy, occupational therapy, speech therapy, and audiology
- Individual, family, and caregiver counseling
- Medical social services
- Bereavement support services for the member's family
- Continuous home care or short-term inpatient care provided in a participating hospice inpatient unit, hospital, or skilled nursing facility as required for pain control or symptom management
- Inpatient hospice care will be provided based on criteria established by PacifiCare of Colorado
- Medical supplies ordinarily furnished by the hospice agency, including prescription drugs and biologicals
- Respite care

LIMIT:
Inpatient respite care is limited to five (5) continuous days per occurrence

J.1.1.1. For hospice care to be covered, services must be provided by or under the direction of the member's PCP, who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six (6) months or less. The physician must submit a written plan of care.
J.1.1.2. The member must choose to receive hospice care instead of standard benefits for the terminal illness. It is important for the member to realize that hospice care is for terminal conditions and that the hospice benefit structure is based upon the concept that those members receiving hospice care choose not to avail themselves of other health care benefits for care related to the terminal condition. While receiving hospice care, in the member's home or in a hospice facility, if a member requires treatment for a condition not related to the terminal illness, PacifiCare of Colorado will continue to pay for all covered services.

J.1.1.3. The coverage of these services will not prevent PacifiCare of Colorado from re-evaluating the member's status and subsequently redetermining the status of care.

**NOT COVERED:**
- Services and supplies related to the terminal condition that are not a part of hospice care
- Services of a caregiver other than as provided by the hospice agency as part of this benefit, including, but not limited to, someone who lives in the member's home or someone who is a relative of the member
- Domestic or housekeeping services that are unrelated to the member's care
- Services that provide a protective environment where no professional skill is required, such as companionship or sitter services
- Services not directly related to the medical care of the member including, but not limited to:
  - Estate planning, drafting of will, or other legal services
  - Funeral counseling or funeral arrangements or services
  - Food services such as Meals on Wheels
  - Transportation services, except covered benefits for necessary professional ambulance services

K. **Hospital Care**

K.1. **Ancillary Services**

K.1.1. Hospital ancillary services, including laboratory, pathology, radiology, radiation therapy, respiratory therapy, and physical, occupational, and speech therapy.

K.1.2. Oxygen, other gases, drugs, medications, and biologicals as prescribed.

**NOT COVERED:**
- Take-home drugs

K.2. **Blood**

K.2.1. Blood, blood plasma, and blood products, including processing and administration.

K.2.2. Wound healing products that meet criteria established by PacifiCare of Colorado.

K.2.3. Drawing and storage of the member's blood or blood products when prescribed by a participating physician and used as replacement therapy for a covered procedure.

**NOTE:**
Also see Z.1.15 under Section Z., General Exclusions, in this chapter.

**NOT COVERED:**
- Special blood handling fees
- Storage of cord blood

K.3. **Discharge Planning**

K.3.1. Coordinated discharge planning services.

K.4. **Implants**

K.4.1. Devices that are medically necessary and must be implanted by surgical means. These may include pacemakers, replacement joints, and permanent replacement lenses following cataract surgery.

K.4.2. Cochlear implants to the extent preauthorized, based on criteria established by PacifiCare of Colorado.

**NOT COVERED:**
- Experimental/investigational or cosmetic implants
- Penile implants
K.5. *Nursing Services*

K.5.1. General nursing care.

K.5.2. Intensive care services when medically necessary.

*NOT COVERED:*
Private duty nursing

K.6. *Room and Board*

K.6.1. The following provided by a hospital or a skilled nursing facility:

- Accommodations necessary for covered services, including bed, meals, and services of a dietitian
- Use of operating and specialized treatment rooms
- Use of intensive care facilities
- Use of room and bed for prescribed observation services

*NOT COVERED:*
- Personal comfort and convenience items, such as television, telephone, guest meals, articles for personal hygiene, and any other similar incidental services and supplies
- Private room except when medically necessary

K.7. *Supplies*

K.7.1. Surgical and anesthetic supplies furnished by the hospital as a regular service.

*NOT COVERED:*
Take-home supplies

L. *Injectables*

L.1. *Outpatient Injectables*

L.1.1. Outpatient injectables approved by the Food and Drug Administration (FDA) for the given diagnosis or protocol, when oral administration of prescribed medication is not medically appropriate.

L.1.1.1. Services include administration, supplies and medical monitoring when administered in the physician's office or through an authorized home infusion company.

L.1.2. Outpatient injectables that can be obtained by the member through a pharmacy, or can be self-administered, whether obtained at the pharmacy or not, must be preauthorized and are subject to the applicable copayment. A copayment will be collected for up to a 30-day supply of medications, course of therapy or treatment of an acute episode, whichever is shorter. No more than a thirty (30) day supply will be dispensed at one time.

M. *Laboratory/Pathology*

M.1. *Services*

M.1.1. Laboratory and pathology services, including preventive diagnostic services, in accordance with criteria established by PacifiCare of Colorado.
N. Medical Foods

N.1. Medical Foods

N.1.1. Medical Foods, for the purpose of this benefit, refer exclusively to prescription metabolic formulas and their modular counterparts, obtained through a pharmacy. Medical Foods are specifically designated and manufactured for the treatment of Inherited Enzymatic Disorders caused by Single Gene Defects.

N.1.1.1. Coverage for Inherited Enzymatic Disorders caused by Single Gene Defects shall include, but not be limited to the following diagnosed conditions: Phenylketonuria, Maternal Phenylketonuria, Maple Syrup Urine Disease, Tyrosinemia, Homocystinuria, Histidinemia, Urea Cycle Disorders, Hyperlysinemia, Glutaric Acidemias, Methylmalonic Acidemia, and Propionic Acidemia. Covered care and treatment of such conditions shall include, to the extent medically necessary, medical foods for home use for which a participating physician has issued a written, oral, or electronic prescription.

N.1.1.2. The maximum age to receive this benefit for Phenylketonuria is twenty-one (21) years of age; except that the maximum age to receive this benefit for Phenylketonuria for women who are child-bearing age is thirty-five (35) years of age.

LIMIT:
Medical Foods will be subject to a fifty (50) percent copayment.

O. Mental Health Services

NOTES:
• To access mental health services please refer to the Guide to Accessing Mental Health and Substance Abuse Benefits in Chapter Eight, How to Get Help.
• Refer to Subsection L.1, Confidentiality, in Chapter Two, Your Rights and Responsibilities for information on confidentiality of medical records.
• Refer to Subsection O.6, Refusal of Compliance, in Chapter Two, Your Rights and Responsibilities for information on Refusal of Compliance.
• A PCP referral is not required to obtain mental health services. All benefits must be referred by, and are available only through, the mental health provider.

O.1. Inpatient Mental Health Care

O.1.1. Medically necessary inpatient mental health care.

LIMITS:
• Maximum of forty-five (45) days for inpatient care per contract year;
  OR
• Maximum of ninety (90) partial hospitalization days per contract year

NOTES:
• "Partial hospitalization" is defined as treatment for at least three (3) hours, but not more than twelve (12) hours, in a 24-hour period.
• For the purpose of computing the period for which benefits are payable, each two days of partial hospitalization care shall reduce by one day the forty-five days available for inpatient care, and each day of inpatient care shall reduce by two days the ninety days available for partial hospitalization care.

O.2. Outpatient Mental Health Care

O.2.1. Medically necessary outpatient mental health care.

LIMIT:
The number of visits allowed, and any coverage of services necessary to fulfill the designated treatment program in addition to those services listed here, are based on medical necessity as determined by the participating provider.
O.3. **Biologically-Based Mental Illnesses**

O.3.1. Pursuant to C.R.S. 10-16-104 (5.5), care for schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder shall be covered as any other physical illness and will not be subject to the limitations of Mental Health Services as described in this Section O.

O.4. **Mental Health Services Not Covered**

**NOTE:**
Also see Subsection W.8, Therapies/Rehabilitation Not Covered, in this chapter.

O.4.1. Confinement, treatment, service or supply that is not authorized, except in the event of an emergency.

O.4.2. Confinement, treatment, service or supply that is not ordinarily provided for the specific treatment which was authorized.

O.4.3. Confinement, treatment, service or supply obtained through or required by a governmental agency or program.

O.4.4. Weight control programs and treatment for addictions to tobacco, nicotine or food.

O.4.5. Treatment or psychological testing for any reading or learning disorder, mental retardation, or other developmental disorders as defined by the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV).

O.4.6. Counseling for adoption, custody, family planning or pregnancy in the absence of a DSM-IV diagnosis.

O.4.7. Counseling associated with or in preparation for a sex change operation.

O.4.8. Sexual therapy programs, including therapy for sexual addiction, the use of sexual surrogates, and sexual treatment.

O.4.9. Vocational, pastoral or spiritual counseling.

O.4.10. Dance, poetry, music or art therapy, except as part of a treatment program in an inpatient setting.

O.4.11. Non-organic therapies including, but not limited to, bioenergetics therapy, confrontation therapy, crystal healing therapy, educational remediation, Eye Movement Desensitization Reprocessing, guided imagery, marathon therapy, primal therapy, rolfing, sensitivity training, training psychoanalysis, transcendental meditation, and Z therapy.

O.4.12. Organic therapies including, but not limited to, aversion therapy, carbon dioxide therapy, environmental ecological treatment or remedies, herbal therapies, homodialysis for schizophrenia, vitamin or orthomolecular therapy, narcotherapy with LSD, and sedative action electrostimulation therapy.

O.4.13. Surgery or acupuncture as a mental health benefit.

O.4.14. Laboratory fees as a mental health benefit for outpatient treatment plans.

O.4.15. Services which are not medically necessary for the treatment of mental health disorders.

O.4.16. Services that are required by a court order as a part of parole or probation, or instead of incarceration, which are not medically necessary.

O.4.17. Long-term insight-oriented psychotherapies that regress the member emotionally or behaviorally.

O.4.18. Personal enhancement, self-actualization therapy or other similar treatment plans.

O.4.19. Services provided by a non-licensed provider.

O.4.20. Neurological services and tests, including, but not limited to, EEGs, Pet scans, beam scans, MRIs, skull x-rays and lumbar punctures. These services must be pre-authorized by the PCP.

O.4.21. Treatments which do not meet the national standards for mental health professional practice.

O.4.22. Medical treatment for eating disorders.

O.4.23. Treatment sessions by telephone or computer Internet services.

O.4.24. Evaluation or treatment for education, professional training, employment investigations, fitness for duty evaluations, or career counseling.
P. **Physician Services**

P.1. **Allergy Treatment**

P.1.1. Outpatient allergy treatment and allergy treatment materials.

P.2. **Exams and Consultation (Office, In/Outpatient)**

P.2.1. Physician's services including time for visits and examinations, consultation, and personal attendance with the patient in the physician's office, or in a hospital or skilled nursing facility.

P.2.2. Physician's visits to the member's home when medically necessary and only if the member is too ill or disabled to go to the physician's office.

P.2.3. Medical consultation services, including charges made by a physician for a second or third surgical opinion.

**NOT COVERED:**
- Examination for employment, licensing, insurance, adoption purposes, or examination or treatment ordered by a court
- Expenses for medical reports, including preparation and presentation
- Expenses for examinations and treatment conducted for the purpose of medical research

P.3. **Growth Hormones**

P.3.1. Growth hormones on a limited basis to the extent preauthorized based on criteria established by PacifiCare of Colorado.

P.4. **Health Appraisals**

P.4.1. Periodic health appraisals for children and adults that include all tests routinely made in connection with such health appraisals. The frequency of the health appraisals as a benefit will be established by PacifiCare of Colorado.

P.5. **Immunizations**

P.5.1. Pediatric and adult immunizations in accordance with the recommendations of the American Academy of Pediatrics and the Centers for Disease Control immunization guidelines.

P.5.2. Immunizations recommended for travel by the Centers for Disease Control immunization guidelines.

**NOT COVERED:**
Immunizations that are recommended because of increased risk due to type of employment

P.6. **Surgical (In/Outpatient)**

P.6.1. Surgical services in the hospital, in the office, or in a licensed outpatient surgical facility. This may include, when medically required:
- A surgical assistant
- Anesthesiologist services

See Section V., Surgery, in this chapter, for details about surgery benefits.

P.7. **Well-Baby/Well-Child Care**

P.7.1. Well-baby/well-child care visits in a physician's office based on guidelines established by PacifiCare of Colorado.

Q. **Pregnancy/Maternity/Newborn**

Q.1. **Newborn**

Q.1.1. Hospital care and services for newborn infants of subscribers.
Q.2. Delivery

Q.2.1. Hospital obstetrical delivery care and services for covered female members.

NOT COVERED:
- Home delivery
- Normal delivery outside of the PacifiCare of Colorado service area

NOTES:
- Normal delivery is generally considered to be within five (5) weeks of the expected due date.
- Under Federal law, group health plans may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

Q.3. Postpartum

Q.3.1. Complete hospital and outpatient postpartum care and services for covered female members. The office visit copayment applies to postpartum visits in the physician's office.

Q.3.2. Mothers with newborns released from the hospital one day early based on Federal guidelines are entitled to one (1) visit by a registered nurse as well as the services of a homemaker for four (4) hours on two (2) days within thirty (30) days following delivery. The homemaker may perform such duties as grocery shopping, preparing meals, laundry, and light housekeeping.

Q.4. Prenatal Services

Q.4.1. Prenatal care and services for covered female members.

Q.4.2. Amniocentesis based on criteria established by PacifiCare of Colorado. The participating physician must request this procedure and provide the necessary information to PacifiCare of Colorado.

NOT COVERED:
- Any procedure intended solely for sex determination
- Birthing classes

R. Radiology

R.1. Services

R.1.1. Radiological services, such as electrocardiography (EKG), electroencephalography (EEG), and the use of radioactive isotopes.

R.1.2. Preventive diagnostic services in accordance with criteria established by PacifiCare of Colorado. This includes, but is not limited to mammograms, chest x-rays, electrocardiograms, and laboratory services.
S. **Skilled Nursing Facility/Comprehensive Rehabilitation Facility/Extended Care**

S.1. **Extended Care Services**

S.1.1. Skilled nursing facility, extended care facility, and comprehensive rehabilitation facility or unit services as follows:

- Only on order of the participating PCP when approved by the PacifiCare of Colorado Medical Director, and
- Only when significant measurable improvement can be anticipated

S.1.2. Services include accommodations, meals, general nursing care, medical supplies and equipment ordinarily furnished by the facilities, and all prescribed drugs and biologicals.

**LIMITS:**
- During each contract year, up to 120 days of these prescribed services at approved facilities
- The member's status may also be reevaluated and, if it is determined that the status of the care is no longer acute, it may not be covered

**NOT COVERED:**
- Custodial care
- Maintenance care
- Convalescent care
- Care for chronic conditions
- Private duty nursing
- Personal comfort or convenience items, such as television or telephone
- Private room, except when medically necessary

T. **Subacute Care Facilities**

T.1. **Services**

T.1.1. Subacute care facility services following hospitalization, including accommodations, meals, general nursing care, medical supplies and equipment ordinarily furnished by the facility and prescribed drugs and biologicals.

**LIMIT:**
- Up to sixty (60) days per contract year at an approved subacute care facility.

U. **Substance Abuse**

**NOTES:**
- To access substance abuse services please refer to the Guide to Accessing Your Mental Health and Substance Abuse Benefits in Chapter Eight, How to Get Help.
- Refer to Subsection L.1, Confidentiality, in Chapter Two, Your Rights and Responsibilities for information on confidentiality of medical records.
- Refer to Subsection O.6, Refusal of Compliance, in Chapter Two, Your Rights and Responsibilities for information on Refusal of Compliance.
- A PCP referral is not required to obtain substance abuse services. All benefits must be referred by and are available only through the substance abuse provider.
U.1. Alcohol-Drug Rehabilitation

U.1.1. A medically necessary course of treatment may be either inpatient or outpatient or a combination of both if authorized by the participating mental health provider.

LIMITS:
- One course of treatment per contract year
- Two courses of treatment for each member during his/her lifetime

NOT COVERED:
- Rapid anesthesia opiate detoxification.
- Services which are not medically necessary for the treatment of Substance Abuse disorders.
- Services that are required by a court order as a part of parole or probation, or instead of incarceration, which are not medically necessary.
- Methadone maintenance or treatment.

U.2. Detoxification

U.2.1. Services for detoxification are limited to removal of the toxic substance or substances from the system, including diagnosis, evaluation, and care of emergency or acute medical conditions.

U.3. Inpatient Alcohol-Drug Rehabilitation

U.3.1. Alcohol-drug inpatient rehabilitation services at the facility designated by PacifiCare of Colorado. Inpatient services are those services provided to members who reside for the course of their treatment program at the program site.

LIMIT:
Services are covered at the designated facility up to a maximum of twenty-one (21) days per contract year or until the participating provider has determined satisfactory completion of the inpatient program, whichever is less.

U.4. Outpatient Alcohol-Drug Rehabilitation

U.4.1. Alcohol-drug outpatient rehabilitation services at the facility designated by PacifiCare of Colorado. Outpatient services are those services provided to members who are living at home and receiving services at the program site on an ambulatory basis.

LIMIT:
The number of visits allowed is based on medical necessity as determined by the participating provider.

V. Surgery

V.1. Breast Surgery

V.1.1. The cost of reconstructive breast surgery to the extent preauthorized following a mastectomy.

V.1.2. Coverage of reconstructive breast surgery as described above shall include:
- Reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the unaffected breast to produce a symmetrical appearance
- Surgically implanted breast prostheses
- Coverage of physical complications resulting from the mastectomy, including lymphedemas

V.1.3. The cost of surgical bras, including external prosthesis(s), in lieu of reconstructive breast surgery will be covered to the extent preauthorized if the mastectomy was performed as a result of diagnosed cancer.

LIMIT:
$500 per member per contract year
V.2. Oral and Dental Surgery

V.2.1. Oral surgery and certain medical service charges associated with dental services only as follows:

- Emergency treatment received within twenty-four (24) hours of the occurrence of accidental injury to the jaw or mouth

  *NOT COVERED:*
  
  Follow-up dental restoration procedures

- Treatment for tumors of the mouth when cancer is suspected

- Treatment of congenital conditions of the jaw that may be demonstrated to cause actual significant deterioration in the member's physical condition because of inadequate nutrition or respiration

- Hospital and anesthesia charges associated with dental services to the extent preauthorized by PacifiCare upon determination that a medical condition or other criteria requires such services to be obtained in a medical facility

- Cleft lip, cleft palate, or any condition or illness that is related to or developed as a result of the cleft lip or cleft palate will be considered to be compensable for coverage under the provisions of Colorado law for newborn children born with cleft lip or cleft palate or both. The following care and treatment is covered to the extent medically necessary and when ordered by a participating physician:
  
  - Oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons
  
  - Prosthetic treatment such as obturators, speech appliances, and feeding appliances
  
  - Medically necessary orthodontic treatment
  
  - Medically necessary prosthodontics treatment
  
  - Habilitative speech therapy
  
  - Otolaryngology treatment
  
  - Audiological assessments and treatment

  *NOTE:*
  
  If a dental insurance policy is in effect at the time of the birth, or is purchased after the birth of a child with cleft lip or cleft palate or both, no benefit under this Agreement will be provided for any orthodontics or dental care needed as a result of the cleft lip or cleft palate or both.

  *NOT COVERED:*
  
  - Orthognathic surgery
  
  - Metallic bone cylinder implants (bone screws)

V.2.2. During an inpatient admission for a covered dental problem, medical consultation and diagnostic procedures ordered by the medical consultant related to a strictly medical condition.

V.3. Services

V.3.1. Surgical services in the hospital, physician's office, or in a licensed outpatient surgical facility. This includes the services of a surgical assistant and anesthesiologist with surgical services when medically necessary.

V.4. Surgery Not Covered

V.4.1. Plastic, reconstructive or cosmetic surgery, including skin lesions that are removed for cosmetic purposes. Exceptions for reconstructive surgery must be approved in writing by PacifiCare of Colorado and will be considered only when performed primarily to improve the physical health and function of the patient. Any non-covered services received prior to written approval will not be reimbursed by PacifiCare of Colorado and will be the financial responsibility of the member.

V.4.2. Reconstructive nasal surgery, including rhinoplasty.

V.4.3. Revision of a previous procedure performed for cosmetic purposes including, but not limited to breast augmentation.

V.4.4. Surgical treatment for obesity, except for cases that meet the standards of medically necessary care as accepted by PacifiCare of Colorado for cases of morbid obesity and that are then preauthorized in writing by PacifiCare of Colorado's Medical Director.

V.4.5. Reconstructive surgery which does not correct or materially improve a physiological function.
However, the expenses of plastic, reconstructive or cosmetic surgery will be covered if the surgery is performed as soon as medically feasible and it is medically necessary for either of the following reasons:

- To repair an injury sustained while the member is a member of PacifiCare of Colorado and repair is initiated within one (1) year following the injury
- The correction of a congenital defect that substantially impairs major organ function, or leads to a progressive deterioration of health of a covered child

### W. Therapies/Rehabilitation

#### W.1. Cardiac

W.1.1. Short-term cardiac rehabilitation based on criteria established by PacifiCare of Colorado at an approved facility for the short-term follow-up of acute care for a myocardial infarct or cardiac revascularization procedure. This benefit is an extension of the treatment for an inpatient acute care episode and must begin within two (2) months of discharge from the acute care facility.

W.1.2. Cardiac rehabilitation based on criteria established by PacifiCare of Colorado at an approved facility for the short-term follow-up of acute care for stable angina pectoris.

**LIMIT:**
A maximum of $1,000 within a ninety (90) day period

#### W.2. Chemotherapy

W.2.1. Outpatient injectable chemotherapy, when oral administration of prescribed medication is not medically appropriate.

W.2.2. Services and materials for chemotherapy.

**NOTE:**
Also see Z.1.18 under Section Z., General Exclusions, in this chapter.

#### W.3. Hemodialysis

W.3.1. All necessary services for hemodialysis for chronic renal disease and for kidney transplants, including training and expendable medical supplies.

#### W.4. Occupational/Physical

W.4.1. Short-term, outpatient occupational and physical therapy by licensed therapists who are participating providers or approved by PacifiCare of Colorado. This short-term, outpatient physical therapy is for treatment of acute conditions that are subject to significant improvement within two (2) months of when treatment begins.

**LIMITS:**
- Not to exceed twenty (20) sessions combined for physical and occupational therapy per acute condition
- Requires prior written authorization of an approved treatment plan by PacifiCare of Colorado

W.4.2. The member's status may be reevaluated and, if it is determined that the condition is no longer acute, it may not be covered.

W.4.3. Physical and occupational therapy for the care and treatment of congenital defects and birth abnormalities for children up to age five (5), without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

**LIMIT:**
Not to exceed twenty (20) sessions each per year for physical and occupational therapy

#### W.5. Radiation Therapy

W.5.1. Services for radiation therapy.

**NOTE:**
Also see Z.1.18 under Section Z., General Exclusions, in this chapter.
W.6. **Respiratory**

W.6.1. Respiratory therapy by a licensed respiratory therapist on an outpatient basis is limited to emergency care.

W.7. **Speech**

W.7.1. Services of licensed speech therapists who are participating providers or approved by PacifiCare of Colorado. This therapy is a benefit only for the short-term rehabilitation required immediately following these acute episodes: stroke, accidental brain injury (not occurring during birth), and injury or surgery directly affecting the larynx and/or vocal cords or for treatment of vocal cord nodules in lieu of surgery. Also, for treatment of speech delay in three- to five-year-old patients, secondary to persistent otitis media or serous otitis media documented as persisting longer than six (6) months with documented bilateral 25 decibel hearing loss. The goal of this therapy is a significant improvement of a member's condition within two (2) months.

*NOTE:*
See Subsection V.2, Oral and Dental Surgery, in this chapter, for information on coverage of speech therapy for cleft lip and/or cleft palate.

*LIMITS:*
- Not to exceed twenty (20) sessions per acute condition
- Requires prior written authorization of an approved treatment plan by PacifiCare of Colorado
- The member's status may be reevaluated and, if it is determined that the condition is no longer acute, it may not be covered

*NOT COVERED:*
Speech therapy related to a developmental or communication delay

W.7.2. Speech therapy for the care and treatment of congenital defects and birth abnormalities for children up to age five (5), without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

*LIMIT:*
Not to exceed twenty (20) sessions per year

W.8. **Therapies/Rehabilitation Not Covered**

W.8.1. Special evaluation and/or therapy for:

- Behavior disorders
- Communication delay
- Learning disability
- Mental retardation and related conditions
- Motor dysfunction
- Multiple handicaps
- Perceptual disorders
- Post-traumatic stress
- Pulmonary rehabilitation
- Sensory deficit
- Sex addiction
- Speech (except as covered in Subsections V.2, Oral and Dental Surgery or W.7, Speech, in this chapter)
- Vision
W.8.2. Special evaluations and therapies including:

- Behavioral training
- Biofeedback (except as covered under pain clinics and as related to acute pelvic muscle rehabilitation)
- Cognitive therapy
- Coma stimulation
- Developmental and neuroeducational testing or treatment
- Educational studies
- Hearing therapy
- Hypnotherapy
- Myofunctional therapy
- Neuromuscular rehabilitation for chronic conditions
- Psychological testing
- Sleep therapy
- Vision therapy/orthoptics
- Vocational rehabilitation

X. **Transplants**

X.1. **Transplant Criteria**

X.1.1. All necessary services for covered transplants at designated transplant facilities. Services are covered to the extent preauthorized based on medical criteria established by PacifiCare of Colorado and provided only upon referral by the member's participating provider. Covered services include the directly related, reasonable medical and hospital expenses of the donor.

X.1.2. Donor screening charges for immediate family members to include spouses, parents, children, siblings, and, if appropriate, grandparents.

X.1.3. Referrals are subject to determination by a participating provider that the service referred represents the preferred method of treatment.

X.1.4. Coverage will be restricted to transplant services provided to the donor and recipient only when the recipient is a PacifiCare of Colorado member.

X.1.5. Neither PacifiCare of Colorado nor its participating providers will be responsible to furnish a donor or to assure the availability or capacity of designated facilities.

X.1.6. If, after referral, the participating provider determines that the member does not satisfy its criteria for the service involved, PacifiCare of Colorado's obligation is limited to paying for covered services provided prior to such determination.

X.2. **Bone Marrow**

X.2.1. Allogeneic bone marrow or stem cell transplants for members with aplastic anemia, leukemia, severe combined immunodeficiency disease or Wiskott-Aldrich Syndrome.

X.2.2. Autologous bone marrow or stem cell transplants for members with high risk stage II and stage III breast cancer, acute leukemia in remission, resistant non-Hodgkin's lymphomas or those who have a poor prognosis following an initial response, recurrent or refractory neuroblastoma, advanced Hodgkin's disease who have failed conventional therapy and have no HLA-matched donor.
X.2.3. Autologous bone marrow or stem cell transplants, including tandem autologous bone marrow or stem cell transplants, for members with multiple myeloma.

NOTE: Coverage of autologous bone marrow or stem cell transplants for members with high risk stage II breast cancer is considered based on criteria established by PacifiCare of Colorado only when ten (10) or more lymph nodes are positive.

NOT COVERED:
- Autologous bone marrow or stem cell transplants and chemotherapy requiring a bone marrow or stem cell transplant for stage I and stage IV breast cancer, ovarian cancer and other solid tumors
- Repeat bone marrow or stem cell transplants (allogeneic, autologous or any combination) for the same disease, except as described in W.2.3 above, regardless of whether or not the original transplant was covered under this Agreement.

NOTE: Also see Z.1.18 under Section Z., General Exclusions, in this chapter.

X.3. Cornea
X.3.1. Cornea transplants.

X.4. Heart
X.4.1. Heart transplants, subject to the limitations in X.11.1 of this section.

X.5. Heart/Lung (Combined)
X.5.1. Combined heart/lung transplants, subject to the limitations in X.11.1 of this section.

X.6. Kidney

X.7. Kidney/Pancreas (Combined)
X.7.1. Combined kidney/pancreas transplants, subject to the limitations in X.11.1 of this section.

X.8. Liver
X.8.1. Liver transplants for children under age eighteen (18) with biliary atresia or other end-stage liver disease.
X.8.2. Liver transplants for members age eighteen (18) and over, subject to the limitations in X.11.1 of this section.

X.9. Lung
X.9.1. Lung transplants, subject to the limitations in X.11.1 of this section.

X.10. Skin Grafts
X.10.1. Skin grafts.

NOT COVERED:
Skin grafts performed for cosmetic purposes

X.11. Transplant Limitations and Transplants Not Covered
X.11.1. Services, materials or expenses related to liver transplants for members age eighteen (18) and over, heart transplants, combined heart/lung transplants, lung transplants and combined kidney/pancreas transplants are excluded during the first six (6) months after the effective date of coverage under the Plan if the member has been a candidate for such transplant or if the condition resulting in the need for such transplant is one for which the member incurred charges, received medical treatment, consulted a health professional or took prescription drugs during the six-month period immediately preceding the effective date of coverage. This limitation is subject to credit for creditable coverage as required by the Health Insurance Portability and Accountability Act of 1996.
X.11.2. The following are not covered transplants:

- Pancreas only
- Multiple organs (except as listed as covered in this Agreement)
- Non-human
- Artificial organs and their implantation
- All other transplants not listed in this Agreement as covered benefits

X.12. Transplant Guidelines

X.12.1. The following guidelines apply to transplants:

- Any request for a covered transplant, except cornea transplants and skin grafts, must be made in writing to the PacifiCare of Colorado Medical Director.
- The PacifiCare of Colorado Medical Director will issue a written response within thirty-one (31) days.
- Written preauthorization of any covered transplant benefit must be given prior to initiation of services.
- PacifiCare of Colorado will not cover services received prior to issuance of its written preauthorization.

Y. Treatment Alternatives

Y.1. Treatment Alternatives

Y.1.1. Treatment alternatives and limited adaptations to coverage under this Agreement are reserved to the sole discretion of PacifiCare of Colorado. While this Agreement is the definitive statement of PacifiCare of Colorado's legal obligation to provide benefits, experience has shown that there may be unusual and extraordinary circumstances that are not contemplated by this Agreement. Therefore, PacifiCare of Colorado specifically reserves the right, at its sole discretion and based on prudent business and medical judgment (with the input of its Medical Director), to adapt the coverage and benefits set forth in this Agreement.

Y.1.2. The fact that PacifiCare of Colorado makes an adaptation to this Agreement will not require or act as precedent requiring that it make future adaptations in similar or other situations, or otherwise be prevented from administering this Agreement in strict accordance with its terms.

Y.1.3. In addition, PacifiCare of Colorado may, at its sole discretion, reevaluate and discontinue any adaptation granted under this provision if it determines that the original basis for granting the adaptation is no longer valid and supportive of the adaptation or is no longer likely to lead to measurable improvement in the health of the member.

Y.1.4. Any request for coverage of treatment alternatives and/or limited adaptations to this Agreement must be made in writing, by a participating physician or a member, to PacifiCare of Colorado's Medical Director. The coverage decision will be made by PacifiCare of Colorado. PacifiCare of Colorado will provide a written response; only services specifically authorized and received after the member's receipt of the written response will be covered. PacifiCare of Colorado shall have the sole discretionary authority to interpret this plan and determine all questions arising in the administration, interpretation, and application of the plan, and all such determinations shall be final, conclusive, and binding.
Z. General Exclusions

Z.1. Services Not Covered

Z.1.1. Any service that is:
- Not included in this Agreement, even though provided or referred by a PacifiCare of Colorado physician
- Not reasonably and medically necessary, even if listed as a covered service in this Agreement
- Not required in accordance with accepted standards of medical, surgical, or psychiatric practice, even though provided or referred by a PacifiCare of Colorado physician
- Not selected by the subscribing group
- Required only for the convenience of the member or the member's physician
- Any service provided by a non-participating provider unless authorized in advance by PacifiCare of Colorado or as set forth in Section E. Emergencies and Urgent Care Outside the PacifiCare of Colorado Service Area.

Z.1.2. Services that PacifiCare of Colorado has no legal obligation to cover:
- Free clinics
- Government free programs
- Any charge made solely because the member has the benefit covered by PacifiCare of Colorado
- Services and supplies paid for directly or indirectly by any local, State or Federal Government agency, except when the member would have a legal obligation to pay for the services

Z.1.3. All medical and hospital care associated with conditions for which written preauthorization by PacifiCare of Colorado's Medical Director is required and was not received; and/or for which treatment by participating physicians or hospital was required but was not so provided.

Z.1.4. Expenses for medical and/or hospital services incurred prior to membership in PacifiCare of Colorado or services provided after PacifiCare of Colorado coverage or eligibility terminates.

Z.1.5. Braces and artificial limbs (except as described in Section C., Durable Medical Equipment, in this chapter). Artificial aids, prosthetic devices, corrective appliances, and breast pumps.

Z.1.6. Medical supplies including without limitation, on an outpatient basis, enteral feeding substance and infant formula, medical foods except as specified in Section N. Medical Foods, of this chapter.

Z.1.7. Total parenteral nutrition (TPN).

Z.1.8. Services of chiropractors.

Z.1.9. Acupuncture.

Z.1.10. Sex transformation procedures, services, and supplies.

Z.1.11. Sexual dysfunction or inadequacy medications, procedures, services, and supplies, including penile implants/prosthesis except testosterone injections for documented low testosterone levels. Coverage of testosterone injections is based on criteria established by PacifiCare of Colorado.

Z.1.12. Post-mortem testing.

Z.1.13. Charges for missed appointments in provider's offices and/or charges incurred when scheduled services are canceled by the member.

Z.1.14. Services that PacifiCare of Colorado members are entitled to as a result of class action or special group settlements, for example, Agent Orange treatment programs and asbestosis indemnification funds. If specific treatment facilities are not stipulated by the responsible agency or group, PacifiCare of Colorado will provide the services contingent on either coordination of benefits or the subrogation rights explained in Chapter Two, Your Rights and Responsibilities, Section D., Coordination of Benefits and Subrogation.

Z.1.15. Special blood handling fees and storage of cord blood.

Z.1.16. Take-home drugs.

Z.1.17. Gene manipulation therapy.
Z.1.18. Bone marrow or stem or progenitor cell transplants or rescue procedures and any related services and chemotherapy or radiation therapy for which a bone marrow or stem or progenitor cell transplant or rescue is required or recommended, for the treatment of any disease, including, but not limited to, stage I and stage IV breast cancer, except for those specific diseases named in Subsection X.2, Bone Marrow, in this chapter. The procedure is excluded whether the bone marrow or stem or progenitor cells are taken from the member (autologous) or a third party (allogeneic) or from the bone marrow or peripheral blood supply. The entire procedure hereby excluded is frequently referred to as a Bone Marrow Transplant (BMT) or High Dose Chemotherapy with Autologous (Self) Bone Marrow Transplant or HDC/ABMT. (It may also be known as autologous stem or progenitor cell support or rescue, hematopoietic stem or progenitor cell rescue and peripheral stem or progenitor cell rescue, all of which may be accompanied by the term high dose chemotherapy.)

Z.1.19. Outpatient prescription drugs unless covered under the optional prescription drug benefit purchased by the subscribing group.

Z.1.20. Personal comfort or convenience items or services obtained or rendered in or out of a hospital or other facility, such as television, telephone, guest meals, articles for personal hygiene, and any other similar incidental services and supplies.

Z.1.21. Services rendered by a provider with the same legal residence as the member, or a member of the member's family, including spouse, brother, sister, parent or child.

Z.1.22. Custodial, maintenance, convalescent and/or domiciliary care, respite care (except as specifically provided for in Section J., Hospice Care, in this chapter), rest cures, whether furnished in the home or in an institution, including a nursing home or similar facility.

Z.1.23. Travel or transportation expenses (except ambulance service as specifically provided in this Agreement) even though prescribed by a physician or to reach a participating or designated PacifiCare of Colorado facility.

Z.1.24. Cosmetic procedures and services performed for cosmetic reasons, whether or not due to a medical condition except as covered under Section V., Surgery, in this chapter.

Z.1.25. Elective or voluntary enhancement procedures, services, supplies, and medications including, but not limited to weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance.

Z.1.26. New procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved as covered by PacifiCare of Colorado.

Z.1.27. Treatment or care for maxillary and mandibular osteotomies, and jaw or orthognathic conditions.

Z.1.28. Orthognathic surgery and associated costs of each related to the treatment for misalignment or similar malfunction of the jaw joint, commonly known as temporomandibular joint problems or TMJ syndrome.

Z.2. Dental Services Not Covered

Z.2.1. These include, but are not limited to:

- General dental services and dental x-rays, including treatment on or to the teeth or gums
- Any services customarily provided by a general dentist, an oral surgeon, or any other dental specialist
- Any procedure involving osteotomy of the jaw
- Periodontal treatment and/or surgery
- Treatment or care for overbite or underbite
- Treatment or care for maxillary and mandibular osteotomies, and jaw or orthognathic conditions
- Dental prosthetics and metallic bone cylinder implants (bone screws)
- Hospital costs for dental surgery or other dental reasons
- Orthodontic treatment, orthognathic surgery and associated costs of each related to the treatment for misalignment or similar malfunction of the jaw joint, commonly known as temporomandibular joint problems or TMJ syndrome
Z.3. **Experimental, Investigational, Unproven, Unusual, or Not Customary Treatments, Procedures, Devices, and/or Drugs Not Covered**

Z.3.1. Treatments, procedures, devices and/or drugs shall be deemed excluded as experimental, investigational, unproven, unusual, or not customary if:

- it cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) or other governmental agency and such approval has not been granted at the time of its use or proposed use,
  - or
- it is the subject of a current investigational new drug or new device application on file with the FDA,
  - or
- it is being administered for non FDA-approved indications,
  - or
- it is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial,
  - or
- it is being provided pursuant to a written protocol which describes among its objectives, determinations of safety, toxicity, effectiveness or effectiveness in comparison to conventional alternatives,
  - or
- it is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS),
  - or
- the predominant opinion among experts as expressed in the published authoritative literature is that usage should be substantially confined to research settings,
  - or
- if the predominant opinion among experts as expressed in the published authoritative literature is that further research is necessary in order to define safety, toxicity, effectiveness or effectiveness compared with conventional alternatives,
  - or
- it is not a covered benefit under Medicare as determined by the Centers for Medicare and Medicaid Services (CMS) of HHS,
  - or
- it is experimental, investigational, unproven, unusual or not customary or is not a generally acceptable medical practice in the predominant opinion of independent experts,
  - or
- a majority of a representative sample of not less than three health insurance or benefit providers or administrators consider the requested treatment, procedure, device or drugs to be experimental, investigational, unproven, unusual or not customary based upon criteria and standards regularly applied by the industry,
  - or
- it is not experimental or investigational in itself pursuant to the above, and would not be medically necessary, but for being provided in conjunction with the provision of a treatment, procedure, device or drug which is experimental, investigational, unproven, unusual or not customary.
Z.3.2. Determinations under this section will be based on the following:

- the member's medical records,
- the protocol(s) pursuant to which the treatment is to be delivered,
- any informed consent documents the member is required to read and/or execute, as a condition of receiving the treatment,
- the published authoritative medical or scientific literature regarding the procedure at issue as applied to the member's medical condition,
- regulations, bulletins, letter rulings or other official actions and publications issued by the FDA, HHS, CMS, the National Institutes for Health (NIH), the National Cancer Institute (NCI) or other applicable regulatory agencies,
- the opinions of independent experts,
- materials prepared by, for or on behalf of other health insurance or benefit providers and administrators concerning the requested treatment, procedure, device or drug, and/or recognized technology assessments or evaluations by private or federal entities (e.g. Blue Cross & Blue Shield Association, American Medical Association, Office of Technology Assessment)
- other materials that, in the exercise of PacifiCare of Colorado's discretion, are relevant.

Z.3.3. No treatment, procedure, device and/or drug excluded by this Subsection Z.3 on the inception date of this Agreement shall be covered because it subsequently ceases to meet the criteria of this section during the remaining contract year, unless PacifiCare of Colorado issues a written amendment expressly making it a covered benefit.

Z.3.4. Treatments, procedures, devices and/or drugs considered to be experimental, investigational, unproven, unusual, or not customary include, but are not limited to:

- Orthomolecular medicine
- Holistic medicine
- Environmental medicine
- Chelation therapy, unless medically necessary for the treatment of metal poisoning
- Cytotoxin testing
- Hair analysis
- Colonics
- Gene manipulation therapy
- Autologous bone marrow transplants and chemotherapy requiring a bone marrow transplant for stage I and stage IV breast cancer, ovarian cancer and other solid tumors
- Transplants not specifically listed as covered
- Medications that are experimental, investigative, or used in ways not approved by the Food and Drug Administration (FDA). Medications included in these categories are those prescribed for:
  - Use in dosage forms not commercially available
  - Use by routes of administration not approved by the FDA
  - Non-FDA approved indications
- Naturopathic services
- Megavitamin therapy

Z.3.5. PacifiCare of Colorado shall have the discretionary authority to interpret this plan and determine all questions arising in the administration, interpretation, and application of the plan including determining what procedures, devices or drugs are experimental, investigational, unusual, not customary, or unproven. All such determinations shall be final, conclusive, and binding.
AA. General Limits

AA.1. Cumulative Benefits

AA.1.1. Any service provided a subscriber or dependent during a contract year is limited cumulatively to these benefits covered in this Agreement. The following changes in a member's status may not increase any restriction or limitation on the number of services or benefits a member can receive in a contract year:

- From subscriber to dependent
- From dependent to subscriber
- From group coverage to continuation coverage, individual plan coverage, or conversion coverage

AA.1.2. If both this Agreement and the associated coverage have a maximum amount payable or other benefit limit for a particular service in a contract year, then any benefits provided under the associated coverage for that service will apply toward the maximum amount payable or other benefit limit under this Agreement. When the cumulative benefits provided under both coverages reach the applicable maximum or limit for the service under this Agreement, no further benefits will be payable for that service under this Agreement.

AA.2. Circumstances Beyond PacifiCare of Colorado’s Control

AA.2.1. If, due to circumstances not reasonably within the control of PacifiCare of Colorado, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, disability of a significant part of hospital or physicians associated with PacifiCare of Colorado, or similar causes, the rendition or provisions of benefits covered hereunder is delayed or rendered impractical, hospitals and physicians associated with PacifiCare of Colorado will use good faith effort to provide benefits covered hereunder, but neither PacifiCare of Colorado, hospitals, nor any physician associated with PacifiCare of Colorado, has any other liability or obligation for delay or such failure to provide or arrange for any such services to the extent the disaster or epidemic causes unavailability of facilities or personnel.

AA.3. Major Disaster or Epidemic

AA.3.1. If a major disaster or epidemic occurs, physicians and hospitals will provide medical and hospital services and arrange extended care services and home health services as far as is practical according to their best judgement. These services will be within the limitation of available facilities and personnel, but neither PacifiCare of Colorado, hospitals, nor any physician associated with PacifiCare of Colorado, has any liability or obligation for delay or failure to provide or arrange for any such services to the extent the disaster or epidemic causes unavailability of facilities or personnel.
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CHAPTER FOUR
STATE OF COLORADO
MANDATORY COVERAGE PROVISIONS

The following is a summary of health care benefits mandated under Colorado law (10-16-104 C.R.S.) for Health Maintenance Organizations covering members within a group. This summary of specific benefits mandated by Colorado law is included in this Evidence of Coverage for your information only, and is not to be relied upon for determining or interpreting Covered Benefits under your PacifiCare of Colorado health plan. While every effort has been made to summarize Colorado law accurately, you must refer to the actual language of the Colorado law for a completely accurate description of the specific mandated benefits. Covered benefits under your PacifiCare of Colorado health plan are determined and interpreted in accordance with (i) the Schedule of Benefits chapter of the Evidence of Coverage, (ii) the terms and conditions set forth in this Evidence of Coverage, and (iii) the actual language of the Colorado insurance laws regarding the specific mandated benefits.

For Health Maintenance Organizations, the following benefits are covered benefits only if the services are rendered by a provider who is designated by, and affiliated with, the Health Maintenance Organization.

A. Mandated Benefits

A.1. Newborn Children

A.1.1. Coverage for a dependent newborn child of the subscriber begins from the moment of birth. Except as provided for cleft lip or cleft palate coverage, the benefits available to newborn children consist of coverage of injury or sickness, including all medically necessary care and treatment of congenital defects and birth abnormalities for the first thirty-one (31) days of the newborn's life, notwithstanding policy limitations and exclusions applicable to the other conditions or procedures covered by the policy. With regard to newborn children born with cleft lip or cleft palate or both, there shall be no age limit on benefits for such conditions, and care and treatment includes to the extent medically necessary: Oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons; prosthetic treatment such as obturators, speech appliances, and feeding appliances; medically necessary orthodontic treatment; medically necessary prosthetodontic treatment; habilitative speech therapy; otolaryngology treatment; and audiological assessments and treatment. Coverage for newborn children also includes any orthodontics or dental care needed as the result of the child being born with a cleft lip or cleft palate or both. However, please note that if there is a dental insurance policy or prepaid dental contract which is in effect at the time of birth of a child with a cleft lip or cleft palate or both, or if such a policy or contract is purchased after the birth, that dental policy must provide fully for any orthodontics or dental care needed as a result of the cleft lip of cleft palate or both.

A.1.2. Except as provided for cleft lip and cleft palate coverage, after the first thirty-one (31) days of life, policy limitations and exclusions that are generally applicable under the policy may apply, except that all health benefit plans shall provide medically necessary physical, occupational, and speech therapy for the care and treatment of congenital defects and birth abnormalities for covered children up to five (5) years of age. The number of visits shall be the greater of the number of such visits provided under the policy or plan or twenty (20) therapy visits per year each for physical therapy, occupational therapy, and speech therapy. These therapy visits shall be distributed as medically appropriate throughout the yearly term of the policy, without regard to whether the condition is acute or chronic and without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.

A.2. Complications of Pregnancy and Childbirth

A.2.1. Coverage for a sickness or disease which is a complication of pregnancy or childbirth is provided in the same manner as any other similar sickness or disease.

A.3. Maternity Coverage

A.3.1. Coverage for the expense of normal pregnancy and childbirth is provided in the same manner as any other sickness, injury, disease, or condition.
A.4. **Low-Dose Mammography**

A.4.1. Coverage for routine and certain diagnostic screening by low-dose mammography for the presence of breast cancer in adult women.

A.4.2. Routine and diagnostic screenings are provided without deductibles. Coverage shall be the lesser of sixty dollars per mammography screening, or the actual charge for such screening. Coverage is provided according to the following guidelines:

A.4.2.1. Provision of a single baseline mammogram for women thirty-five (35) years of age and under forty (40) years of age;

A.4.2.2. Screening not less than once every two years for women forty (40) years of age, but at least once each such year, as specified in the policy or contract, for a woman with risk factors to breast cancer as determined by her physician.

A.4.2.3. Annual screening as specified in the policy or contract for women who are fifty (50) to sixty-five (65) years of age.

A.5. **Mental Illness**

A.5.1. In the case of confinement as an inpatient or partial hospitalization in a hospital or psychiatric hospital, benefits are payable for at least forty-five (45) days for inpatient care or ninety (90) days for partial hospitalization in any one twelve-month-benefit period. For the purpose of computing benefits which are payable, each two (2) days of partial hospitalization care shall reduce by one (1) day the forty-five (45) days available for inpatient care, and each one (1) day of inpatient care shall reduce by two (2) days the ninety (90) days available for partial hospitalization care. Each one (1) day as an inpatient or each two (2) days of partial hospitalization shall reduce by one (1) day the total days available for all other illnesses during any one twelve-month-benefit period. Each one (1) day as an inpatient or each two (2) days of partial hospitalization shall reduce by one (1) day the available days of coverage.

**NOTE:**

“Partial hospitalization” is defined as continuous treatment for at least three (3) hours, but not more than twelve (12) hours, in any twenty-four-hour period.

A.5.2. A carrier may establish a copayment requirement for mental illness, which may or may not differ from the copayment requirement established for any other condition or illness; except that copayment requirements for mental illness shall not exceed a fifty-percent (50%) copayment. In addition, the aggregate benefits payable for outpatient mental health services cannot be less than $1,000 in any twelve (12) month period.

A.6. **Biologically-Based Mental Illness**

A.6.1. Coverage for the treatment of biologically-based mental illness that is no less extensive than the coverage provided for any other physical illness. “Biologically-based mental illness” is defined as schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, and panic disorder.

A.7. **Prostate Cancer Screening**

A.7.1. Coverage for annual screening for the early detection of prostate cancer in men over the age of fifty (50) years and in men over the age of forty (40) years who are in high-risk categories. Coverage shall be the lesser of sixty-five (65) dollars per screening or the actual charge for such screening. Such benefits shall in no way diminish or limit diagnostic benefits otherwise allowable under the policy or contract. The screening shall consist, at a minimum, of the following tests:

A.7.1.1. A prostate-specific antigen (“PSA”) blood test;

A.7.1.2. Digital rectal examination.

A.7.1.3. At least one screening per year shall be covered for any man fifty (50) years of age or older.

A.7.1.4. At least one screening per year shall be covered for any man from forty (40) to fifty (50) years of age who is at increased risk of developing prostate cancer.
A.8. **Hospitalization and General Anesthesia for Dental Procedures for Dependent Children**

A.8.1. Coverage for general anesthesia when rendered in a hospital, outpatient surgical facility, or other licensed facility, and for associated hospital or facility charges for dental care provided to a dependent child who meets the following criteria:

A.8.1.1. The child has a physical, mental, or medically compromising condition; or

A.8.1.2. The child has dental needs for which local anesthesia is ineffective because of acute infection, anatomic variations, or allergy; or

A.8.1.3. The child is an extremely uncooperative, unmanageable, anxious, or uncommunicative child or adolescent with dental needs deemed sufficiently important that dental care cannot be deferred; or

A.8.1.4. The child has sustained extensive orofacial and dental trauma.

A.8.2. A carrier may:

A.8.2.1. Require prior authorization for general anesthesia and outpatient surgical facilities or hospitalization for dental care procedures in the same manner that prior authorization is required for hospitalization for other covered diseases or conditions; and

A.8.2.2. Restrict coverage to include anesthesia provided by an anesthesia provider only during procedures performed by an educationally qualified specialist in pediatric dentistry or other dentist educationally qualified in a recognized dental specialty for which hospital privileges are granted or who is certified by virtue of completion of an accredited program of post-graduate hospital training to be granted hospital privileges.

A.8.3. The provisions of this Section A.8. shall not apply to treatment rendered for temporomandibular joint (TMJ) disorders.

A.9. **Diabetes**

A.9.1. Equipment, supplies, and outpatient self-management training and education, including medical nutrition therapy if prescribed by a health care provider licensed to prescribe such items.

A.9.2. Diabetes outpatient self-management training and education when prescribed shall be provided by a certified, registered, or licensed health care professional with expertise in diabetes.

A.9.3. The benefits provided in this Subsection A.9. are subject to the same annual deductibles or copayments established for all other covered benefits within a given policy.

A.9.4. Private third-party payors shall not reduce or eliminate coverage due to the requirements of this subsection A.9.

A.10. **Prosthetic Devices**

*NOTE:* For the purposes of this subsection, “prosthetic device” means an artificial device to replace, in whole or in part, an arm or leg.

A.10.1. Coverage for prosthetic devices that equal those benefits provided under Medicare.

A.10.2. Covered benefits are limited to the most appropriate model that adequately meets the medical needs of the patient as determined by the member’s treating physician.

A.10.3. Repair and replacement of prosthetic devices, unless necessitated by misuse or loss.

A.10.4. A carrier may require prior authorization for prosthetic devices in the same manner that prior authorization is required for any other benefit.

A.11. **Medical Foods**

A.11.1. Medical Foods, for the purpose of this benefit, refer exclusively to prescription metabolic formulas and their modular counterparts, obtained through a pharmacy. Medical Foods are specifically designated and manufactured for the treatment of Inherited Enzymatic Disorders caused by Single Gene Defects.
A.11.2. Coverage for Inherited Enzymatic Disorders caused by Single Gene Defects shall include, but not be limited to the following diagnosed conditions: Phenylketonuria, Maternal Phenylketonuria, Maple Syrup Urine Disease, Tyrosinemia, Homocystinuria, Histidinemia, Urea Cycle Disorders, Hyperlysinemia, Glutaric Acidemias, Methylmalonic Acidemia, and Propionic Acidemia. Covered care and treatment of such conditions shall include, to the extent medically necessary, medical foods for home use for which a participating physician has issued a written, oral, or electronic prescription.

A.11.3. The maximum age to receive this benefit for Phenylketonuria is twenty-one (21) years of age; except that the maximum age to receive this benefit for Phenylketonuria for women who are child-bearing age is thirty-five (35) years of age.

A.12. Child Health Supervision Services

A.12.1. “Child health supervision services” are defined as those preventive services and immunizations required to be provided in basic and standard health benefit plans, to dependent children up to age thirteen (13).

Schedule of Recommended Immunizations:

<table>
<thead>
<tr>
<th>Recommended Age</th>
<th>Immunizations</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>Hepatitis B</td>
<td>For infants born to mothers who are HBsAg-positive. Initial dose must be given within 12 hours. Also HBIG within 12 hours.</td>
</tr>
<tr>
<td>1 month</td>
<td>Hepatitis B</td>
<td>To be given to children of HBsAg-positive mother.</td>
</tr>
<tr>
<td>2 months</td>
<td>DTP-HIB or DTP and HIB Polio (IPV or OPV)*</td>
<td>Must check for immunosuppression prior to oral polio administration - see special HIB schedule. May initiate Hepatitis B in HBsAg-negative family.</td>
</tr>
<tr>
<td>4 months</td>
<td>DTP-HIB or DPT and HIB Polio (IPV or OPV)*</td>
<td>May give all immunizations if given in different locations. 6-8 weeks minimum interval for oral polio.</td>
</tr>
<tr>
<td>6 months</td>
<td>DTP-HIB or DTP and HIB Polio (IPV or OPV)*</td>
<td>Note change - Total of polio remains the same. Third OPV given at 6 months instead of 15-18 months.</td>
</tr>
<tr>
<td>12 months</td>
<td>Pneumococcal</td>
<td></td>
</tr>
<tr>
<td>12-18 months</td>
<td>Varicella (chicken pox)</td>
<td>It is unknown at this time whether chicken pox vaccine boosters will be needed and how often. Parents may choose instead to allow their children to catch the natural disease which provides lifelong immunity.</td>
</tr>
<tr>
<td>12-15 months</td>
<td>MMR</td>
<td>Since 92% of children immunized against measles at 12-14 months of age are protected, routine administration of measles vaccine is recommended from 12-15 months. Tuberculin testing may be done during this visit. MMR is recommended over single virus vaccines.</td>
</tr>
<tr>
<td>15 months</td>
<td>HIB</td>
<td>Any HIB may be used.</td>
</tr>
<tr>
<td>15-18 months</td>
<td>DTP, Polio or DTaP may be used</td>
<td>May be given at 15 month or 18 month visit.</td>
</tr>
<tr>
<td>24 months - 18 years</td>
<td>Hepatitis A</td>
<td>For high risk children.</td>
</tr>
<tr>
<td>4-6 years</td>
<td>DTP, Polio or DTaP may be used</td>
<td>At or before school entry.</td>
</tr>
<tr>
<td>Age</td>
<td>Vaccine</td>
<td>Remarks</td>
</tr>
<tr>
<td>--------------</td>
<td>---------------------------</td>
<td>------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>11-12 years</td>
<td>Hepatitis B Varicella</td>
<td>Adolescents who have not previously receive 3 doses of hepatitis B vaccine should initiate or complete the series at this time.</td>
</tr>
<tr>
<td></td>
<td>(if not received earlier)</td>
<td>A second dose should be give upon entry to elementary school or at any opportunity including entry to college.</td>
</tr>
<tr>
<td>4-20 years</td>
<td>MMR</td>
<td>For those children who have not had chicken pox by this age.</td>
</tr>
<tr>
<td>12 years</td>
<td>Varicella (chicken pox)</td>
<td>Repeat every 10 years throughout life.</td>
</tr>
<tr>
<td>14-16 years</td>
<td>Td</td>
<td>*The ACIP recommend that the first two polio vaccinations be IPV's and the second two be OPV's. Schedules with all OPV's or IPV's are also safe and effective.</td>
</tr>
</tbody>
</table>

* Sources: This table is based on the Jan-Dec 1999 Recommendations of the Advisory Committee on Immunization Practices and the American Academy of Family Physicians.

| Abbreviations: | DTP - diphtheria-tetanus-pertussis vaccine;  |
|                | OPV - oral polio vaccine;                   |
|                | MMR - measles-mumps-rubella vaccine;        |
|                | Td - diphtheria-tetanus vaccine;            |
|                | DTaP - diphtheria-tetanus-acellular pertussis vaccine. |

A.12.2. Benefits for child health supervision services shall be exempt from a deductible or dollar limit provision. Any copayment or coinsurance applicable to these benefits shall not exceed the copayment or coinsurance applicable to a physician visit.

**Covered Preventive Visits**

<table>
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<th>Preventive Visit</th>
</tr>
</thead>
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<tr>
<td>All Persons</td>
<td>1 smoking cessation education program benefit under physician supervision or as authorized by plan per lifetime, not to exceed $150 payment by insurer. Chicken pox vaccination for all persons who have not had chicken pox.</td>
</tr>
<tr>
<td>All Children</td>
<td>Immunizations. (Covered immunizations are listed at the end of this document.) Immunization deficient children are not bound by “recommended ages” on immunization chart.</td>
</tr>
<tr>
<td>Age 0-12 months</td>
<td>1 newborn home visit during first week of life if newborn released from hospital less than 48 hours after delivery. 5 well-child visits 1 PKU</td>
</tr>
<tr>
<td>Age 13-35 months</td>
<td>2 well-child visits</td>
</tr>
<tr>
<td>Age 3-6</td>
<td>3 well-child visits</td>
</tr>
<tr>
<td>Age 7-12</td>
<td>3 well-child visits</td>
</tr>
<tr>
<td>Age 13-18</td>
<td>1 age-appropriate health maintenance visit every year 1 Td Females (excluding women who have had a non-cancer related hysterectomy): screening PAP smears not to exceed 1 per year 1 hepatitis B vaccination if not given previously</td>
</tr>
</tbody>
</table>

1“Well child visit” means a visit to a primary care provider that includes the following elements: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, injury prevention counseling, discuss dietary issues, review age appropriate behaviors, etc.), and growth and development assessment. For older children, this also includes safety and health education counseling.

2“Age-appropriate health maintenance visit” means an exam which includes the following components: age appropriate physical exam (but not a complete physical exam unless this is age appropriate), history, anticipatory guidance and education (e.g., examine family functioning and dynamics, discuss dietary issues, review health promotion activities of the patient, etc.), and exercise and nutrition counseling (including folate counseling for women of child bearing age).
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<tr>
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<td>Outpatient Prescription Drugs Not Covered</td>
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CHAPTER FIVE

OUTPATIENT PRESCRIPTION DRUGS

The outpatient prescription drug benefit is covered only if it has been selected by your employer as part of the subscribing group's plan and if obtained from participating providers. To find out if this benefit applies to your plan, check the following:

- Your PacifiCare of Colorado ID card
- Your employer's benefit or personnel office
- PacifiCare of Colorado Customer Service (see Chapter Eight, How to Get Help)

If you have the optional prescription drug benefit, one of the following plans – Plan A, Plan B, Plan C or Plan R – will apply to you. Please examine your I.D. card carefully to identify the plan in which you are enrolled. The benefits for each plan are described below.

PacifiCare of Colorado, through its Pharmacy and Therapeutics Committee, has developed and maintains a prescription drug formulary (preferred drug list). The PacifiCare preferred drug list is a comprehensive list of medications used by PacifiCare contracting physicians. All of the medications on this broad list of drugs are reviewed and approved by PacifiCare contracting physicians and clinical pharmacists for use by PacifiCare members. The preferred drug list is reviewed and revised every other month throughout the year. The PacifiCare preferred drug list includes brand-name drugs and FDA-approved generic drugs. Most therapeutic classes (i.e. antibiotics, antidepressants, antihypertensives, etc.) are covered and the majority of commonly prescribed medications are included. Benefits provided by the outpatient prescription drug program are based on the usage of PacifiCare’s preferred drug list. You may obtain a copy of the PacifiCare preferred drug list by calling Customer Service (see Chapter Eight, How to Get Help), or by logging onto the PacifiCare website at www.pacificare.com. Refer to your ID card for information regarding which copayments apply to your plan.

NOTE:
PacifiCare of Colorado does not coordinate benefits for outpatient prescription drugs.

A. Plan A - Outpatient Prescription Drugs

A.1. Covered Medications

A.1.1. The following prescription drugs listed on the PacifiCare preferred drug list, and non-formulary drugs when prescribed by a PacifiCare of Colorado participating physician, an approved non-participating physician or a licensed dentist when filled at a participating pharmacy, unless otherwise listed as not covered in this section, or Section Z., General Exclusions of Chapter Three, What is Covered: Your Schedule of Benefits:

- Drugs that can only be dispensed upon the written prescription of a physician or other prescriber who is authorized to prescribe that drug under applicable State law
- Compounded medication that is made up of at least one prescription drug
- All compound drugs require prior authorization
- Diabetic supplies, insulin, glucagon kits and glucose testing strips on the preferred drug list
- Immunosuppressants to prevent organ rejection
- Oral birth control medications, diaphragms, and cervical caps on the preferred drug list that require a physician’s prescription by law

A.1.2. PacifiCare of Colorado may determine medical necessity by using precertification or prior authorization programs as deemed appropriate by PacifiCare of Colorado. Drugs from some drug classes require prior authorization. Drugs that require prior authorization are covered only when requested by a participating provider and preauthorized by PacifiCare, based on criteria established by PacifiCare.

A.1.3. Quantity limitations for medications may be set as deemed appropriate by PacifiCare of Colorado.

A.2. Medications/Refills—Standard Quantities

A.2.1. Prescribed medications and refills of tablets and/or capsules dispensed through participating pharmacies for outpatient use are dispensed for up to a thirty (30) day supply. A copayment is applicable for each prescription unit. No more than a thirty (30) day supply may be dispensed at one time. For some medications, a physician may prescribe less than a thirty (30) day supply.
A.2.2. A ninety (90) day supply of a maintenance medication, or a three cycle maximum of oral contraceptives, are available through a mail-order prescription pharmacy, for two (2) copayments, unless specifically excluded in Subsection A.8, Outpatient Prescription Drugs Not Covered or outlined in Subsection A.3, Medications/Refills—Other Quantities.

A.2.2.1. A prescription drug is considered a maintenance medication when it is intended to be used for more than ninety (90) days.

A.2.2.2. Medications such as Schedule II substances, (e.g., Morphine, Ritalin, and Dexedrine), antibiotics and other medications for short-term or acute illnesses, and drugs with special packaging requirements, (e.g., Pulmozyme), are not available through the mail-order prescription drug program.

NOTE: Contact Customer Service (see Chapter Eight, How to Get Help) for information on how to use the mail-order prescription drug program.

A.3. Medications/Refills—Other Quantities

A.3.1. Prepackaged units such as tubes, vials and inhalers are dispensed at a single copayment per prepackaged unit at the pharmacy; one copayment per two (2) prepackaged units of the same medication, including strength, through mail-order. The brand-name copayment, if applicable, will apply to diaphragms dispensed at a pharmacy.

A.3.2. Insulin is limited to two (2) vials of the same kind of insulin per applicable copayment at a plan pharmacy, or up to three (3) vials of the same kind of insulin per applicable copayment through the mail-order pharmacy.

A.3.3. Insulin syringes and needles, when used with insulin products covered by this Agreement, are limited to one (1) prepackaged unit per applicable copayment at a plan pharmacy, or two (2) prepackaged units per applicable copayment through the mail-order pharmacy. If applicable, the brand-name copayment will apply.

A.3.3.1. Glucose and ketone test strips and lancets on the preferred drug list are dispensed in the manufacturer’s trade-size package and are subject to the applicable copayment per trade-size package unit.

LIMITS:
- Coverage of glucose and ketone test strips is limited to 200 strips per thirty (30) days
- Coverage of lancets is limited to 200 units per thirty (30) days

A.3.4. The participating pharmacist is authorized to limit the quantity dispensed for a copayment to a reasonable carry-over supply if the member cannot present his/her current PacifiCare of Colorado ID card and the pharmacist cannot confirm eligibility because it is outside of PacifiCare of Colorado's normal business hours. The member may return at a time when membership can be confirmed, and obtain the remainder of the prescribed quantity. No copayment will be charged for the return visit.

A.4. Generic Equivalents

A.4.1. Food and Drug Administration (FDA) approved generic equivalents of brand-name products or PacifiCare of Colorado's preferred brand will be used when available. If the member or physician insists on a brand-name drug for whatever reason, the member is responsible for the brand-name copayment plus the difference between the cost of the generic and the brand-name drug.

A.5. Delivery Charge

A.5.1. If the participating pharmacy routinely charges all its customers for delivery service, the member must pay the delivery charge in addition to the applicable copayment.

A.6. Abuse

A.6.1. Drug utilization will be monitored periodically for all members. A consistent pattern of early refills or other abuse may lead to suspension of the member's outpatient prescription drugs benefit.
A.7. **Outpatient Prescription Drugs Benefits Outside the PacifiCare of Colorado Service Area**

A.7.1. A prescription resulting from an emergency episode is a covered benefit, only if the member has the optional outpatient prescription drugs benefit. The normal applicable outpatient prescription drugs benefit copayment applies.

**LIMIT:**
A seven (7) day supply, except for antibiotics which may be dispensed in up to a fourteen (14) day supply

A.7.2. Prescription medications the member already takes on a regular basis obtained outside the PacifiCare of Colorado service area are a covered benefit only when filled and processed electronically at a PacifiCare participating pharmacy. Copayments are applicable as set forth elsewhere in this chapter. You may obtain information on participating pharmacies outside of Colorado by contacting Customer Service or logging on to the PacifiCare website at www.pacificare.com.

A.8. **Outpatient Prescription Drugs Not Covered**

A.8.1. The following are not covered benefits with the optional outpatient prescription drugs benefit:

- Convenience Dosage Forms: Unit dose, individual packets, etc.
- Diabetic Supplies: All diabetic supplies such as insulin pens, penfills, pumps and associated supplies, except as specified in Subsection A.3 of this chapter
- Dietary products: Dietary or nutritional products and food supplements, whether prescription or non-prescription
- Drugs administered by a physician or physician’s staff
- Drugs administered while the member is receiving skilled care as an inpatient in a Skilled Nursing Facility or Extended Care Facility
- Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance
- Experimental or Investigational: Medications that are experimental, investigational, or used in ways not approved by the Food and Drug Administration (FDA). Medications included in these categories are those prescribed for:
  - Non-FDA approved indications
  - Use by routes of administration not approved by the FDA
  - Use in dosage forms not commercially available
- Fertility Drugs: Drug therapy for infertility
- Injectable Medications: All injectable medications except insulin, glucagon and bee sting kits
- New procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by PacifiCare
- Non-Approved Drugs: Drugs determined by the PacifiCare of Colorado Pharmacy and Therapeutics Committee to be non-formulary or to be ineffective, duplicative or to have preferred therapeutic alternatives available
- Non-Covered Services: Any prescription drug prescribed in connection with a service excluded under this Agreement
- Non-Drug Supplies and Equipment: Non-drug supplies such as stockings, support garments and other therapeutic devices or appliances, even though a prescription may be required, except as specifically listed as a covered benefit
- Over the Counter Medications: Medications (except insulin) which can be obtained without a prescription or have a nonprescription therapeutic equivalent, unless specified by the PacifiCare of Colorado preferred drug list.
- Progesterone and Estrogen Products: Specially compounded progesterone and estrogen products including progesterone suppositories
- Recreation or Travel - Medications when used for the purpose(s) of recreation and/or travel, other than those medications recommended for travel by guidelines established by the Centers for Disease Control
- Saline and medications for irrigation
- Sexual Dysfunction: Prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasm or hyporgasm
- Smoking Cessation: Smoking cessation drugs and/or aids
• Take-Home Use From a Facility: Drugs received from a hospital, skilled nursing facility, convalescent home or similar facility for take-home use
• Immunizations, except oral typhoid
• Vitamins and Minerals: Vitamins and minerals, except when requiring a prescription for a medically necessary vitamin or mineral
• Work-Related Medications: Medications recommended because of increased risk due to type of employment
• Other Exclusions and Limitations: All exclusions and limitations as listed in this Agreement apply to the outpatient prescription drug benefit

B. Plan B - Outpatient Prescription Drugs

B.1. Covered Medications

B.1.1. The following prescription drugs listed on the PacifiCare preferred drug list, when prescribed by a PacifiCare of Colorado participating physician, an approved non-participating physician or a licensed dentist when filled at a participating pharmacy, unless otherwise listed as not covered in this section, or Section Z., General Exclusions of Chapter Three, What is Covered:
• Drugs that can only be dispensed upon the written prescription of a physician or other prescriber who is authorized to prescribe that drug under applicable State law
• Compounded medication that is made up of at least one prescription drug
• All compounded drugs require prior authorization
• Diabetic supplies, insulin, glucagon kits and glucose testing strips on the preferred drug list
• Immunosuppressants to prevent organ rejection
• Oral birth control medications, diaphragms, and cervical caps on the preferred drug list that require a physician’s prescription by law

B.1.2. PacifiCare of Colorado may determine medical necessity by using precertification or prior authorization programs as deemed appropriate by PacifiCare of Colorado. Non-formulary drugs are covered only when requested by a participating provider and preauthorized by PacifiCare, based on PacifiCare criteria.

B1.3 Quantity limitations for medications may be set as deemed appropriate by PacifiCare of Colorado.

B.2. Medications/Refills—Standard Quantities

B.2.1. Prescribed medications and refills of tablets and/or capsules dispensed through participating pharmacies for outpatient use are dispensed for up to a thirty (30) day supply. A copayment is applicable for each prescription unit. No more than a thirty (30) day supply may be dispensed at one time. For some medications, a physician may prescribe less than a thirty (30) day supply.

B.2.2. A ninety (90) day supply of a maintenance medication, or a three cycle maximum of oral contraceptives, are available through a mail-order prescription pharmacy for two (2) applicable copayments, unless specifically excluded in Subsection B.8, Outpatient Prescription Drugs Not Covered or outlined in Subsection B.3, Medications/Refills—Other Quantities.

B.2.2.1. A prescription drug is considered a maintenance medication when it is intended to be used for more than ninety (90) days.

B.2.2.2. Medications such as Schedule II substances, (e.g. Morphine, Ritalin, and Dexedrine), antibiotics and other medications for short-term or acute illnesses, and drugs with special packaging requirements, (e.g. Pulmozyme), are not available through the mail-order prescription drug program.

NOTE:
Contact Customer Service (see Chapter Eight, How to Get Help) for information on how to use the mail-order prescription drug program.

B.3. Medications/Refills—Other Quantities

B.3.1. Prepackaged units such as tubes, vials and inhalers are dispensed at a single copayment per prepackaged unit at a plan pharmacy; one (1) copayment per two (2) prepackaged units of the same medication, including strength, through the mail-order pharmacy. The brand-name copayment, if applicable, will apply to diaphragms dispensed at a pharmacy.
B.3.2. Insulin is limited to two (2) vials of the same kind of insulin per applicable copayment at a plan pharmacy, or up to three (3) vials of the same kind of insulin per applicable copayment through the mail-order pharmacy.

B.3.3. Insulin syringes and needles, when used with insulin products covered by this Agreement, are limited to one (1) prepackaged unit per applicable copayment at a plan pharmacy, or two (2) prepackaged units per applicable copayment through the mail-order pharmacy. If applicable, the brand-name copayment will apply.

B.3.3.1. Glucose and ketone test strips and lancets on the preferred drug list are dispensed in the manufacturer’s trade-size package and are subject to the applicable copayment per trade-size package unit.

LIMITS:
- Coverage of glucose and ketone test strips is limited to 200 strips per thirty (30) days
- Coverage of lancets is limited to 200 units per thirty (30) days

B.3.4. The participating pharmacist is authorized to limit the quantity dispensed for a copayment to a reasonable carry-over supply if the member cannot present his/her current PacifiCare of Colorado ID card and the pharmacist cannot confirm eligibility because it is outside of PacifiCare of Colorado's normal business hours. The member may return at a time when membership can be confirmed, and obtain the remainder of the prescribed quantity. No copayment will be charged for the return visit.

B.4. Generic Equivalents

B.4.1. Food and Drug Administration (FDA) approved generic equivalents of brand-name products or PacifiCare of Colorado's preferred brand will be used when available. If the member or physician insists on a brand-name drug for whatever reason, the member is responsible for the generic copayment plus the difference between the cost of the generic and the brand-name drug.

B.5. Delivery Charge

B.5.1. If the participating pharmacy routinely charges all its customers for delivery service, the member must pay the delivery charge in addition to the applicable copayment.

B.6. Abuse

B.6.1. Drug utilization will be monitored periodically for all members. A consistent pattern of early refills or other abuse may lead to suspension of the member's outpatient prescription drugs benefit.

B.7. Outpatient Prescription Drugs Benefits Outside the PacifiCare of Colorado Service Area

B.7.1. A prescription resulting from an emergency episode is a covered benefit, only if the member has the optional outpatient prescription drugs benefit. The normal applicable outpatient prescription drugs benefit copayment applies.

LIMIT:
A seven (7) day supply, except for antibiotics which may be dispensed in up to a fourteen (14) day supply

B.7.2. Prescription medications the member already takes on a regular basis obtained outside the PacifiCare of Colorado service area are a covered benefit only when filled and electronically processed at a PacifiCare participating pharmacy. Copayments are applicable as set forth elsewhere in this chapter. You may obtain information on participating pharmacies outside of Colorado by calling Customer Service or logging on to the PacifiCare website at www.pacificare.com.

B.8. Outpatient Prescription Drugs Not Covered

B.8.1. The following are not covered benefits with the optional outpatient prescription drugs benefit:

- Convenience Dosage Forms: Unit dose, individual packets, etc.
- Diabetic Supplies: All diabetic supplies such as insulin pens, penfills, pumps and associated supplies, except as specified in Subsection B.3 of this chapter
- Dietary products: Dietary or nutritional products and food supplements, whether prescription or non prescription
- Drugs administered by a physician or physician’s staff
- Drugs administered while the member is receiving skilled care as an inpatient in a Skilled Nursing Facility or Extended Care Facility
- Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance
- Experimental or Investigational: Medications that are experimental, investigational, or used in ways not approved by the Food and Drug Administration (FDA). Medications included in these categories are those prescribed for:
  - Non-FDA approved indications
  - Use by routes of administration not approved by the FDA
  - Use in dosage forms not commercially available
- Fertility Drugs: Drug therapy for infertility
- Injectable Medications: All injectable medications except insulin, glucagon and bee sting kits
- Medications determined by PacifiCare of Colorado Pharmacy and Therapeutics Committee to be non-formulary, except as specified in Subsection B.1.2 of this chapter
- New procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by PacifiCare
- Non-Approved Drugs: Drugs determined by the PacifiCare of Colorado Pharmacy and Therapeutics Committee to be ineffective, duplicative or to have preferred therapeutic alternatives available
- Non-Covered Services: Any prescription drug prescribed in connection with a service excluded under this Agreement
- Non-Drug Supplies and Equipment: Non-drug supplies such as stockings, support garments and other therapeutic devices or appliances, even though a prescription may be required, except as specifically listed as a covered benefit
- Over the Counter Medications: Medications (except insulin) which can be obtained without a prescription or have a nonprescription therapeutic equivalent, unless specified by the PacifiCare of Colorado preferred drug list
- Progesterone and Estrogen Products: Specially compounded progesterone and estrogen products including progesterone suppositories
- Recreation or Travel - Medications when used for the purpose(s) of recreation and/or travel, other than those medications recommended for travel by guidelines established by the Centers for Disease Control.
- Sexual Dysfunction: Prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmia or hyporgasmia
- Smoking Cessation: Smoking cessation drugs and/or aids
- Take-Home Use From a Facility: Drugs received from a hospital, skilled nursing facility, convalescent home or similar facility for take-home use
- Immunizations, except oral typhoid
- Vitamins and Minerals: Vitamins and minerals, except when requiring a prescription for a medically necessary vitamin or mineral
- Work-Related Medications: Medications recommended because of increased risk due to type of employment
- Other Exclusions and Limitations: All exclusions and limitations as listed in this Agreement apply to the outpatient prescription drug benefit
C. Plan C - Outpatient Prescription Drugs

C.1. Covered Medications

C.1.1. The following prescription drugs listed on the PacifiCare preferred drug list, and non-formulary drugs when prescribed by a PacifiCare of Colorado participating physician, an approved non-participating physician, or a licensed dentist when filled at a participating pharmacy, unless otherwise listed as not covered in this section, or Section Z., General Exclusions of Chapter Three, What is Covered: Your Schedule of Benefits:

- Drugs that can only be dispensed upon the written prescription of a physician or other prescriber who is authorized to prescribe that drug under applicable State law
- Compounded medication that is made up of at least one prescription drug
- All compounded drugs require prior authorization
- Diabetic supplies, insulin, glucagon kits and glucose testing strips on the preferred drug list
- Immunosuppressants to prevent organ rejection
- Oral birth control medications, diaphragms, and cervical caps on the preferred drug list, that require a physician’s prescription by law

C.1.2. PacifiCare of Colorado may determine medical necessity by using precertification or prior authorization programs as deemed appropriate by PacifiCare of Colorado.

C.1.3. Quantity limitations for medications may be set as deemed appropriate by PacifiCare of Colorado.


C.2.1. Prescribed medications and refills of tablets and/or capsules dispensed through participating pharmacies for outpatient use are dispensed for up to a thirty (30) day supply. A copayment is applicable for each prescription unit. No more than a thirty (30) day supply may be dispensed at one time. For some medications, a physician may prescribe less than a thirty (30) day supply.

C.2.2. A ninety (90) day supply of a maintenance medication, or a three cycle maximum of oral contraceptives, are available through a mail-order prescription pharmacy for two (2) applicable copayments, unless specifically excluded in subsection C.8, Outpatient Prescription Drugs Not Covered.

C.2.2.1. A prescription drug is considered a maintenance medication when it is intended to be used for more than ninety (90) days.

C.2.2.2. Medications such as Schedule II substances, (e.g. Morphine, Ritalin, and Dexedrine), antibiotics and other medications for short-term or acute illnesses, and drugs with special packaging requirements, (e.g. Pulmozyme), are not available through the mail-order prescription drug program.

NOTE: Contact Customer Service (see Chapter Eight, How to Get Help) for information on how to use the mail-order prescription drug program.

C.3. Copayments

C.3.1. If the member obtains a generic medication from the preferred drug list, the generic copayment will apply; if the member obtains a brand-name) medication from the preferred drug list, the brand-name copayment will apply; if the member obtains a medication not on the PacifiCare preferred drug list and not specifically excluded, the non-formulary copayment will apply.

C.3.2. Food and Drug Administration (FDA) approved generic equivalents of brand-name products or PacifiCare of Colorado’s preferred brand will be used when available. If the member or physician insists on a brand-name drug when a generic equivalent on the preferred drug list is available, for whatever reason, the member is responsible for the non-formulary copayment.

C.4. Medications/Refills—Other Quantities

C.4.1. Prepackaged units such as tubes, vials and inhalers are dispensed for one (1) applicable copayment per prepackaged unit at a plan pharmacy; one (1) applicable copayment per two (2) prepackaged units of the same medication including strength, through the mail-order pharmacy.
C.4.2. Insulin is limited to two (2) vials of the same kind of insulin per applicable copayment at a plan pharmacy or up to three (3) vials of the same kind of insulin per applicable copayment through the mail-order pharmacy.

C.4.3. Insulin syringes and needles, when used with insulin products covered by this Agreement, are limited to one (1) prepackaged unit for one (1) applicable copayment at a plan pharmacy, or two (2) prepackaged units through the mail-order pharmacy.

C.4.4. Glucose and ketone test strips and lancets on the preferred drug list are dispensed in the manufacturer’s trade-size package and are subject to the applicable copayment per trade-size package unit.

LIMITS:
- Coverage of glucose and ketone test strips is limited to 200 strips per thirty (30) days
- Coverage of lancets is limited to 200 units per thirty (30) days

C.4.5. The participating pharmacist is authorized to limit the quantity dispensed for a copayment to a reasonable carry-over supply if the member cannot present his/her current PacifiCare of Colorado ID card and the pharmacist cannot confirm eligibility because it is outside of PacifiCare of Colorado's normal business hours. The member may return at a time when membership can be confirmed, and obtain the remainder of the prescribed quantity. No copayment will be charged for the return visit.

C.5. Delivery Charge

C.5.1. If the participating pharmacy routinely charges all its customers for delivery service, the member must pay the delivery charge in addition to the applicable copayment.

C.6. Abuse

C.6.1. Drug utilization will be monitored periodically for all members. A consistent pattern of early refills or other abuse may lead to suspension of the member's outpatient prescription drugs benefit.

C.7. Outpatient Prescription Drugs Benefits Outside the PacifiCare of Colorado Service Area

C.7.1. A prescription resulting from an emergency episode is a covered benefit, only if the member has the optional outpatient prescription drugs benefit. The normal applicable outpatient prescription drugs benefit copayment applies.

LIMIT:
A seven (7) day supply, except for antibiotics which may be dispensed in up to a fourteen (14) day supply

C.7.2. Prescription medications the member already takes on a regular basis obtained outside the PacifiCare of Colorado service area are a covered benefit only when filled and processed electronically at a PacifiCare participating pharmacy. Copayments are applicable as set forth elsewhere in this chapter. You may obtain information on participating pharmacies outside of Colorado by contacting Customer Service or logging on to the PacifiCare website at www.pacificare.com.

C.8. Outpatient Prescription Drugs Not Covered

C.8.1. The following are not covered benefits with the optional outpatient prescription drugs benefit:
- Convenience Dosage Forms: Unit dose, individual packets, etc.
- Diabetic Supplies: All diabetic supplies such as insulin pens, penfills, pumps and associated supplies, except as specified in Subsection C.4 of this chapter
- Dietary products: Dietary or nutritional products and food supplements, whether prescription or non-prescription
- Drugs administered by a physician or physician’s staff
- Drugs administered while the member is receiving skilled care as an inpatient in a Skilled Nursing Facility or Extended Care Facility
- Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance
• Experimental or Investigational: Medications that are experimental, investigational, or used in ways not approved by the Food and Drug Administration (FDA). Medications included in these categories are those prescribed for:
  • Non-FDA approved indications
  • Use by routes of administration not approved by the FDA
  • Use in dosage forms not commercially available
• Fertility Drugs: Drug therapy for infertility
• Injectable Medications: All injectable medications except insulin, glucagon and bee sting kits
• New procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by PacifiCare
• Non-Approved Drugs: Drugs determined by the PacifiCare of Colorado Pharmacy and Therapeutics Committee to be ineffective, duplicative or to have preferred therapeutic alternatives available
• Non-Covered Services: Any prescription drug prescribed in connection with a service excluded under this Agreement
• Non-Drug Supplies and Equipment: Non-drug supplies such as stockings, support garments and other therapeutic devices or appliances, even though a prescription may be required, except as specifically listed as a covered benefit
• Over the Counter Medications: Medications (except insulin) which can be obtained without a prescription or have a nonprescription therapeutic equivalent, unless specified by the PacifiCare of Colorado preferred drug list.
• Progesterone and Estrogen Products: Specially compounded progesterone and estrogen products including progesterone suppositories
• Recreation or Travel - Medications when used for the purpose(s) of recreation and/or travel, other than those medications recommended for travel by guidelines established by the Centers for Disease Control.
• Saline and medications for irrigation
• Sexual Dysfunction: Prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmia or hyporgasmia
• Smoking Cessation: Smoking cessation drugs and/or aids
• Take-Home Use From a Facility: Drugs received from a hospital, skilled nursing facility, convalescent home or similar facility for take-home use
• Immunizations, except oral typhoid
• Vitamins and Minerals: Vitamins and minerals, except when requiring a prescription for a medically necessary vitamin or mineral
• Work-Related Medications: Medications recommended because of increased risk due to type of employment
• Other Exclusions and Limitations: All exclusions and limitations as listed in this Agreement apply to the outpatient prescription drug benefit

D. Plan R - Outpatient Prescription Drugs

D.1. Covered Medications

D.1.1. The following prescription drugs listed on the PacifiCare preferred drug list and non-formulary drugs when prescribed by a PacifiCare of Colorado participating physician, an approved non-participating physician, or a licensed dentist when filled at a participating pharmacy, unless otherwise listed as not covered in this section, or Section Z., General Exclusions of Chapter Three, What is Covered: Your Schedule of Benefits:

• Drugs that can only be dispensed upon the written prescription of a physician or other prescriber who is authorized to prescribe that drug under applicable State law
• Compounded medication that is made up of at least one prescription drug
• All compounded drugs require prior authorization
• Diabetic supplies, insulin, glucagon kits and glucose testing strips on the preferred drug list
• Immunosuppressants to prevent organ rejection
• Oral birth control medications, diaphragms, and cervical caps on the preferred drug list, that require a physician’s prescription by law
D.1.2. PacifiCare of Colorado may determine medical necessity by using precertification or prior authorization programs as deemed appropriate by PacifiCare of Colorado. Drugs from some drug classes require prior authorization. Drugs that require prior authorization are covered only when requested by a participating provider and preauthorized by PacifiCare, based on criteria established by PacifiCare.

D.1.3. Quantity limitations for medications may be set as deemed appropriate by PacifiCare of Colorado.

D.2. Medications/Refills—Standard Quantities

D.2.1. Prescribed medications and refills of tablets and/or capsules dispensed through participating pharmacies for outpatient use are dispensed for up to a thirty (30) day supply. A copayment is applicable for each prescription unit. No more than a thirty (30) day supply may be dispensed at one time. For some medications, a physician may prescribe less than a thirty (30) day supply.

D.2.2. A ninety (90) day supply of a maintenance medication, or a three cycle maximum of oral contraceptives, are available through a mail-order prescription pharmacy for two (2) applicable copayments, unless specifically excluded in subsection D.8, Outpatient Prescription Drugs Not Covered.

D.2.2.1. A prescription drug is considered a maintenance medication when it is intended to be used for more than ninety (90) days.

D.2.2.2. Medications such as Schedule II substances, (e.g. Morphine, Ritalin, and Dexedrine), antibiotics and other medications for short-term or acute illnesses, and drugs with special packaging requirements, (e.g. Pulmozyme), are not available through the mail-order prescription drug program.

NOTE:
Contact Customer Service (see Chapter Eight, How to Get Help) for information on how to use the mail-order prescription drug program.

D.3. Copayments

D.3.1. If the member obtains a generic medication from the preferred drug list, the generic copayment will apply; if the member obtains a brand-name medication from the preferred drug list, the brand-name copayment will apply; if the member obtains a medication not on the PacifiCare preferred drug list and not specifically excluded, the non-formulary copayment will apply.

D.3.2. Food and Drug Administration (FDA) approved generic equivalents of brand-name products or PacifiCare of Colorado’s preferred brand will be used when available. If the member or physician insists on a brand-name drug when a generic equivalent on the preferred drug list is available, for whatever reason, the member is responsible for the non-formulary copayment.

D.4. Medications/Refills—Other Quantities

D.4.1. Prepackaged units such as tubes, vials and inhalers are dispensed for one (1) applicable copayment per prepackaged unit at a plan pharmacy; one (1) applicable copayment per two (2) prepackaged units of the same medication including strength, through the mail-order pharmacy.

D.4.2. Insulin is limited to two (2) vials of the same kind of insulin per applicable copayment at a plan pharmacy or up to three (3) vials of the same kind of insulin per applicable copayment through the mail-order pharmacy.

D.4.3. Insulin syringes and needles, when used with insulin products covered by this Agreement, are limited to one (1) prepackaged unit for one (1) applicable copayment at a plan pharmacy, or two (2) prepackaged units through the mail-order pharmacy.

D.4.4. Glucose and ketone test strips and lancets are dispensed in the manufacturer’s trade-size package and are subject to the applicable copayment per trade-size package unit.

LIMITS:
- Coverage of glucose and ketone test strips is limited to 200 strips per thirty (30) days
- Coverage of lancets is limited to 200 units per thirty (30) days
D.4.5. The participating pharmacist is authorized to limit the quantity dispensed for a copayment to a reasonable carry-over supply if the member cannot present his/her current PacifiCare of Colorado ID card and the pharmacist cannot confirm eligibility because it is outside of PacifiCare of Colorado's normal business hours. The member may return at a time when membership can be confirmed, and obtain the remainder of the prescribed quantity. No copayment will be charged for the return visit.

D.5. Delivery Charge

D.5.1. If the participating pharmacy routinely charges all its customers for delivery service, the member must pay the delivery charge in addition to the applicable copayment.

D.6. Abuse

D.6.1. Drug utilization will be monitored periodically for all members. A consistent pattern of early refills or other abuse may lead to suspension of the member's outpatient prescription drugs benefit.

D.7. Outpatient Prescription Drugs Benefits Outside the PacifiCare of Colorado Service Area

D.7.1. A prescription resulting from an emergency episode is a covered benefit, only if the member has the optional outpatient prescription drugs benefit. The normal applicable outpatient prescription drugs benefit copayment applies.

LIMIT:
A seven (7) day supply, except for antibiotics which may be dispensed in up to a fourteen (14) day supply

D.7.2. Prescription medications the member already takes on a regular basis obtained outside the PacifiCare of Colorado service area are a covered benefit only when filled and electronically processed at a PacifiCare participating pharmacy. Copayments are applicable as set forth elsewhere in this chapter. You may obtain information on participating pharmacies outside of Colorado by contacting Customer Service or logging on to the PacifiCare website at www.pacificare.com.

D.8. Outpatient Prescription Drugs Not Covered

D.8.1. The following are not covered benefits with the optional outpatient prescription drugs benefit:

- Convenience Dosage Forms: Unit dose, individual packets, etc.
- Diabetic Supplies: All diabetic supplies such as insulin pens, penfills, pumps and associated supplies, except as specified in Subsection D.4 of this chapter
- Dietary products: Dietary or nutritional products and food supplements, whether prescription or non-prescription
- Drugs administered by a physician or physician’s staff
- Drugs administered while the member is receiving skilled care as an inpatient in a Skilled Nursing Facility or Extended Care Facility
- Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance
- Experimental or Investigational: Medications that are experimental, investigational, or used in ways not approved by the Food and Drug Administration (FDA). Medications included in these categories are those prescribed for:
  - Non-FDA approved indications
  - Use by routes of administration not approved by the FDA
  - Use in dosage forms not commercially available
- Fertility Drugs: Drug therapy for infertility
- Injectable Medications: All injectable medications except insulin, glucagon and bee sting kits
- New procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by PacifiCare
- Non-Approved Drugs: Drugs determined by the PacifiCare of Colorado Pharmacy and Therapeutics Committee to be ineffective, duplicative or to have preferred therapeutic alternatives available
- Non-Covered Services: Any prescription drug prescribed in connection with a service excluded under this Agreement
- Non-Drug Supplies and Equipment: Non-drug supplies such as stockings, support garments and other therapeutic devices or appliances, even though a prescription may be required, except as specifically listed as a covered benefit
• Over the Counter Medications: Medications (except insulin) which can be obtained without a prescription or have a nonprescription therapeutic equivalent, unless specified by the PacifiCare of Colorado preferred drug list
• Progesterone and Estrogen Products: Specially compounded progesterone and estrogen products including progesterone suppositories
• Recreation or Travel - Medications when used for the purpose(s) of recreation and/or travel, other than those medications recommended for travel by guidelines established by the Centers for Disease Control.
• Saline and medications for irrigation
• Sexual Dysfunction: Prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmia or hyporgasmia
• Smoking Cessation: Smoking cessation drugs and/or aids
• Take-Home Use From a Facility: Drugs received from a hospital, skilled nursing facility, convalescent home or similar facility for take-home use
• Immunizations, except oral typhoid
• Vitamins and Minerals: Vitamins and minerals, except when requiring a prescription for a medically necessary vitamin or mineral
• Work-Related Medications: Medications recommended because of increased risk due to type of employment
• Other Exclusions and Limitations: All exclusions and limitations as listed in this Agreement apply to the outpatient prescription drug benefit
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CHAPTER SIX

OPTIONAL BENEFITS

The following services are optional covered benefits that you have only if they have been selected by your employer as part of the subscribing group's plan and if obtained from participating providers. To find out if these benefits apply to your plan, check the following:

- Your PacifiCare of Colorado ID card
- Your employer's benefit or personnel office
- PacifiCare of Colorado Customer Service (see Chapter Eight, How to Get Help)

A. Chiropractic Care

A.1. Accessing Chiropractic Benefits

A.1.1. A PCP referral is not required to obtain chiropractic services. All benefits are available only through participating chiropractic providers.

A.1.2. The member must schedule an initial evaluation visit. To obtain chiropractic service, the member must schedule an initial evaluation appointment with a participating chiropractor. Only one initial evaluation visit is provided without authorization for each neuromusculoskeletal condition or injury requiring chiropractic treatment.

A.1.3. A pretreatment authorization is required for further services. Before a member can receive additional covered services the participating chiropractor must obtain a pretreatment authorization from the chiropractic management company. If the member completes the treatment plan and the chiropractor believes additional visits are necessary, these visits may be authorized through the chiropractic management company.

A.2. Covered Services

A.2.1. As initial examination is performed by the participating chiropractor to determine the nature of the member’s problem, and, if covered services appear warranted, to prepare a treatment plan of services to be furnished. One initial examination will be provided for each new patient.

A.2.2. Subsequent office visits, as set forth in a treatment plan approved by the chiropractic management company, may involve an adjustment, a brief re-examination, and other services, in various combinations.

A.2.3. Adjunctive therapy, as set forth in a treatment plan approved by the chiropractic management company, may involve therapies such as ultrasound, hot packs, cold packs, electrical muscle stimulation and other therapies.

A.2.4. A re-examination may be performed by the participating chiropractor to assess the need to continue, extend or change a treatment plan approved by the chiropractic management company. A reevaluation may be performed during a subsequent office visit or separately.

A.2.5. X-rays and lab tests are payable in full when prescribed by a participating chiropractor and authorized by the chiropractic management company. Radiological consultations are a covered benefit when authorized by the chiropractic management company as medically necessary and provided by a licensed chiropractic radiologist, medical radiologist, radiology group, or hospital which has contracted with the chiropractic management company to provide those services.

A.2.6. Chiropractic appliances are payable up to a maximum of $50.00 per year when prescribed by a participating chiropractor and authorized by the chiropractic management company.

NOTE: The number of visits are determined by our employer. Please consult your employer, your plan documents or PacifiCare Customer Service to obtain this information.
A.3. **Chiropractic Services Not Covered**

A.3.1. Any services or treatments not authorized by the chiropractic management company, except for an initial examination and emergency services.

A.3.2. Any services or treatments not delivered by participating providers for the delivery of chiropractic care to members, except for emergency services.

A.3.3. Services for examinations and/or treatments for conditions other than those related to neuromusculo-skeletal disorders.

A.3.4. Hypnotherapy, behavior training, sleep therapy and weight programs.

A.3.5. Thermography.

A.3.6. Services, lab tests, x-rays and other treatments not documented as clinically 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.

A.3.7. Services and/or treatment which are not documented as medically necessary services.

A.3.8. Magnetic resonance imaging, CAT scans and any types of diagnostic radiology.

A.3.9. Transportation costs including local ambulance charges.

A.3.10. Education programs, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing.

A.3.11. Services or treatments for pre-employment physicals or vocational rehabilitation.

A.3.12. Any services or treatments caused by or arising out of the course of employment or covered under any public liability insurance.

A.3.13. 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 A.2.6.

A.3.14. Prescription drugs or medicines or medication not requiring a prescription order.

A.3.15. Hospitalization, anesthesia, manipulation under anesthesia, or other related services.

A.3.16. 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.

A.3.17. Adjunctive therapy not associated with spinal, muscle or joint manipulation.

A.3.18. Vitamins, minerals, nutritional supplements or other similar products.

B. **Eye wear**

B.1. **Prescription Glasses or Prescription Contact Lenses**

B.1.1. Prescription glasses or prescription contact lenses obtained from PacifiCare participating providers.

*NOTE:* The frequency and dollar limit of the eye wear benefit is determined by the benefit plan selected by the subscribing group. A referral from the PCP is not required for this benefit. To determine the limit applicable to your plan, contact your employer's benefit or personnel office or PacifiCare of Colorado Customer Service (see Chapter Eight, How to Get Help).

*NOT COVERED:*
- Glasses or contact lenses ordered before the effective date of coverage or after the termination of coverage
- Nonprescription frames and lenses including, but not limited to sunglasses, photosensitive, or anti-reflective lenses
CHAPTER SEVEN

DEFINITION OF TERMS

These terms are used in this Agreement and any supplements, amendments, or riders to this Agreement according to the specific definitions given here.

**Acute Care**
A pattern of health care in which a patient is treated for an acute (immediate and severe) episode of illness, for the subsequent treatment of injuries related to an accident or other trauma, or during recovery from surgery. Acute care is usually given in a hospital by specialized personnel using complex and sophisticated technical equipment and materials. Unlike chronic care, acute care is often necessary for only a short time.

**Acute Condition**
An acute (immediate and severe) episode of illness or the treatment of injuries related to an accident or other trauma, or during recovery from surgery.

**Agreement**
The written documents, issued by PacifiCare of Colorado to the subscribing group, consisting of Chapters One, Two, Three, Four, Five, Six, Seven and Eight of the Evidence of Coverage and Owner's Manual, the Evidence of Coverage and Owner's Manual Signature Sheet, the application of the subscribing group, the individual applications of the members, and any written amendments constitute the entire contract between the parties.

**Associated Coverage**
An out-of-network supplement purchased by the subscribing group and entered into concurrently with this PacifiCare of Colorado HMO Agreement.

**Calendar Year**
The period from January 1 of any year through December 31 of the same year. During the first year an individual is a member, a calendar year means the period from his/her effective date of coverage through December 31 of that year.

**Cardiac Rehabilitation**
A structured rehabilitation program provided to individuals following acute cardiac episodes. Cardiac rehabilitation services are provided on an outpatient basis.

**Chronic Care**
A pattern of care that focuses on long-term care of individuals with chronic (long-standing, persistent) diseases or conditions. It includes care specific to the problem as well as other measures to encourage self-care, to promote health, and to prevent loss of function.

**Common Law Marriage**
Evidence of cohabitation as husband and wife, and general reputation that the two individuals are living together as husband and wife and claiming to be such. By general reputation is meant the understanding among the neighbors and acquaintances with whom the parties associate in their daily lives, that they are living together as husband and wife, and not that they are merely living together.

**Common Law Spouse**
Party to a common law marriage.

**Continuation Coverage**
Coverage provided to a terminated subscriber and/or his/her eligible dependents as mandated or required by Section 10-16-108 C.R.S., Title X, Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, or any other applicable law.

**Contract Year**
The period that begins on the effective date of coverage for the subscribing group and ends on the day before the anniversary date of the effective date of coverage.

**Conversion Coverage**
The coverage available to members as described in Chapter Two, Your Rights and Responsibilities, Section C., Conversion.

**Copayment**
The predetermined amount or percentage to be paid to the provider by the member for a specific service. It will not exceed the amount permitted by applicable regulation.

**Cosmetic Procedure**
Those procedures which change physical appearance, but which do not correct or materially improve a physiological function, and therefore are not medically necessary.
Coverage  The right of a member to receive services provided under this Agreement, subject to the terms, limits, and exclusions of this Agreement.

Covered Benefit  A medically necessary service that is specifically provided for under the provisions of this Agreement. A covered benefit must always be medically necessary; but not every medically necessary service is a covered benefit. For example, some elements of custodial or maintenance care, which are excluded from coverage, may be medically necessary, but nevertheless are not covered.

Creditable Coverage  Benefits or coverage provided under Medicare or Medicaid; an employee welfare benefit plan or group health insurance or health benefit plan; an individual health benefit plan; a state health benefits risk pool (including, but not limited to the Colorado uninsurable health insurance plan); or Chapter 55 of title 10 of the United States code, a medical care program of the federal Indian health service or of a tribal organization, a health plan offered under Chapter 89 of title 5, United States code, a public health plan, or a health benefit plan under section 5(e) of the federal “Peace Corps Act” (22 U.S.C. Sec. 2504 (e)); if there was no gap in coverage of more than sixty-three (63) days between such individual policies, and the most recent coverage ended not more than ninety (90) days prior to the effective date of this coverage.

Custodial Care  Any skilled or non-skilled health services, or personal comfort or convenience related services, which provide general maintenance, supportive, preventive and/or protective care. Custodial care:
  • does not seek a cure.
  • can be provided in any setting.
  • may be provided between periods of acute or intercurrent health care needs.
  • is care provided to an individual whose health services requirements are stabilized and whose current medical condition is not expected to significantly and objectively improve or progress over a specified period of time.

Custodial care may include the supervision or participation of a physician, licensed nurse, or registered therapist as necessary or desirable services. The mere participation of these professionals does not preclude the services as being custodial in nature. If the nature of the services can be safely and effectively performed by a trained non-medical person, the services are custodial. Further, custodial care and the nature of those services are not altered by the availability of the non-medical person. Custodial care may also be referred to as maintenance, domiciliary, respite, and/or convalescent care.

Dependent  Any member of a subscriber's family who meets applicable requirements of Chapter Two, Your Rights and Responsibilities, Section F., Eligibility, who is enrolled under this Agreement, and for whom the monthly premium has been received by the PacifiCare of Colorado.

Drug Formulary  A list of prescription drugs that provide physicians with choices of effective medications from which to prescribe. The drug formulary (preferred drug list) is approved by the PacifiCare of Colorado Pharmacy and Therapeutics Committee which is comprised of pharmacists and participating physicians. Some benefit plans may require that a medication be listed on the formulary (preferred drug list) in order to be a covered benefit.

Durable Medical Equipment  Items of medical equipment owned or rented that are placed in the home of the patient to facilitate treatment and/or rehabilitation. Generally, these are items that can withstand repeated use, are primarily and customarily used to serve a medical purpose, are usually not useful to an individual in the absence of illness or injury.

Effective Date of Coverage  The date that coverage under this Agreement becomes effective. The effective date of coverage for the subscribing group is shown on the Signature Sheet. The effective date of coverage for a member is in the subscribing group's records.

Eligible Employee  An employee of the subscribing group who meets the eligibility requirements specified in the Signature Sheet, and who resides within the service area.

Emergency Medical Condition  An event or medical condition which the member, acting as a prudent layperson, reasonably believes threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

Emergency Services  Inpatient and outpatient services that are furnished by a provider qualified to furnish emergency services, and that are needed to evaluate or stabilize an emergency medical condition.
**Exclusion**  Any provision of this Agreement whereby coverage for a specific service or condition is entirely eliminated regardless of medical necessity.

**Group Open Enrollment Period**  That time when eligible persons may enroll themselves and eligible dependents under this Agreement by submitting an enrollment application to PacifiCare of Colorado.

**HMO**  Health Maintenance Organization

**Hospice Care**  A system, both inpatient and outpatient, of supportive and palliative family-centered care designed to assist the terminally ill individual to be comfortable and to maintain a satisfactory lifestyle through the terminal phases of dying.

**Hospital**  An institution licensed and operated pursuant to law which is primarily engaged in providing health services on an inpatient basis for the care and treatment of injured or sick individuals through medical, diagnostic and surgical facilities (including a surgical facility which has a bona fide arrangement, by agreement or otherwise, with an accredited hospital to perform such surgical procedures) by, or under the supervision of, a staff of physicians and which has twenty-four (24) hour nursing services. A hospital is not primarily a place for rest or custodial care of the aged, and is not a nursing home, convalescent home or similar institution. A "participating hospital" is one that is accredited as a hospital by the Joint Commission on Accreditation of Health Care Organizations and maintains contractual arrangements with PacifiCare of Colorado.

**Intensive Care**  Constant, complex, detailed health care requiring special training and provided in various acute, life threatening conditions.

**Level of Care**  The intensity of effort required to diagnose, treat, preserve, or maintain any member's current physical or emotional status. Depending on what the current level of care is determined to be, from time to time, PacifiCare of Colorado will have complete, limited, or no responsibility to provide the services appropriate for that level.

Redetermination of status and the appropriate level of care will be made by the participating primary care physician and PacifiCare of Colorado. Most limitations of or exclusions to PacifiCare of Colorado's responsibility at each level of care are included in each section of Chapter Three, What is Covered: Your Schedule of Benefits.

Terms commonly used to identify levels of care include: acute, chronic, emergency, rehabilitation, intensive, custodial, domiciliary, maintenance, skilled nursing, private duty nursing, and hospice.

**Limits**  Any provision, other than an exclusion, which restricts coverage under this Agreement, regardless of medical necessity.

**Location of Care**  The setting in which covered services, appropriate for the member's current level of care, are provided.

Terms commonly used to identify locations of care include: physician's office, outpatient department or facility, emergency room or facility, general/acute care hospital, rehabilitation hospital, psychiatric hospital, specialty hospital, skilled nursing facility, and home.

**Maintenance Care**  All services that are provided solely to maintain a patient's condition at the level to which it has been restored or stabilized, and from which level no significant practical improvement can be expected.

**Medical Director**  The physician so named by PacifiCare of Colorado as the Medical Director, or his or her designee.
Medically Necessary

An intervention will be covered under the PacifiCare Health Plan if it is an otherwise covered category of service, 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. An intervention is medically necessary if, as recommended by the treating physician and determined by the medical director of PacifiCare or the Participating Medical Group, it is (all of the following):

(a) A health intervention for the purpose of treating a medical condition;
(b) The most appropriate supply or level of service, considering potential benefits and harms to the Member;
(c) Known to be effective in treating the medical condition. 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 which may be provided safely and effectively to the Member.

In applying the above definition of medical necessity, the following terms shall have the following meanings:

(i) 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 condition that lies outside the range of normal, age-appropriate human variation. A health intervention is defined by the intervention itself, the medical condition and the patient indications for which it is being applied.

(ii) Effective means that the intervention can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.

(iii) Scientific evidence consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that suggest a causal relationship between the intervention and health outcomes can be used. Such studies 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.

(iv) A new intervention is one which 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.

(v) 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.

Medicare

Part A (hospital coverage) and Part B (physician coverage) of the insurance program established by Title XVIII, United States Social Security Act, as later amended, 42 U.S.C. Sections 1394, et seq.
**Medicare Member**
Any member entitled to benefits under both parts of Medicare (part A—hospital coverage, part B—physician coverage).

**Member**
Any individual meeting the definition of either a dependent or subscriber.

**PacifiCare of Colorado**
PacifiCare of Colorado, Inc., dba PacifiCare of Colorado, is a state licensed health maintenance organization offering Federally qualified and non-Federally qualified products.

**PacifiCare of Colorado Criteria**
Written guidelines established by PacifiCare of Colorado to determine medical necessity and/or coverage for certain procedures and treatments. PacifiCare of Colorado criteria are based on research of scientific literature, collaboration with physician specialists and compliance with federal and national regulatory agency guidelines. Criteria are approved by the PacifiCare Health Care Standards and Education Committee and are reviewed and revised on a regular basis. Criteria are available for review by the member’s participating physician, the member or the member’s representative.

**Participating Provider**
Any physician, physician specialist, hospital, skilled nursing facility, extended care facility, individual, organization, agency or other provider who/which has entered into a contractual arrangement with PacifiCare of Colorado to provide health services to members. PacifiCare of Colorado may contract with a provider for a specified member, a specified period of time and/or a specified service. In that case, the provider is a participating provider only for the service(s) contracted and/or for the designated period.

**Plan**
Any insurance policy, self-funded plan, welfare plan, trustee plan, or prepaid medical plan or program.

**Premium**
The monthly fee required for each subscriber and each member in accordance with the terms of this Agreement.

**Primary Care Physician (PCP)**
A physician so designated by PacifiCare of Colorado who:
- Supervises, coordinates, and provides medical care to members
- Initiates all referrals for specialist care
- Maintains continuity of patient care

**Private Duty Nursing**
Full-shift, continuous attention of a licensed nurse.

**Qualified Beneficiary**
Any individual who, on the day before a qualifying event, is covered under a group health plan maintained by the employer of a covered employee. This can be:
- The covered employee
- The spouse of the covered employee
- The dependent child of the covered employee

**Qualifying Event**
A qualifying event refers to an occurrence which triggers a person's right to continuation of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) as amended.

**Reasonable Charges**
The amount of a provider's bill that can be reasonably justified by the circumstances involved. Such circumstances include the level of care and experience needed, the prevailing or common cost of the supplies and services and any other factors that determine value.

**Reconstructive Surgery**
Surgery performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance.

**Redetermination of Status**
The right of and process by which PacifiCare of Colorado may review the level of care to identify changes in a member's status and prognosis. This may result in a different determination of level of care and a different level of PacifiCare of Colorado's responsibility for covered benefits. Each such determination will supersede earlier determinations and PacifiCare of Colorado's obligation for coverage provided.

**Rehabilitative Care**
The restoration of an individual to normal or near-normal function following a disabling disease, injury, or addiction.

**Respite Care**
The provision of infrequent and temporary substitute care in a patient's home or licensed care facility for the purpose of relieving the patient's family or other caregiver for unforeseen emergencies and the daily demands of care for the patient.
**Service Area**
The geographic area encompassing Adams, Arapahoe, Boulder, Clear Creek, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Jefferson, Larimer, Lincoln, Logan, Morgan, Park, Teller, Washington and Weld Counties of the State of Colorado and such other area in which PacifiCare of Colorado is licensed and qualified to conduct the business of an HMO.

**Signature Sheet**
The Evidence of Coverage and Owner's Manual Signature Sheet that forms a part of this Agreement. A signed copy of the Signature Sheet is maintained in the subscribing group's files.

**Skilled Nursing Care**
Those home health care services that:
- Can only be provided by an RN or LPN
- Can produce the best possible and most timely outcome for a disease process and/or treatment regimen according to a professional assessment and plan
- Cannot be made available outside of the home because of the immediate home-bound nature of the member
- Can furnish reliable information to the participating physician and PacifiCare of Colorado's Medical Director sufficient for proper determination of the status of the member's condition and the level of care required for that condition

**Subacute Care Facility**
A facility which provides a pattern of health care in which a patient is treated for an ongoing condition as a result of an acute injury or illness. A subacute facility specializes in care which does not require acute hospitalization but is more intensive than can be provided in a skilled nursing facility.

**Subrogation**
The assumption by a third party of another's legal right to collect a debt or damages.

**Subscriber**
A person who meets applicable requirements of Chapter Two, Your Rights and Responsibilities, Section F., Eligibility, enrolls hereunder, and for whom the monthly premium has been received by PacifiCare of Colorado.

To be eligible to enroll as a subscriber, an individual must be an eligible employee of the subscribing group, and must reside in the PacifiCare of Colorado service area. For legally required exceptions to the provision, see Chapter Two, Your Rights and Responsibilities, Section B., Continuation of Coverage.

**Subscribing Group**
The contract holder who has elected coverage for a group of subscribers and their family dependents as described in this Agreement, and who has signed the applicable Signature Sheet.

**Urgently Needed Services**
Benefits covered under this Agreement that are required in order to prevent serious deterioration of a member's health that results from an unforeseen illness or injury if:
- The member is temporarily absent from PacifiCare of Colorado's service area
- The receipt of the health care service cannot be delayed until the member's return to the PacifiCare of Colorado service area
CHAPTER EIGHT

HOW TO GET HELP

Customer Service

You can contact PacifiCare of Colorado's Customer Service department for assistance concerning anything about PacifiCare of Colorado and your benefits. The following are examples of the subjects you might call about:

• You have changed your address.
• You cannot find a specific detail about your coverage in your Evidence of Coverage and Owner's Manual.
• You want to change your Primary Care Physician (PCP).
• You need an updated copy of the Provider Directory.

The Customer Service staff can usually answer your question while you are on the line. If not, they will get the answer you need and promptly return your call.

To Call

You may call Customer Service at 1-800-877-9777 Monday through Friday during the hours of 8 a.m. to 6 p.m. Call early to receive the most prompt service. Please have your membership number (usually the subscriber's Social Security number) from your ID card ready.

Spanish language assistance is available by calling Customer Service at 1-800-877-9777 Monday through Friday during the hours of 8 a.m. to 6 p.m. Call early to receive the most prompt service. Please have your membership number (usually the subscriber's Social Security number) from your ID card ready.

Se oferece asistencia en Espanol, si llama al Centro de Servicio 1-800-877-9777 Lunes a Viernes durante las horas de 8 a.m. a 6 p.m. Favor de llamar temprano para recibir servicio rapido. Se requiera que tenga su numero de identificacion de su tarjeta disponible para recibir servicio (numero igual a su numero de Seguro Social).

To Write

If you need to write to Customer Service please note your membership number (usually the subscriber's Social Security number) from your ID card on any correspondence. The following is the address for Customer Service:

PacifiCare of Colorado Customer Service
P. O. Box 6770
Englewood, CO 80155

VSP®

Toll Free (888) 426-4877

Mental Health/Substance Abuse Assistance

Please see the following page for instructions on how to access your mental health/substance abuse benefits.
GUIDE TO ACCESSING YOUR PACIFICARE OF COLORADO MENTAL HEALTH AND SUBSTANCE ABUSE BENEFITS

Important points to remember:

- All benefits must be referred by, and are available only through, the applicable mental health/substance abuse provider.
- A Primary Care Provider (PCP) referral is not required to obtain mental health or substance abuse services.
- Privileged information from medical records of members, including mental health and substance abuse records, and information about the physician-patient relationship will be confidential. PacifiCare of Colorado will not voluntarily disclose this information without prior written consent of the member except for use of the medical records necessary to administer this Agreement; use of the medical records for medical research and education; bona fide peer review during records review or utilization review programs established to promote quality medical care; provision of statistical utilization data to the subscribing group; use of the medical records for a bona fide medical emergency; and any other exceptions provided by law.

The provider responsible for mental health and substance abuse benefits will be determined by your PCP’s affiliation. To determine your PCP’s affiliation, please check your ID card, contact your PCP, or call Customer Service at 1-800-877-9777. Once you have determined your PCP’s Integrated Care Team affiliation, use this chart to determine whom to call in order to access your PacifiCare of Colorado mental health and/or substance abuse benefits:

<table>
<thead>
<tr>
<th>If your PCP is affiliated with:</th>
<th>Your mental health/substance abuse benefits provider is:</th>
<th>Phone number:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colorado Pediatric Partners</td>
<td>Physician Health Partners Mental Health</td>
<td>Toll free: (877) 700-5300</td>
</tr>
<tr>
<td>Primary Physician Partners (PPP) physician group</td>
<td>Pro Behavioral Health</td>
<td>Toll free: (800) 944-6527</td>
</tr>
<tr>
<td>MedWest Medical Group (PRC) physician group</td>
<td>Pro Behavioral Health</td>
<td>Toll free: (800) 944-6527</td>
</tr>
<tr>
<td>All other physician groups</td>
<td>PacifiCare Behavioral Health</td>
<td>Toll free: (888) 777-2735</td>
</tr>
</tbody>
</table>

If you have any questions about how to access mental health or substance abuse benefits, or any other element of your plan, please call Customer Service at 1-800-877-9777.