

PLAN 4

2004 INDIVIDUAL PLAN HMO SUMMARY OF BENEFITS

Plan Highlights

Benefit Description	Member Responsibility
Outpatient Provider Care PacifiCare Contracted PCP <i>(including OB/GYN)</i> PacifiCare Contracted Specialist	\$20 PCP Copayment per outpatient visit with a PacifiCare Contracted Provider \$40 SPC Copayment per outpatient visit with a PacifiCare Contracted Provider
Inpatient Hospitalization	\$350 Copayment per inpatient day per inpatient admit up to three (3) days in a PacifiCare Contracted Hospital Normal prenatal, delivery and postpartum maternity care are covered if the delivery occurs after the Member has been enrolled for twelve (12) consecutive calendar months
Outpatient Surgery	\$300 Copayment per outpatient visit in a PacifiCare contracted facility
Emergency Care	\$125 ER Copayment per outpatient emergency room visit, not waived if admitted Inpatient hospitalization benefits apply if admitted.
Urgent Care	\$35 Copayment per outpatient visit with a PacifiCare contracted Urgent Care facility
Annual Copayment Maximum Individual Family	\$4,000 per Benefit Plan Year \$12,000 per Benefit Plan Year All Copayment and/or Coinsurance amounts, excluding prescription drug Copayments apply to the Annual Copayment Maximum amount
Lifetime Benefit Maximum Individual	Unlimited per lifetime

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<p>Alcohol, Drug or Other Substance Abuse Detoxification Detoxification is the medical treatment of withdrawal from alcohol, drug or other substance addiction. In most cases of alcohol, drug or other substance abuse or toxicity, outpatient treatment is appropriate unless another medical condition requires close inpatient monitoring. Detoxification is initially covered up to forty-eight (48) hours and extended when Medically Necessary.</p> <p>Inpatient treatment in an acute care setting when admitted to a contracted facility is covered for the acute stage of alcohol, drug or other substance abuse withdrawal when medical complications occur or are highly probable.</p> <p>Methadone treatment for detoxification is not covered.</p> <p>Rehabilitation for substance abuse or addiction is not covered.</p> <p>Outpatient counseling for Members, group or covered family.</p>	<p>\$350 Copayment per inpatient day per inpatient admit up to three (3) days in a PacifiCare Contracted Hospital</p> <p>\$40 SPC Copayment per outpatient visit with a PacifiCare Contracted Provider</p>
<p>Allergy Testing</p>	<p>\$20 PCP or \$40 SPC Copayment per outpatient visit with a PacifiCare Contracted Provider</p>
<p>Allergy Treatment Allergens and serum are covered according to an established treatment plan.</p>	<p>Covered 100%</p>
<p>Ambulance</p>	<p>Covered 100%</p>
<p>Blood and Blood Products Blood and blood derivatives, which include blood products, blood factor replacements and synthetic blood product when ordered by a PacifiCare Contracted Provider.</p> <p>Self-donated blood</p> <p>Direct-donated blood</p>	<p>Included in inpatient hospitalization costs</p> <p>Included in outpatient surgery costs</p> <p>All costs for the transportation and processing of direct-donated blood over \$120 per unit are the Member's responsibility</p>
<p>Cancer Clinical Trials Limited to costs that are directly associated with a cancer clinical trial that is offered in Arizona and in which the Member voluntarily participates are covered.</p> <p>Includes coverage for any medical services necessary to administer the drug to the Member.</p> <p>It must be shown that there is no clearly superior, non-investigational treatment alternative and the available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as efficacious as any non-investigational alternative.</p>	<p>Copayment matches place of service (i.e., PCP, SPC, outpatient facility, inpatient hospitalization)</p>

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<p>Cancer Clinical Trials (continued)</p> <p>The treatment must be part of a scientific study of a new therapy or intervention that is being conducted at an institution in Arizona and is for the treatment, palliation or prevention of cancer in humans.</p> <p>The scientific study must include all of the following: specific goals, a rationale and background for the study, criteria for patient selection, specific directions for administering the therapy and monitoring patients, a definition of quantitative measures for determining treatment response, methods for documenting and treating adverse reactions.</p> <p>The treatment must be provided as part of a study being conducted in a phase I, phase II, phase III or phase IV cancer clinical trial and provided as part of a study being conducted in accordance with a clinical trial approved by at least one of the following: one of the National Institutes of Health, a National Institutes of Health cooperative group or center, the U.S. FDA in the form of an investigational new drug application, the U.S. Department of Defense, the U.S. Department of Veterans Affairs, a qualified research entity that meets the criteria established by the National Institutes of Health for grant eligibility, or a panel of qualified recognized experts in clinical research within academic health institutions in this State.</p> <p>The proposed treatment or study must have been reviewed and approved by an institutional review board of an institution in Arizona.</p> <p>The personnel providing the treatment or conducting the study must provide the treatment or conduct the study within their scope of practice, experience and training and must be capable of providing the treatment and agree to accept reimbursement as payment in full from the accountable Health Plan at the rates that are established by the plan and that are not more than the level of reimbursement applicable to other similar services provided by health care Providers with the plan's Provider network.</p> <p>No party is liable for damages associated with the treatment provided during any phase of a cancer clinical trial.</p> <p>Coverage shall not substitute any portion of the clinical trial that is customarily paid for by government, biotechnical, pharmaceutical or medical device industry sources.</p>	
<p>Chiropractic Care</p> <p>Limited to twelve (12) self-referred Medically Necessary chiropractic visits per Benefit Plan Year for nonsurgical and noninvasive treatment of neck and back pain through physiotherapy, musculoskeletal manipulation and other physical correction of musculoskeletal conditions within the scope of chiropractic devices.</p>	<p>\$10 Copayment per outpatient visit with a with a PacifiCare Contracted Provider</p>
<p>Diabetic Footwear</p> <p>Therapeutic shoes for Members who suffer from diabetic foot disease.</p>	<p>Covered 100%</p>

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<p>Diabetic Management, Treatment and Self-Management Items These services must be provided under the direction of and prescribed by a PacifiCare Contracted Provider</p> <p>Coverage includes outpatient self-management training, education and medical nutrition therapy services. Appropriately licensed or registered health care professionals will provide the diabetes outpatient self-management training, education and medical nutrition therapy services covered under this benefit. These services must be provided under the direction of and prescribed by a PacifiCare Contracted Provider.</p>	<p>\$20 PCP or \$40 SPC Copayment (depending on type of Provider visited) per outpatient visit with a PacifiCare Contracted Provider</p>
<p>Equipment and supplies for the management and treatment of Type 1, Type 2 and gestational diabetes are covered, based upon the medical needs of the Member, including, but not necessarily limited to: intermittent blood glucose monitors, blood-testing strips and lancets (covered under the Member's DME benefit), modified blood glucose monitors and supplies for the visually impaired (covered under the Member's DME benefit) such as voice synthesizers, automatic timers, and specially designed supplies to promote self-management.</p> <p>Members must have coverage under the Outpatient Prescription Drug Benefit for insulin, glucagon and other diabetic medications to be covered.</p> <p>Qualifications for coverage of insulin pumps and refills are based on PacifiCare guidelines and Medical Necessity. They require Preauthorization by the Contracted Medical Group or PacifiCare.</p> <p>Visual aids are covered for Members who have a visual impairment that would prohibit the proper dosing of insulin. Visual aids do not include eyeglasses (frames and lenses) or contact lenses. The Member's PacifiCare Contracted Provider will prescribe insulin syringes, lancets, glucose test strips and ketone urine test strips to be filled at a pharmacy that contracts with PacifiCare.</p>	<p>Covered 100%</p>
<p>Dialysis</p>	<p>\$20 PCP Copayment per outpatient visit with a PacifiCare Contracted Provider</p>
<p>Durable Medical Equipment (Rental, Purchase or Repair) Standard DME Medically Necessary equipment such as glucose monitoring devices, apnea monitoring devices, transneuromuscular stimulators (TENS) devices, wheelchairs, manually operated hospital beds and oxygen</p>	<p>Covered 100%</p>
<p>Specialty/Custom, including, but not limited to, specialty beds and specialty mattresses, custom wheelchairs and electric wheelchairs, passive-motion exercise devices (CPM machines)</p>	<p>\$50 Copayment per item</p>
<p>Prosthetic devices (including, but not limited to, arms, legs and eyes)</p>	<p>50% Coinsurance</p>
<p>Corrective appliances</p>	<p>Covered 100%</p>
<p>At least two postoperative, externally worn breast prostheses and surgical bras, including replacement</p>	<p>Covered 100%</p>
<p>Emergency Medical Services Worldwide coverage</p>	<p>\$125 ER Copayment per outpatient emergency room visit, not waived if admitted</p> <p>Inpatient hospitalization benefits apply if admitted</p>

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Family Planning Contraceptives counseling Examination, insertion and removal of contraceptive devices (IUDs) Contraceptive implants Injectable contraceptive devices	\$20 PCP Copayment (depending on type of Provider visited) per outpatient visit with a PacifiCare Contracted Provider
Vasectomy Tubal ligation Abortions for life-threatening pregnancies to the mother	Copayment matches place of service
Hearing Services Routine testing once per benefit year	\$20 PCP or \$40 SPC Copayment per outpatient visit with a PacifiCare Contracted Provider
Home Health Care	\$40 Copayment per day
Hospice Services Covered for Members with terminal illness and prognosis of life of twelve (12) months or less	Covered 100% in a PacifiCare contracted facility
Hospitalization Benefits/Acute Care (Inpatient Care) Hospitalization Room and board (<i>semi-private</i>) Lab, X-ray and other tests Drugs, medicines, anesthetics PacifiCare Contracted Provider, Specialist and Surgeon care Bloodless surgery (when available in Member's Contracted Medical Group)	\$350 Copayment per inpatient day per inpatient admit up to three (3) days in a PacifiCare Contracted Hospital
Infusion Therapy Includes, but is not limited to, chemotherapy Home infusion therapy	\$40 SPC Copayment per outpatient visit with a PacifiCare Contracted Provider
Injectable and Self-Injectable Medications Covered when administered in the PacifiCare Contracted Provider's office (except insulin); self-injectable medications are covered (except insulin) when the Member is being trained in the use of the medication. Pen devices for the delivery of medication, other than for insulin, are not covered.	\$20 PCP or \$40 SPC Copayment (depending on type of Provider visited) per outpatient visit with a PacifiCare Contracted Provider
Laboratory Services	Covered 100%
Mastectomy Includes coverage for surgical services for a mastectomy and coverage incidental to the Member's covered mastectomy for surgical services for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; treatment of physical complications for all stages of the mastectomy, including lymphedemas; and at least two external postoperative prostheses. Member's Copayment and/or Coinsurance responsibility matches the place of service (i.e., inpatient hospitalization, outpatient surgical center, Provider's office, Durable Medical Equipment, etc.)	\$350 Copayment per inpatient day per inpatient admit up to three (3) days in a PacifiCare Contracted Hospital \$300 Copayment per outpatient visit in a PacifiCare contracted facility

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<p>Maternity Care, Tests and Procedures (includes Newborn Care) Inpatient Care Normal prenatal, delivery and postpartum maternity care are covered if the delivery occurs after the Member has been enrolled for twelve (12) consecutive calendar months.</p> <p>Complications of pregnancy are covered, regardless of the delivery date or the length of time the Member has been enrolled. Complications of Pregnancy means those conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy, but are adversely affected by the pregnancy or are caused by pregnancy, such as:</p> <ul style="list-style-type: none"> ▪ acute nephritis ▪ nephrosis ▪ cardiac decompensation ▪ missed abortion ▪ and similar medical and surgical conditions of comparable severity <p>Complications of Pregnancy also means nonelective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible, eclampsia (toxemia) and latent diabetes. Complications of Pregnancy shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically (that branch of medicine that deals with the classification of diseases) distinct complication of pregnancy.</p> <p>For items not listed above, for distinguishing between complications of pregnancy and conditions associated with the management of a difficult pregnancy; PacifiCare will accept a certification from the treating Physician that the condition is a complication of pregnancy not the management of a difficult pregnancy unless determined otherwise by an independent external obstetrical review.</p> <p>Inpatient benefit includes normal delivery, delivery by cesarean section, miscarriage, involuntary abortion and any complications of pregnancy or childbirth.</p> <p>Newborns are covered and the coverage is automatic for the first thirty-one (31) days of life. However, Health Plan Premiums are due for that period if the Child is enrolled within those thirty-one (31) days. If the newborn constitutes the first or second Dependent, the newborn needs to be enrolled and Premiums paid in order for coverage to continue past those first thirty-one (31) days. Coverage will cease at the end of those thirty-one (31) days if the newborn has not been enrolled. If the newborn constitutes the third Dependent, no Premium will be due. However, to ensure proper enrollment of the newborn, submission of proper notification of birth is recommended within those thirty-one (31) days. Failure to submit the necessary documentation within the time frame requested may result in nonpayment of the newborn coverage after the first thirty-one (31) days.</p> <p>Newborns remain enrolled with mother's PCP from birth until discharged from the Hospital. A newborn may be enrolled with a different PCP following the newborn's discharge. If a PCP is not chosen, the newborn will remain with the mother's PCP.</p>	<p>\$350 Copayment per inpatient day per inpatient admit up to three (3) days in a PacifiCare Contracted Hospital</p> <p>Normal prenatal, delivery and postpartum maternity care are covered if the delivery occurs after the Member has been enrolled for twelve (12) consecutive calendar months</p>
<p>Maternity Care, Tests and Procedures (includes Newborn Care) Outpatient Care Normal prenatal, delivery and postpartum maternity care are covered if the delivery occurs after the Member has been enrolled for twelve (12) consecutive calendar months.</p> <p>Complications of pregnancy are covered, regardless of the delivery date or the length of time the Member has been enrolled. Complications of Pregnancy means those conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy, but are adversely affected by the pregnancy or are caused by pregnancy, such as:</p>	<p>\$20 PCP Copayment per outpatient visit with a PacifiCare Contracted Provider</p> <p>Normal prenatal, delivery and postpartum maternity care are covered if the delivery occurs after the Member has been enrolled for twelve (12) consecutive calendar months</p>

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<p>Maternity Care, Tests and Procedures (includes Newborn Care) Outpatient Care (continued)</p> <ul style="list-style-type: none"> ▪ acute nephritis ▪ nephrosis ▪ cardiac decompensation ▪ missed abortion ▪ and similar medical and surgical conditions of comparable severity <p>Complications of Pregnancy also means nonelective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible, eclampsia (toxemia) and latent diabetes. Complications of Pregnancy shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically (that branch of medicine that deals with the classification of diseases) distinct complication of pregnancy.</p> <p>For items not listed above, for distinguishing between complications of pregnancy and conditions associated with the management of a difficult pregnancy; PacifiCare will accept a certification from the treating Physician that the condition is a complication of pregnancy not the management of a difficult pregnancy unless determined otherwise by an independent external obstetrical review.</p> <p>Outpatient PacifiCare Contracted Provider visits, laboratory services and radiology services are covered for prenatal and postpartum maternity care.</p> <p>Nurse midwife services are covered when available within and authorized by the Member's Contracted Medical Group.</p>	
<p>Mental Health Services Inpatient coverage limited to seven (7) inpatient days per benefit year. No Referral necessary.</p>	<p>\$350 Copayment per inpatient day per inpatient admit up to three (3) days in a PacifiCare Contracted Hospital</p>
<p>Outpatient limited to 20 outpatient visits per benefit year. No Referral necessary.</p>	<p>\$40 SPC Copayment per outpatient visit with a PacifiCare Contracted Provider</p>
<p>Non-Surgical Diagnostic Testing</p>	<p>\$20 Copayment per outpatient visit with a PacifiCare Contracted Provider</p>
<p>Oral Surgery and Dental Services Emergency Services for stabilizing an acute injury to sound natural teeth, the jawbone or the surrounding structures are covered. Coverage is limited to treatment provided within forty-eight (48) hours of injury.</p>	<p>Copayment matches place of service (i.e. PCP, SPC, outpatient facility, Urgent Care facility, emergency room)</p>
<p>Organ Procurement, Transplant, Bone Marrow and Stem Cell Transplants and Transplant Services Human organ and tissue transplants are limited to non-Experimental procedures that are determined to be Medically Necessary. Coverage is provided for the medical, surgical and Hospital Services required for pretransplant, transplant and post-transplant. All transplant procedures must be performed by a PacifiCare-approved transplant Facility. Examples of covered Transplant Services include:</p> <ul style="list-style-type: none"> Heart transplants; Lung transplants; Heart/lung transplants; Kidney transplants; Simultaneous pancreas/kidney transplants; Pancreas transplant after kidney transplant; 	<p>\$350 Copayment per inpatient day per inpatient admit up to three (3) days in a PacifiCare Contracted Hospital</p> <p>\$300 Copayment per outpatient surgical visit in a PacifiCare contracted facility</p>

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<p>Organ Procurement, Transplant, Bone Marrow and Stem Cell Transplants and Transplant Services (continued)</p> <p>Cornea transplants; Allogenic bone marrow transplants; Autologous bone marrow transplants.</p> <p>Costs of computerized national and international searches for bone marrow donors conducted through a registry are covered when Member is the intended recipient up to maximum of \$10,000 or 50 potential donors, whichever occurs first, per lifetime. Computerized searches must be conducted by a PacifiCare center of excellence. These limitations apply to searches only. There is no dollar limitation for Transplant Services once a donor is identified.</p> <p>PacifiCare shall review developments in medical technology from time to time based on scientific evidence and determine whether the list of covered transplants should be revised.</p> <p>Benefit limited to \$1,000,000 per lifetime. Retransplantation limited to fifty (50) percent. Transportation, lodging and meals limited to \$10,000 per lifetime. Lodging and meals limited to \$200 per day.</p>	
<p>Outpatient Surgery Covered Services include lab, X-ray and other tests, drugs, medicines, anesthetics, PacifiCare Contracted Provider, Specialist and Surgeon care.</p>	<p>\$300 Copayment per outpatient visit in a PacifiCare contracted facility</p>
<p>Phenylketonuria (PKU) Testing and Treatment Testing for Phenylketonuria (PKU) is covered to prevent the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU enzyme deficiency.</p>	<p>Included with “Inpatient Maternity Care, Tests and Procedures” costs</p> <p>\$0 Copayment per outpatient visit with a PacifiCare contracted facility</p>
<p>FDA-approved special low-protein formulas and food products that are specially formulated to have less than one gram of protein per serving specifically approved for PKU, galactosemia, homocystinuria and maple syrup disease are covered.</p> <p>Food products naturally low in protein are not covered.</p> <p>The maximum annual benefit for medical foods is limited to \$5,000 per benefit year and applies to the cost of all prescribed modified low protein foods and metabolic formula.</p>	<p>Covered 50% Coinsurance deducted from reimbursement after submission of receipts to PacifiCare for reimbursement for the cost of medical foods prescribed</p>
<p>Physical Exams (Periodic Health Evaluations) One physical exam per year (with exams every four months for Children under age two) or as Medically Necessary, including a screening for vision and hearing.</p> <p>Includes coverage for mammograms, hearing, prostate, Well-Baby and Well-Woman Care, which includes routine Pap smears, breast and pelvic exams.</p> <p>A medical history and health examination is covered for each new enrollee within one year of enrollment.</p>	<p>\$20 PCP Copayment per outpatient visit with a PacifiCare Contracted Provider</p>
<p>Provider Care PacifiCare Contracted PCP (includes OB/GYN)</p>	<p>\$20 PCP Copayment per outpatient visit with a PacifiCare Contracted Provider</p>
<p>PacifiCare Contracted Specialist</p> <p>Includes coverage for immunizations, flu, pneumonia and Hepatitis B</p>	<p>\$40 SPC Copayment per outpatient visit with a PacifiCare Contracted Provider</p>

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<p>Radiation Therapy Standard – photon beam radiation therapy</p> <p>Complex – Includes, but is not limited to, brachytherapy (radioactive implants) and conformal photon beam radiation. For a complete listing, please call Customer Service.</p>	<p>\$40 SPC Copayment per outpatient visit with a PacifiCare Contracted Provider facility</p>
<p>Radiology Services Standard X-ray and other tests</p>	<p>\$20 Copayment per outpatient visit with a PacifiCare Contracted Provider facility</p>
<p>Specialized scanning and imaging treatments (<i>includes, CT, SPECT, PET, IMRT, MRAs and MRI</i>). For a complete listing, please call Customer Service.</p>	<p>\$150 Copayment per outpatient visit with a PacifiCare contracted facility</p>
<p>Reconstructive Surgery To correct abnormal structures of the body to improve function</p>	<p>\$350 Copayment per inpatient day per inpatient admit up to three (3) days in a PacifiCare Contracted Hospital</p> <p>\$300 Copayment per outpatient visit in a PacifiCare contracted facility</p>
<p>Rehabilitation Care – Physical, Occupational and Speech Therapy Acute inpatient rehabilitation limited to 40 inpatient days per benefit plan year Acute inpatient rehabilitation services include, but are not limited to, physical, occupational, and speech therapy and consist of the combined and coordinated use of medical, social, educational and vocational measures for training or retraining individuals disabled by disease or injury that must be provided in an inpatient facility.</p>	<p>\$350 Copayment per inpatient day per inpatient admit up to three (3) days in a PacifiCare Contracted Hospital</p>
<p>Outpatient rehabilitation limited to 40 outpatient visits per benefit plan year</p>	<p>\$40 SPC Copayment per outpatient visit with a PacifiCare Contracted Provider</p>
<p>Cardiac rehabilitation Medically Necessary inpatient and/or outpatient cardiac rehabilitation services allow for unlimited inpatient days and/or outpatient visits</p>	<p>\$20 PCP Copayment per outpatient visit with a PacifiCare Contracted Provider</p>
<p>Skilled Nursing Facility (Transitional Care) Limited to 30 inpatient days per Benefit Plan Year</p>	<p>\$350 Copayment per inpatient day per inpatient admit up to three (3) days in a PacifiCare Contracted Hospital</p>
<p>Temporomandibular Joint (TMJ) Limited to treatment which is Medically Necessary Coverage excludes those methods of treatment which are recognized as dental procedures, including, but not limited to, the extraction of teeth and the application of orthodontic devices and splints. TMJ of dental origin is not covered.</p>	<p>20% Coinsurance of the Usual and Customary Charges for such treatment Treatment for TMJ is limited to \$1,000 maximum benefit per Member per lifetime</p>

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Urgent Care	\$35 Copayment per visit with a PacifiCare contracted Urgent Care facility or out-of-area Non-Contracted Provider facility
Vision Care Routine refraction testing once per Benefit Plan Year	\$40 SPC Copayment per outpatient visit with a PacifiCare Contracted Provider

Exclusions and Limitations

Unless described as a Covered Service, all services and benefits described below are excluded from coverage or limited under this Health Plan. NOTE: Additional benefit exclusions and limitations may be listed within the preceding *Summary of Benefits* and in your *HMO Individual Plan Agreement* and *Evidence of Coverage* document.

- Services that are rendered without Preauthorization from the Member's Contracted Medical Group or PacifiCare except for Emergency Services or Urgently Needed Services described in this *Combined Evidence of Coverage and Disclosure Form* and for obstetrical and gynecological Provider services obtained directly from a PacifiCare Contracted OB/GYN, family practice Provider.
- Services obtained from Non-Contracted Providers or Contracted Providers who are not affiliated with the Member's Contracted Medical Group, when such services were offered or Preauthorized by the Member's Contracted Medical Group and the Member refused to obtain the services as offered by the Member's Contracted Medical Group, are not covered.
- Services rendered prior to the Member's effective date of enrollment or after the effective date of disenrollment are not covered.
- PacifiCare does not cover the cost of services that result from a treatment plan for a Non-Covered Service and that are the sole, direct and predictable consequence of a Non-Covered Service (as recognized by the organized medical community in the state of Arizona). However, PacifiCare will cover Medically Necessary services required to treat an illness or injury that may be a consequence of Non-Covered Services but are not predictable in advance, such as unexpected, life-threatening complications of cosmetic surgery.
- Treatment of an injury or condition sustained in the commission of an illegal act by the Member is not covered. Treatment of an injury or condition resulting from an intentional act committed by the Member is not covered.
- Routine or foreseeable care provided outside the Geographic Service Area is not covered.
- Services performed by immediate relatives or members of your household are not covered.
- All services and items incident to the improvement of the function of a malformed portion of the body or system, unless determined by PacifiCare Medical Director or their designee to be Medically Necessary, consistent with professionally accepted standard or practice, is not covered.
- Abortion/Termination of Pregnancy – Not covered unless the mother's life or health is at risk.
- Acupuncture/Acupressure – Not covered.
- Allergy Testing and Injections – Provocative and neutralizing testing (subcutaneous) for food allergies and sublingual provocative testing is not covered.
- Ambulance Transportation – Non-emergency ambulance or medical transportation services are not covered. Air ambulance services when ground ambulance transportation time poses no medical threat or when the point of pick-up by land vehicle is accessible is not covered.
- Bariatric Surgery – Gastric stapling, gastroplasty, gastric banding and other similar restrictive gastrointestinal surgery, and/or reversals of such surgeries, regardless of the purpose, including the purpose of weight loss and/or weight management, are not covered.
- Behavioral Health – Services that are not Medically Necessary for the treatment of Mental Health disorders or chemical dependency disorders are not covered. Confinement, treatment, services or supplies that are not authorized by PacifiCare Behavioral Health Services Provider (except in the case of an emergency) are not covered. Treatment of eating disorders is not covered.
- Behavioral Health (Outpatient) – The following services are not covered: meals and transportation; activity therapies; group activities or other services and programs which are solely recreational or diversional activities.
- Biofeedback – Not covered except for urinary incontinence.

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- Birth Control – Over-the-counter supplies and devices are not covered.
 - Blood and Blood Products – A platelet-derived wound-healing formula used in the repair of chronic, non-healing, cutaneous ulcers or wounds is not covered. Blood that is stored, but not used when the Member cancels or reschedules and elective surgery, or blood charges associated with nonauthorized or non-covered procedures, or direct donor, or synthetic clotting factors when natural factors are available are not covered.
 - Chemotherapy – Alternative medicines are not covered.
 - Cosmetic Surgery – Not covered unless following a mastectomy in order to maintain symmetry or for breast reconstruction following a mastectomy or lumpectomy.
 - Custodial Care – Routine Custodial Care, home caregiver, respite care and convalescent care are not covered.
 - Durable Medical Equipment – Disposable supplies such as bandages, elastic stockings, bathtub lifts, breast pumps and grab bars are not covered. Lightweight, portable oxygen devices and lightweight oxygen-conserving devices, including supplies, are not covered.
 - Experimental and Investigational Therapy – Experimental and Investigational procedures are those not generally or customarily provided because the medical safety and efficacy has not been demonstrated are not covered.
 - Family Planning/Infertility – Second-generation fertility drugs such as Pergonal and injectable Infertility drugs are not covered. In vitro fertilization, gamete and zygote intrafallopian transfers, and other fertility procedures and services related to such procedures are not covered. Infertility diagnosis, including evaluation and diagnostic operative procedures are not covered. Artificial insemination is not covered. Reversal of sterilization is not covered. Infertility medical expenses of surrogate mothers that are not PacifiCare Members are not covered. Injectable medications are not covered. Genetic counseling or testing not associated with an intrauterine pregnancy (or breast cancer genetic testing) is not covered. Human Growth Hormone for Infertility is not covered.
 - Hearing – Hearing aids, examination for hearing aids, audiometric testing to determine the need for a hearing aid or audiology services (other than for acuity) are not covered.
 - Home Health Care – Custodial Care, domiciliary care, home caregiver, respite care and/or private nursing duty are not covered. Homemaker services unrelated to Member care, home meal delivery services or transportation services (e.g., “Dial-A-Ride”) are not covered.
 - Hospice Services – Hospice Services for Members who do not meet the definition of “terminally ill” are not covered. Services that are not reasonable and necessary for the management of a terminal illness and include care provided in non-certified Hospice programs are not covered.
 - Inpatient Hospital Admissions and Services – Experimental and Investigational therapies are not covered.
 - Laboratory Services (Diagnostic) – Paternity testing, premarital blood testing, alcohol-level blood testing, FAA testing requirements, employer required pre- and post-employment drug testing, and testing for school admissions are not covered.
 - Massage Therapy – Not covered.
 - Maternity Care – Normal prenatal, delivery and postpartum maternity care are covered if the delivery occurs after the Member has been enrolled for twelve (12) consecutive calendar months. Complications of pregnancy are covered, regardless of the delivery date or the length of time the Member has been enrolled. Complications of Pregnancy means those conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy, but are adversely affected by the pregnancy or are caused by pregnancy, such as: acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of Pregnancy also means nonelective cesarean section, ectopic pregnancy, which is terminated, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible, eclampsia (toxemia) and latent diabetes. Complications of Pregnancy shall not include false labor, occasional spotting, Physician-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically (that branch of medicine that deals with the classification of diseases) distinct complication of pregnancy.
- For items not listed above, for distinguishing between complications of pregnancy and conditions associated with the management of a difficult pregnancy; PacifiCare will accept a certification from the treating Physician that the condition is a complication of pregnancy not the management of a difficult pregnancy unless determined otherwise by an independent external obstetrical review. Medical and Hospital costs resulting from a normal full-term delivery in a Hospital outside of the Member’s chosen PacifiCare Contracted Network are not covered.
- Miscellaneous – All services and items and services not provided or arranged for by a PacifiCare Contracted Medical Provider, with the exception of Emergency Services and Out-of-Area Urgently Needed Services, are not covered. Treatment of any injury or conditioned

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sustained in the intentional commission of an illegal act, services, supplies and treatment related to sex transformations are not covered.

- Obesity – Treatment for obesity is not covered unless Medically Necessary.
- Office Visits – Services that are oriented toward treating a social, developmental or learning problem as opposed to a medical problem are not covered.
- Oral Surgery and Dental Services – Treatment methods which are considered dental procedures, such as extraction of teeth, treatment of malocclusion or any abnormality resulting from malocclusion, are not covered. TMJ of dental origin is not covered.
- Orthognathic Surgery – Not covered.
- Orthopedic Shoes – Orthopedic shoes or other supportive devices for the feet or for subluxations of the foot are not covered.
- Outpatient Surgery and Procedures – Non-Medically Necessary and/or nonauthorized outpatient surgery and/or procedures are not covered.
- Pain Rehabilitation – Pain management programs are not covered.
- Physicals/Health Assessments – Routine physical examination for insurance qualification, school attendance and employment are not covered.
- Podiatry – Removal or reduction of corns and calluses, clipping of toenails, flat feet, fallen arches and chronic foot strain (except when Medically Necessary for diabetic or neurological involvement or peripheral vascular disease involving the feet) are not covered.
- Prescription Drugs – New procedures, services, supplies, and medications until they are reviewed for safety, efficacy and cost-effectiveness and approved by PacifiCare are not covered.
- Pulmonary Rehabilitation – Not covered.
- Rehabilitative Therapy – Learning disabilities, maintenance therapy, pain management programs, or exercises that are intended only to promote overall fitness are not covered.
- Skilled Nursing Facility Care – Custodial Care, respite care and private-duty nursing/attendant are not covered.
- Specialist/Consultant – Most services provided by a Specialist/Consultant without a Referral and/or prior authorization are not covered.
- Substance Abuse – Inpatient, outpatient or day treatment rehabilitation for chronic alcoholism, drug addiction or other substance abuse is not covered. Methadone treatment for detoxification is not covered.
- Temporomandibular Joint Dysfunction (TMJ) – TMJ of dental origin is not covered and limited to separate lifetime maximum.
- Transplants (Organ Procurement and Transplant Services) – Organ or tissue transplants considered experimental as determined by PacifiCare and in accordance with scientific-based evidence are not covered. Artificial organs, such as hearts, are not covered. Cardiac ventricular assist devices (unless used as a bridge to heart transplant or for cardiac stabilization immediately after open heart surgery) are not covered.
- Vision Care and Services – Corrective lenses and frames, contact lenses (except post-cataract extraction), low vision aids and contact lens fitting and measurements are not covered. Radial keratotomy or other surgical treatments for refractive errors are not covered.
- X-ray and Diagnostic and Therapeutic – Experimental, Investigational or unproved radiological tests or treatments are not covered. Thermography is not covered.

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