

**Appendix A
Colorado Health Plan Description Form**

PacifiCare Life Assurance Company
Name of Carrier

Individual PPO Plan 764 35/80-50/1,000
Name of Plan

PART A: TYPE OF COVERAGE

1. TYPE OF PLAN	Preferred Provider plan
2. OUT-OF-NETWORK CARE COVERAGE? ¹	Yes, but patient pays more for out-of-network care.
3. AREAS OF COLORADO WHERE PLAN IS AVAILABLE	Plan is available throughout Colorado.

PART B: SUMMARY OF BENEFITS

Important Note: This form is not a contract, it is only a summary. The contents of this form are subject to the provisions of the Policy, which contains all terms, covenants and conditions of coverage. Your plan may exclude coverage for certain treatments, diagnoses or services not noted below. The benefits shown in this summary may only be available if required plan procedures are followed (e.g., plans may require prior authorization, a referral from your primary care physician, or use of specified Providers or Facilities). Consult the actual Policy to determine the exact terms and conditions of coverage.

	IN-NETWORK	OUT-OF-NETWORK
4. ANNUAL DEDUCTIBLE	Deductible applies unless otherwise noted, in and out-of-network combined.	Deductible applies unless otherwise noted, in and out-of-network combined.
a) Individual	\$1,000	\$1,000
b) Family	\$3,000	\$3,000
5. OUT-OF-POCKET ANNUAL MAXIMUM ²	The out-of-pocket maximum excludes Deductible and Copayments.	The out-of-pocket maximum excludes Deductible and Copayments.
a) Individual	\$2,000	\$4,000
b) Family	\$4,000	\$8,000
6. LIFETIME OR BENEFIT MAXIMUM PAID BY THE PLAN FOR ALL CARE	\$2,000,000 maximum applies to in and out-of-network combined.	\$2,000,000 maximum applies to in and out-of-network combined.
7A. COVERED PROVIDERS	6,367 Physicians and 64 Hospitals in Colorado as of 1/1/02. See <i>Provider Directory</i> for complete list.	All Providers licensed or certified to provide covered benefits.
7B. With respect to network plans, are all the Providers listed in 7A accessible to me through my primary care physician?	Yes	Not applicable
8. ROUTINE MEDICAL OFFICE VISITS	100% after \$35 Copayment (Participating Outpatient lab and X-ray services in conjunction with a routine medical office visit covered at 80% after Deductible except as noted below.*)	50% of Usual and Customary after Deductible
9. PREVENTIVE CARE	From birth through 12 years: 100% after \$35 Copayment (Participating Outpatient lab and X-ray services in conjunction with a Preventive Care office visit covered at 80% after Deductible except as noted below.*) Age 13 through 18 years: 100% after \$35 Copayment (Participating Outpatient lab and X-ray services in conjunction with a Preventive Care office visit covered at 80% after Deductible except as noted below.*)	From birth through 12 years: 50% of Usual and Customary; Deductible waived for well-baby/well-child care. Age 13 through 18 years: 50% of Usual and Customary. Deductible waived for office visit. Associated lab and X-ray in conjunction with a Preventive Care office visit covered at 50% after Deductible.

* Copayment-based services do not apply to Neuromuscular Skeletal Disorders, Outpatient rehabilitation services other than a routine medical office visit, Chemical Dependency services, Mental Illness services, diagnostic services, including, but not limited to, MRI, PET, CAT scans, ultrasounds, nuclear medicine studies, EKG, ECG, EMG or EEG services and surgery performed in the medical office.

	IN-NETWORK	OUT-OF-NETWORK
9. PREVENTIVE CARE b) Adults' services	Age 19 and over: 100% after \$35 Copayment (Participating Outpatient lab and X-ray services in conjunction with a wellness visit covered at 80% after Deductible, except as noted below.)*\$300 maximum per Calendar Year, in and out-of-network combined.	Age 19 and over: 50% of Usual and Customary. Deductible waived for office visit. Associated lab and X-ray in conjunction with a wellness visit covered at 50% after Deductible. \$300 maximum per Calendar Year, in and out-of-network combined.
10. MATERNITY a) Prenatal care b) Delivery & Inpatient well-baby care	Not covered Delivery not covered. Well-baby care covered at 80% after Deductible.	Not covered Delivery not covered. Well-baby care covered at 50% after Deductible.
11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions	See benefit schedule attached	
12. INPATIENT HOSPITAL	80% after Deductible; additional \$250 Deductible when not Preauthorized.	50% after Deductible; additional \$500 Deductible when not Preauthorized. Up to \$500 maximum benefit per day. Covered Expenses for these services do not apply to the Coinsurance Maximum.
13. OUTPATIENT/AMBULATORY SURGERY	80% after Deductible; additional \$250 Deductible when not Preauthorized.	50% after Deductible; additional \$500 Deductible when not Preauthorized.
14. LABORATORY & X-RAY	80% after Deductible	50% after Deductible
15. EMERGENCY CARE³	\$75 Copayment per occurrence (waived if admitted) then 80% after Deductible.	
16. AMBULANCE	60% after Deductible	
17. URGENT, NON-ROUTINE, AFTER-HOURS CARE	80% after Deductible	50% after Deductible
18. BIOLOGICALLY-BASED MENTAL ILLNESS⁴ CARE	See # 19 (other Mental Health Care)	
19. OTHER MENTAL HEALTH CARE a) Inpatient care b) Outpatient care	50% after Deductible. Maximum benefit \$2,500 per Calendar Year, in and out-of-network combined. 50% after Deductible. \$500 maximum benefit per Calendar Year applies toward \$2,500 Calendar Year benefit.	50% after Deductible. Maximum benefit \$2,500 per Calendar Year, in and out-of-network combined. 50% after Deductible. \$500 maximum benefit per Calendar Year applies toward \$2,500 Calendar Year benefit.
20. ALCOHOL & SUBSTANCE ABUSE a) Inpatient care b) Outpatient care	Not covered Not covered	Not covered Not covered
21. PHYSICAL, OCCUPATIONAL & SPEECH THERAPY	80% after Deductible. Limited to \$2,000 per Calendar Year, in and out-of-network combined. For children with congenital defects or birth abnormalities up to age 5, 20 visits each for physical, speech and occupational therapy per Calendar Year, in and out-of-network combined.	50% of Usual and Customary after Deductible. Limited to \$2,000 per Calendar Year, in and out-of-network combined. For children with congenital defects or birth abnormalities up to age 5, 20 visits each for physical, speech and occupational therapy per Calendar Year, in and out-of-network combined.

* Copayment-based services do not apply to Neuromuscular Skeletal Disorders, Outpatient rehabilitation services other than a routine medical office visit, Chemical Dependency services, Mental Illness services, diagnostic services, including, but not limited to, MRI, PET, CAT scans, ultrasounds, nuclear medicine studies, EKG, ECG, EMG or EEG services and surgery performed in the medical office.

	IN-NETWORK	OUT-OF-NETWORK
22. DURABLE MEDICAL EQUIPMENT	80% after Deductible. \$2,000 Calendar Year maximum, in and out-of-network combined. See Policy for types and circumstances of coverage.	50% of Usual and Customary after Deductible. \$2,000 Calendar Year maximum, in and out-of-network combined. See Policy for types and circumstances of coverage.
23. OXYGEN	80% after Deductible. Covered as Durable Medical Equipment (see #22).	50% of Usual and Customary after Deductible. Covered as Durable Medical Equipment (see #22).
24. ORGAN TRANSPLANTS	80% after Deductible. All organ transplants are subject to Preauthorization. \$5,000 organ donor maximum. Covered up to Policy Maximum of \$2,000,000.	Not covered
25. HOME HEALTH CARE	80% after Deductible. 60 visits maximum per Calendar Year, in and out-of-network combined.	50% after Deductible. 60 visits maximum per Calendar Year, in and out-of-network combined.
26. HOSPICE CARE	80% after Deductible. 30 days maximum benefit, in and out-of-network combined while insured.	50% after Deductible. 30 days maximum benefit, in and out-of-network combined while insured.
27. SKILLED NURSING FACILITY CARE	80% after Deductible. 30 days maximum benefit per Calendar Year, in and out-of-network combined.	50% after Deductible. 30 days maximum benefit per Calendar Year, in and out-of-network combined.
28. DENTAL CARE	Not covered	
29. VISION CARE	Not covered	
30. CHIROPRACTIC CARE	80% after Deductible. Limited to \$1,000 maximum benefit, in and out-of-network combined per Calendar Year.	50% after Deductible. Limited to \$1,000 maximum benefit, in and out-of-network combined per Calendar Year.
31. SIGNIFICANT ADDITIONAL COVERED SERVICES (list up to 5)	Mammograms limited to the lesser of 1) \$75 per screening or 2) the actual charge per Calendar Year. Prostate cancer screening limited to the lesser of 1) \$65 per screening or 2) the actual charge per Calendar Year.	Mammograms limited to the lesser of 1) \$75 per screening or 2) the actual charge per Calendar Year. Prostate cancer screening limited to the lesser of 1) \$65 per screening or 2) the actual charge per Calendar Year.

PART C: LIMITATIONS AND EXCLUSIONS

32. PERIOD DURING WHICH PRE-EXISTING CONDITIONS ARE NOT COVERED.⁵	None
33. EXCLUSIONARY RIDERS. Can an individual's specific, Pre-Existing Condition be entirely excluded from the policy?	No
34. HOW DOES THE POLICY DEFINE A "PRE-EXISTING CONDITION"?	A Pre-Existing Condition is a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the last 6 months immediately preceding the date of enrollment or, if earlier, the first day of the waiting period; except that Pre-Existing Condition exclusions may not be imposed on a newly adopted child, a child placed for adoption, a newborn and other special enrollees.
35. WHAT TREATMENTS AND CONDITIONS ARE EXCLUDED UNDER THIS POLICY?	Exclusions vary by Policy. A list of exclusions is available immediately upon request from your carrier, agent or plan sponsor (e.g., Employer). Review them to see if a service or treatment you may need is excluded from the Policy.

PART D: USING THE PLAN

	IN-NETWORK	OUT-OF-NETWORK
36. Does the enrollee have to obtain a referral and/or prior authorization for specialty care in most or all cases?	No	No
37. Is prior authorization required for surgical procedures and Hospital care (except in an emergency)?	Yes	Yes
38. If the provider charges more for a Covered Service than the plan normally pays, does the enrollee have to pay the difference?	No	Non-Participating Providers (out-of-network) are reimbursed according to the Usual and Customary amount. The Covered Person is responsible for any charges in excess of the allowable Covered Expense.
39. What is the main customer service number?	Call PacifiCare Life Assurance Company at: 1-866-316-9776.	
40. Whom do I write/call if I have a complaint or want to file a grievance? ⁶	Write to: PacifiCare Life Assurance Company P.O. Box 6098 Cypress, CA 90630	
41. Whom do I contact if I am not satisfied with the resolution of my complaint or grievance?	Write to: Colorado Division of Insurance ICARE Section 1560 Broadway, Suite 850 Denver, CO 80202	
42. To assist in filing a grievance, indicate the form number of this Policy; whether it is individual, small group, or large group; and if it is a short-term Policy.	Policy Form #: IHP-IPLAN-POLICY-CO Group: Individual	

PART E: COST

43. What is the cost of this plan?	Contact your agent, this insurance company, or your Employer, as appropriate, to find out the premium for this plan. In some cases, plan costs are included with this form.
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**PART F: PHYSICIAN PAYMENT METHODS, AND PLAN EXPENDITURES FOR HEALTH EXPENSES,
ADMINISTRATION AND PROFIT**

Any person interested in applying for coverage, or who is covered by, or who purchased coverage under this plan may request answers to the questions listed below. The request may be made orally or in writing to the agent marketing the plan or directly to the insurance company and shall be answered within five (5) working days of the receipt of the request.

- What are the three most frequently used methods of payment for primary care physicians?
- What are the three most frequently used methods of payment for Physician specialists?
- What other financial incentives determine Physician payment?
- What percentage of total Colorado premiums are spent on health care expenses as distinct from administration and profit?

¹ “Network” refers to a specified group of Physicians, Hospitals, medical clinics and other health care Providers that your plan may require you to use in order for you to get any coverage at all under the plan, or that the plan may encourage you to use because it may pay more of your bill if you use their network Providers (i.e., go in-network) than if you don’t (i.e., go out-of-network).

² “Out-of-pocket maximum.” The maximum amount you will have to pay for allowable Covered Expenses under a health plan, which may or may not include the Deductible or Copayments, depending on the contract for the plan.

³ “Emergency care” means services delivered by an emergency care Facility which are necessary to screen and stabilize a Covered Person. The plan must cover this care if a prudent lay person having average knowledge of health services and medicine and acting reasonably would have believed that an emergency medical condition of life- or limb-threatening emergency existed.

⁴ “Biologically based mental illnesses” means schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder and panic disorder.

⁵ Waiver of Pre-Existing Condition exclusions. State law requires carriers to waive some or all of the Pre-Existing Condition exclusion period based on other coverage you recently may have had. Ask your carrier or plan sponsor (e.g., employer) for details.

⁶ Grievances. Colorado law requires all plans to use consistent grievance procedures. Write the Colorado Division of Insurance for a copy of those procedures.

**Outpatient Prescription Drug Benefit
Colorado Health Plan Description Form**

PacifiCare Life Assurance Company
Name of Carrier

Pharmacy Plan 814 (100/15-40-60R3)
Name of Plan

	BENEFIT LEVEL
<p>11. PRESCRIPTION DRUGS Level of coverage and restrictions on prescriptions</p>	<p>In-Network: \$100 Deductible then 100% after Copayments of \$15 Formulary generic, \$40 Formulary brand-name, \$60 non- Formulary.</p> <p>Out-of-Network: \$100 Deductible then 50% after Copayments of \$15 Formulary generic; \$40 Formulary brand-name, \$60 non-Formulary.</p> <p>If a brand-name is dispensed when a generic equivalent is available and listed on the drug Formulary, the Member pays the non-Formulary Copayment for the brand-name medication.</p> <p>PacifiCare requires prior authorization for specific Prescription Drugs.</p> <p>A 90-day supply of maintenance medications, or a three-cycle maximum of oral contraceptives, is available through the mail order prescription pharmacy for two applicable Copayments. Prepackaged units dispensed through the mail order prescription pharmacy will have two applicable Copayments apply per three prepackaged units.</p> <p>For more information on the mail order prescription drug program, or for information on drugs on our approved Formulary list, call Customer Service at 1-866-316-9776.</p> <p>NOTE: PacifiCare’s prescription drug coverage relies on a framework provided by a drug Formulary. A Formulary is a list of preferred or recommended drugs that have been carefully selected by Physicians and pharmacists based upon the safety and effectiveness of those drugs.</p> <p>You pay your applicable Copayment for prescriptions filled at network pharmacies:</p> <ul style="list-style-type: none"> ■ Formulary Generic ■ Formulary Brand ■ Non-Formulary

**P.O. Box 6098
Cypress, CA 90630**

**Customer Service:
866-316-9776
866-816-2018 (TDHI)
www.pacificare.com**

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