PacifiCare®
Health Plans

PacifiCare Health Plans

http://www.pacificare.com

2001

A Health Maintenance Organization

Serving: Arizona, California, Nevada, Oklahoma, Oregon, Texas and Washington

Enrollment in this Plan is limited; see page 10 for requirements.

Enrollment codes for this Plan:

Arizona
A31 Self Only
A32 Self and Family

These plans have Commendable or Excellent Accreditation from the NCQA. See the 2001 Guide for more information on NCQA.

California
CY1 Self Only
CY2 Self and Family

Nevada
K91 Self Only
K92 Self and Family

Oklahoma
2N1 Self Only
2N2 Self and Family

Oregon
7Z1 Self Only
7Z2 Self and Family

Texas
GF1 Self Only
GF2 Self and Family

Washington
WB1 Self Only
WB2 Self and Family

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Federal Employees
Health Benefits Program

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Table of Contents

Introduction

PacifiCare Health Plans
5995 Plaza Drive
Cypress, CA 90630

This brochure describes the benefits of PacifiCare Health Plans under our contract (CS 1937) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means *PacifiCare Health Plans*.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

HMO's emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- PacifiCare Health Systems has been in existence since 1975. We were founded by the Lutheran Hospital Society now called UniHealth America. We began operating as a Federally qualified Health Maintenance Organization (HMO) in 1978.

- PacifiCare is a for profit organization.

If you want more information about us, call 1-800-531-3341, or write to 5995 Plaza Drive MS CY 20-303, Cypress, CA 90630. You may also contact us by fax at 714-226-3575 or visit our website at www.pacificare.com.

Service Area

To enroll with us, you must live or work in our service area. This is where our providers practice.

Our service areas are:

ARIZONA **Serving most of Arizona:**

Apache, Cochise, Coconino, Gila, Graham, Greenlee, LaPaz, Maricopa, Navajo, Pima, Pinal, Santa Cruz, Yavapai, Yuma, and Mohave Co. identified by the following zips codes; 86403, 86404, 86405, 86406.

CALIFORNIA **Serving Northern and Southern California:**

Alameda, Butte, Contra Costa, Fresno, Kern, Kings, Los Angeles (except Catalina Island), Madera, Marin, Mariposa, Merced, Napa, Orange, Sacramento, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Ventura, Yolo, and portions of the following counties as defined by zip codes:

El Dorado:	95613, 95614, 95619, 95623, 95633-36, 95643, 95651, 95656, 95664, 95667, 95672, 95682, 95684, 95709, 95726
Imperial:	92227, 92231-33, 92243-44, 92249, 93350, 92251, 92257, 92259, 92273, 92281
Placer:	95602-04, 95626, 95631, 95648, 95650, 95658, 95661, 95663, 95668, 95677, 95678, 95681, 95703, 95713, 95717, 95722, 95736, 95746, 95747, 95765
Riverside:	91718-20, 91752, 91760, 92201-03, 92210, 92211, 92220, 92223, 92225-26, 92230, 92234-36, 92239-41, 92253-55, 92258, 92260-64, 92270, 92272, 92274-76, 92282, 92292, 92302-03, 92313, 92320, 92330-31, 92343-44, 92348, 92353, 92355, 92360, 92362, 92367, 92369-70, 92379-81, 92383, 92387-88, 92390, 92395, 92396, 92500-99
San Bernardino:	91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-59, 91761-64, 91784, 91785- 8I6, 92252, 92256, 92277, 92278, 92284, 92285, 92286, 92301, 92305, 92307-08, 92310-18, 92321, 92322, 92324-27, 92329, 92333-37, 92339-42, 92345-47, 92350, 92352, 92354, 92356-59, 92365, 92368, 92369, 92371-78, 92382, 92385, 92386, 92391-94, 92397-99, 92400-99
San Luis Obispo:	90031, 90032, 93401-93412, 93420-93424, 93426, 93428, 93430, 93432, 93433, 93435, 93442-49, 93451-53, 93461, 93465, 93483

NEVADA **Serving Parts of Nevada:**

Clark:	88901-88905, 89004-89007, 89009, 89011-12, 89014-16, 89018, 89019, 89021, 89024-27, 89030-33, 89036, 89039-40, 89046, 89052, 89070, 89100-89135, 89137-39, 89141-56, 89158-60, 89163, 89164, 89170, 89177, 89180, 89185, 89191, 89193, 89195 and 89199
Nye:	89003, 89020, 89022, 89023, 89045, 89049 and 89409
Carson City County:	89701, 89702, 89703, 89705, 89706, 89710, 89711, 89712, 89713, 89714, 89721

	Douglas County:	89410, 89411, 89413, 89423, 89448 and 89449
	Esmeralda County:	89010, 89013 and 89047
	Lyon County:	89408, 89428, 89429, 89430, 89444 and 89447
	Mineral County:	89415, 89416, 89420, 89422 and 89427
	Storey County:	89440
	Washoe County:	89402, 89405, 89412, 89431-36, 89439, 89424, 89442, 89450-52, 89501-89507, 89509-89512, 89523, 89599 and 89704

OKLAHOMA **Serving Oklahoma and Tulsa counties:**

Canadian, Cherokee, Cleveland, Creek, Grady, Lincoln, Logan, Mayes, McClain, Okmulgee, Osage, Pottawatomie, Rogers, Seminole, Wagoner, and Washington cities and towns which consist of the following zip codes: 73003, 73007-08, 73010, 73013, 73016, 73019, 73020, 73022, 73026-28, 73034, 73036-37, 73044-45, 73049-50, 73054, 73056, 73058-59, 73063-66, 73068-73, 73078, 73083-85, 73089-90, 73097, 73099, 73100-73199, 73762, 74002, 74008, 74011, 74020-21, 74023, 74026, 74031-33, 74035, 74036-37, 74039, 74041, 74043-44, 74047, 74050, 74053-55, 74059-63, 74066-67, 74070, 74073-76, 74079-82, 74085, 74101-08, 74110, 74112, 74114-17, 74119-20, 74126-37, 74145-49, 74152-53, 74155, 74157-59, 74169-70, 74337, 74352-53, 74421, 74429, 74436, 74446, 74454, 74458, 74466-67, 74477, 74801-02, 74824, 74826, 74830, 74832, 74834, 74837-38, 74840, 74849, 74851-52, 74854, 74855, 74857, 74864, 74866-69, 74873, 74875, 74878, 74881, 74884

OREGON **Serving Metropolitan Portland, Salem, Corvalis, Eugene and Southwest Washington:**

Multnomah, Washington, Clackamas, Marion, Polk, Linn, Benton, Lane, Yamhill and Columbia, and Clark county in Washington.

TEXAS **Serving San Antonio, Dallas /Ft. Worth and Houston:**

Atascosa, Bandera, Bexar, Collin, Comal, Dallas, Denton, Ellis, Fort Bend, Galveston, Guadalupe, Harris, Hood, Hunt, Johnson, Kaufmann, Kendall, Montgomery, Rockwall, Tarrant, and Wise.

WASHINGTON **Serving The Puget Sound area, most of Western Washington and parts of Eastern Washington:**

Grays Harbor, King, Mason, Pierce, Snohomish and Thurston

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will only pay for emergency care. We will not pay for any other health care services.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.

- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed higher cost sharing and shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.

- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling 1-800-531-3341, **or** checking our website at www.pacificare.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:

  •• Speak up if you have questions or concerns.
  •• Keep a list of all the medicines you take.
  •• Make sure you get the results of any test or procedure.
  •• Talk with your doctor and health care team about your options if you need hospital care.
  •• Make sure you understand what will happen if you need surgery.

- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- **Code A3** Your share of the non-Postal premium will increase by 9% for Self Only coverage or 9% for Self and Family coverage
- **Code CY** Your share of the non-Postal premium will increase by 3.1% for Self Only coverage or 8.3% for Self and Family coverage
- **Code GF** Your share of the non-Postal premium will increase by 21% for Self Only coverage or 21.5% for Self and Family coverage
- **Code K9** Your share of the non-Postal premium will increase by 18% for Self Only coverage or 18% for Self and Family coverage
- **Code WB** Your share of the non-Postal premium will increase by 18% for Self Only coverage or 20% for Self and Family coverage
- **Code 2N** Your share of the non-Postal premium will increase by 21% for Self Only coverage or 21.5% for Self and Family coverage
- **Code 7Z** Your share of the non-Postal premium will increase by 69.6% for Self Only coverage or 62.1% for Self and Family coverage

- For prescription drugs, you pay $5 for generic and $15 for brand name formulary drugs. These copays apply to non-formulary drugs when your plan doctor prescribes them.
- For mail order prescription drugs, you pay two copays for a ninety (90) day supply.
- You pay a $50 copay for emergency room treatment.
- Out-of-pocket maximums will change to $1,500 for self only coverage and $3,000 for self and family coverage.
- New dental benefits are available.
- Chiropractic services are available for $10 per visit.

- **Codes A3, K9 and WB.** You pay 50% of the charges for diagnosis and treatment of infertility.
- **Codes A3, 2N and 7Z.** There are no day or visit limits for short-term rehabilitative therapy. You pay $10 for each outpatient visit and nothing for inpatient treatment.
- **Code A3.** You pay $10 for sterilization procedures performed in a physician's office and nothing in an inpatient or outpatient hospital setting.
- **Codes WB and 7Z.** Confinement in a skilled nursing facility is limited to 100 consecutive days.
- **Code WB.** The Plan no longer provides service in Walla Walla and San Juan counties.
- **Code WB.** There are no day or visit limits for cardiac rehabilitation.
- **Code GF.** Gamate intrafallopian transfer (GIFT) is no longer covered.
- **Code K9.** Maternity care is covered in full. You pay $10 copay per pregnancy. We will waive all office visit copays for the remaining maternity care.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-531-3341.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance, and you will not have to file claims unless you receive out of area emergency services.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website, which you can also access at www.pacificare.com.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our web site.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. You may select a primary care doctor by completing the Primary Care Doctor Selection form inside your enrollment packet.

- **Primary care**

Your primary care physician can be a family practitioner, internist, general practitioner or pediatrician for children under 18 years of age. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, women may see an OB/GYN within their medical group without a referral.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will coordinate with your specialist and PacifiCare to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional

referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  - terminate our contract with your specialist for other than cause; or

  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  - reduce our service area and you enroll in another FEHB Plan,

  you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-531-3341. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or

- The day your benefits from your former plan run out; or

- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this the approval process precertification. Your physician must obtain approval for some services such as:

- Cardiovascular bypass surgery
- Septoplasty
- Cholecystectomy
- Hysterectomy
- Arthroplasty
- MRIs and CTs
- Growth Hormone Treatment (GHT)

PacifiCare Health Plans may determine medical necessity by using preauthorization programs and criteria. Our criteria are written guidelines established by us to determine medical necessity and/or coverage for certain procedure and treatments. Our 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.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

- **Copayments**

  A copayment is a fixed amount of money you pay to the provider when you receive services.

  Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay nothing per admission.

- **Deductible**

  We do not have a deductible.

- **Coinsurance**

  Coinsurance is the percentage of our negotiated fee that you must pay for your care.

  Example: In our Plan, you pay 50% of all charges for infertility services.

Your out-of-pocket maximum for coinsurance and copayments

After your copayments and/or coinsurance total $1,500 per person or for copayments and coinsurance $3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription Drugs
- Dental Services
- Chiropractic Services

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

Section 5. Benefits -- OVERVIEW

(See page 8 for how our benefits changed this year and page 57 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-531-3341 or at our website at www.pacificare.com.

Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In a physicians office • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion	$10 per office visit
At home doctors house calls or visits by nurses and health aides	$10 per office visit
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during your office visit; otherwise, $10 per office visit

Preventive care, adult	You pay
Routine screenings, such as: • Blood lead level – One annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including •• Fecal occult blood test	$10 per office visit
•• Sigmoidoscopy, screening – every five years starting at age 50	$10 per office visit
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	$10 per office visit
Routine pap test Note: The office visit is covered if pap test is received on the same day; see Diagnosis and Treatment, above.	$10 per office visit
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	$10 per office visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	$10 per office visit
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit
• Examinations, such as: ••Eye exams to determine the need for vision correction. ••Ear exams to determine the need for hearing correction ••Examinations done on the day of immunizations (up to age 22 years) • Well-child care charges for routine examinations, immunizations and care (up to age 22 years)	$10 per office visit

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 27 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	A single $10 copay for the entire pregnancy.
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per office visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling,	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: •• *intravaginal insemination (IVI)* •• *intracervical insemination (ICI)* •• *intrauterine insemination (IUI)* • Injectable fertility drugs Note: We cover oral fertility drugs under the prescription drug benefit.	50% of all charges
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* •• *in vitro fertilization* •• *embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm*	*All charges.*
Allergy care	
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 25. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: We will only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See Services requiring our prior approval in Section 3.	$10 per office visit
Not covered: *Other treatment services not listed as covered.*	*All charges.*

Rehabilitative therapies	You pay
Physical therapy, occupational therapy and speech therapy – • Unlimited visits for the services of each of the following: •• qualified physical therapists; •• speech therapists; and •• occupational therapists Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury.	$10 per office visit
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided with no day limit.	$10 per outpatient visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs* • *Pulmonary Rehabilitation*	*All charges.*
Hearing services (testing, treatment, and supplies)	
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing (see *Preventive care, children*)	$10 per office visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	$10 per office visit
• Eye exam to determine the need for vision correction for children through age 17 (see preventive care) • Annual eye refractions	$10 per office visit
Not covered: • *Eyeglasses or contact lenses and, after age 17, examinations for them* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges.*

Foot care	You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • Foot Orthotics if you are diabetic • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	Nothing
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *prosthetic replacements provided less than three years after the last one we covered*	*All charges.*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, including repair and adjustment, of, such as oxygen and dialysis equipment. Under this benefit, we also cover durable medical equipment prescribed by your Plan physician such as: • orthopedic brace • hospital beds • wheelchairs • crutches • walkers • insulin pumps Note: Call us at 1-800-531-3341 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	Nothing
Not covered: • *Specialized wheelchairs for comfort and convenience.*	*All charges.*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges.*
Alternative treatments	
Chiropractic Services – You may self refer to a participating chiropractor for up to 30 visits each calendar year.	$10 per office visit
Not covered: • *acupuncture* • *hynotherapy* • *naturopathic services* • *biofeedback*	*All charges.*

Educational classes and programs	You pay
Coverage is limited to: • Smoking Cessation – including all related expenses such as Nicotine Replacement • Taking Charge of Your Heart Health® • Diabetes self-management (Taking Charge of Diabetes®) • Healthy Women & Children	Nothing (Note: There is a $20 Prescription Drug copayment for nicotine replacement prescription)

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)
- YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information. • Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs). Note: Devices are covered under 5(a). • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$10 per office visit; nothing for hospital visits

Surgical procedures *(Continued)*	**You pay**
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing

Oral and maxillofacial surgery *(Continued)*	**You pay**
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*
Organ/tissue transplants	
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogeneic (donor) bone marrow transplant • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

Anesthesia	You pay
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

Section 5 (c). Services provided by a hospital or other facility, and ambulance services

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing

Inpatient hospital *(Continued)*	**You pay**
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Extended care benefits/skilled nursing care facility benefits	
Extended care benefit: We provide a wide range of benefits for full-time nursing care and confinement in a skilled nursing facility when your doctor determines it to be medically necessary. We must also approve this service. All necessary services are covered up to 100 days per calendar year, including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	Nothing
Not covered: • *Custodial care* • *Homemaker Services*	*All charges*

Hospice care	You pay
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility when approved by our Medical Director. Services include: • Inpatient and outpatient care • Family counseling These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered service*s for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

Emergencies within our service area: If you have an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours (unless it is not reasonably possible to do so). It is your responsibility to notify us in a timely manner.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full. Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition. To be covered by us you must get all follow-up care from our providers or follow up care must be authorized by us.

Emergencies outside our service area: Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness. If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full. To be covered by this Plan, you must get all follow up care from plan providers or your follow up care must be approved by the us.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$10 per office visit
• Emergency care at an urgent care center	$10 per office visit
• Emergency care at a hospital, including doctors' services	$50 per visit Note: You pay nothing if you are admitted to the hospital.
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office	$10 per office visit
• Emergency care at an urgent care center	$10 per office visit
• Emergency care at a hospital, including doctors' services	$50 per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a full-term delivery of a baby outside the service area*	*All charges.*
Ambulance	
Professional ambulance service, including air ambulance services when medically appropriate. See 5(c) for non-emergency service.	Nothing

Section 5 (e). Mental health and substance abuse benefits

IMPORTANT

Parity

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
Diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per visit
• Diagnostic tests	$10 per office visit or test
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Mental health and substance abuse benefits *(Continued)*

Preauthorization

To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes:

- Call PacifiCare Behavioral Health at 1-800-999-9585. Our Customer Service department will help you select a provider. Customer Service will conduct a brief interview and you will be given the name of Mental Health Provider near your home or work that meets your needs.
- Call the Provider and schedule an appointment.
- Your Behavioral Health provider will get approval for any additional services you need.
- You can call PacifiCare Behavioral Health to get a list of our providers at 1-800-999-9585 or visit our website at www.pbhi.com or www.pacificare.com.

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days if your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

Section 5 (f). Prescription drug benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

There are important features you should be aware of. These include:

- **Who can write your prescription.** A plan physician must write the prescription.

- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication.

- **We use a formulary.** The PacifiCare Formulary is a list of prescription drugs that Physicians use as a guide when prescribing medications for patients. The Formulary helps us provide safe, effective and affordable prescription drugs to PacifiCare members. We work with physicians and pharmacies to make sure you are getting the drug therapy you need. A Pharmacy and Therapeutics Committee evaluates prescription drugs for safety, effectiveness, quality treatment and overall value. The committee considers the safety and effectiveness of a medication before they review the cost. Our physicians may get pre-authorization for non-formulary drugs. Your doctor may start the pre-authorization request by phoning or faxing it. Requests are usually processed within ten minutes although some may take up to two (2) working days if we need more information from your doctor.

  Non-Formulary drugs will be covered if:

  - No Formulary alternative is appropriate.
  - You have tried the Formulary drugs and they have not worked or you have had side effects or interactions with other drugs. The physicians are asked to provide a copy of the medical chart notes stating treatment failure with the Formulary alternatives.
  - You have been under treatment and remain stable on a non-Formulary prescription drug and changing to a Formulary drug would not be medically suitable.
  - Your physician provides us with documents, records, or clinical trials which shows that use of the requested non-Formulary drug instead of the Formulary drug is medically necessary, as determined by PacifiCare.

- **These are the dispensing limitations.** You can get your prescription drugs at a participating pharmacy as long as it is written by your primary care doctor or specialist. You will get up to a 30 day supply, 2 vials of insulin or one commercially prepared unit (i.e., one inhaler, one vial of ophthalmic medication, topical ointment or cream for a $5 copay per prescription unit or refill for generic drugs or a $15 copayment for name brand drugs when generic substitution is not available. When generic substitution is available (i.e., a generic drug is available and the prescribing doctor does not require the use of a name brand drug), but you request the name brand drug, **you pay** the price difference between the generic and name brand drug and the $15 copay per prescription unit or refill. Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Non-formulary drugs will be covered when prescribed by a Plan doctor.

  Prescription drugs can also be obtained through the mail order program for up to a 90 day supply of oral medication; 6 vials of insulin; or 3 commercially prepared units (i.e., inhaler, vials ophthalmic medication or topical ointments or creams). **You pay** a $10 copay per prescription unit or refill for generic drugs or a $30 copayment for name brand maintenance medications. Call 1-800-562- 6223 for mail order customer service.

- **When you have to file a claim.** Please refer to Section 7 for information on how to file a pharmacy claim, or contact our Customer Service Department at 1-800-562-6223.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. • Insulin • Diabetic supplies such as lancets and blood glucose test strips • Disposable needles and syringes for the administration of covered medications • Contraceptive drugs and devices • Intravenous fluids and medications for home use (covered under Section 5(a) Home Health Services - see page 21) • Prenatal and B-12 vitamins • Injectable medications for home use and self-administration by patient when approved by the Plan • Oral medications prescribed to treat infertility, or the underlying cause of infertility including Clomiphene Citrate, Bromocriptine Mesylate and Dexamethasone (Injectable infertility drugs are covered under Section 5(a) Infertility Services) **Limited benefits** • Drugs to treat sexual dysfunction are covered when Plan's medical criteria is met. Contact the plan for dose limits; you **pay** a 50% copayment up to the dosage limits and all charges above that.	$5 per generic formulary prescription unit or refill. $15 per brand formulary prescription unit or refill Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. • We have a closed formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-800-824-0428.	

Covered medications and supplies *(Continued)*	You pay
Not covered: • *Non-prescription medicines* • *Drugs obtained at a non-Plan pharmacy unless you have an emergency out-of-area.* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them (except B-12 and prenatal Vitamins)* • *Medical supplies such as dressings and antiseptics* • *Drugs for and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Smoking cessation drugs and medication, including nicotine patches unless you are enrolled in our Smoking Cessation program. (See page 38)* • *Diabetic supplies, except those shown above*	*All Charges*

Section 5 (g). Special Features

Feature	Description
Hearing Aids for children	The Oklahoma plan (code 2N) covers hearing aids 100% for children under the age of 13.
Immunizations	The Oklahoma plan (code 2N) covers immunizations 100% for children through age 18. You won't have to pay a copay if you don't have other services when you get your immunization.
Dental anesthesia and anesthesiologist costs	The Oklahoma Plan (code 2N) covers these expenses for certain dental procedures for children under age 8 or for severely disabled children.
Vision Screening eyeglasses and contact lenses	If you are enrolled in the Oklahoma Plan (code 2N) or the Texas Plan (code GF) you will get a 20% discount on eyeglasses, contact lenses and your annual eye exam from participating providers.
Health Improvement Programs	You pay nothing for the following PacifiCare Programs: Managing your Heart Health, Managing Diabetes, Smoking Cessation*, Healthy pregnancy and Managing Depression. *Smoking Cessation nicotine replacement require a $20 copayment.
Centers of excellence for transplants/ heart surgery/etc.	Services performed at Centers of Excellence are covered when medically necessary and preapproved. You pay $10 for outpatient visits and nothing for inpatient hospitalization.
Travel benefit/services overseas	Covered for emergencies only.

Section 5 (h). Dental benefits

IMPORTANT

Here are some important things to keep in mind about these benefits:

- **For more information call PacifiCare Dental Administrators at 1-800-591-5915.**
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Accidental injury benefit	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	You pay a $10 copayment
Dental benefits	

- No network – choose any dentist you wish
- Preventive services covered at 100% of Usual, Customary and Reasonable charges
- Basic and major services covered based on a maximum fee schedule
- No pre-authorization requirements
- No deductibles
- No lifetime maximums
- No waiting periods
- $1,000 per calendar year maximum.

Service	We pay (Scheduled Allowance)	You pay
Dental benefits *(Continued)*		
This dental plan has no deductibles and no lifetime maximums. You may see any provider you like.		
Preventive and Diagnostic		
Comprehensive Oral exam (one every six months)	100% of dentist's Usual, Customary and Reasonable (UCR) fees for all preventive and diagnostic services	If your dentist charges more than the UCR fees for covered services in your area, you will be charged only the amount that exceeds those UCR fees.
Periodic oral exam (one every six months)		
Intraoral X-rays (one bitewing series of four every six months, one full mouth per five years)		
Prophylaxis (once every six months)		
Basic and Major Services		
Amalgam fillings (one tooth surface, permanent teeth)	$18	All charges in excess of the scheduled amounts listed to the left.
Amalgam fillings (two tooth surfaces, permanent teeth)	$23	
Porcelain with metal crown	$200	
Porcelain Crown	$125	
Single root canal	$90	
Bi-root canal	$115	
Periodontal root planing and scaling	$30	
Full mouth dentures	$232	
Partial dentures	$225	
Bridges: Tru-pontic type	$82	
Simple Extractions	$15	

This is not a full list of services. Please call PacifiCare Dental Customer Service at 1-800-591-5915 Monday through Friday from 8 a.m. to 6 p.m. for a full list of services, exclusions and limitations.

Section 5 (i). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and **you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

PacifiCare Health Plan members can enjoy discounts on Alternative care, vision hardware, Lasik surgery, Health baby, Weight Watchers and much more through the PacifiCare Perks program. You will get this benefit automatically just by being a PacifiCare member.

In **California,** for a monthly premium, you can enroll in an HMO dental plan or vision hardware plan through PacifiCare Dental and Vision as a supplement to your FEHB Plan. Call 1-800-228-3384 for more information.

In **Arizona,** for a monthly premium, you can enroll in an HMO dental plan as a supplement to your FEHB dental plan. Call 1-800-531-3341 for more information.

In **Nevada** you can enjoy great savings on prescription eyewear that includes a wide selection of glasses (or contacts) when you take advantage of PacifiCare's Vision Eyewear Only Plan 1-800-228-3384.

Medicare managed care plan

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 1-800-531-3341 for information on the benefits available under the Medicare HMO.

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 48, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later re-enroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those **without** Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask whether the plan covers hospital benefits and , if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 1-800-531-3341 for information on the Medicare prepaid plan and the cost of that enrollment.

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness disease, injury, or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical, hospital, prescription drugs and (DME) benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800-531-3341.

When you must file a claim – such as for out-of-area care – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer –such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to: **PacifiCare Health Plans**
5995 Plaza Drive
MS CY20-303
Cypress, CA 90630

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: 5995 Plaza Drive MS. CY 20-303, Cypress, CA 90630 ; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial – go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must provide a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

6 If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs or supplies. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-531-3341 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- •• If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- •• You can call OPM's Health Benefits Contracts Division III at 202-606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage." When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance

• What is Medicare?

Medicare is a Health Insurance Program for:

•• People 65 years of age and older.

•• Some people with disabilities, under 65 years of age.

•• People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

•• Part A (Hospital Insurance). Most people do not have to pay for Part A.

•• Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

• The Original Medicare Plan

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PCP, or precertified as required. We will not waive any of our copayments. (Primary Payor chart begins on next page.)

The following chart illustrates whether Original Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you – or your covered spouse – are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…		
a) The position is excluded from FEHB or,	✓	
b) The position is not excluded from FEHB		✓
Ask your employing office which of these applies to you.		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you – or a covered family member – have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary fo you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or	✓	
b) Are an active employee		✓

Please note, if your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

Claims process – You probably will never have to file a claim form when you have both our Plan and Medicare.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 1-800-531-3341 or visit us on our we site at www.pacificare.com, you can fax us at 714-226-3575.

• Medicare managed care plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Managed Care Plan. These are health care choices (like HMO's) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan the following options are available to you:

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments, coinsurance, or deductibles for your FEHB coverage.

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, but we will not waive any of our copayments.

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care plan service area.

• Enrollment in Medicare Part B

Note: If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

TRICARE

TRICARE is the health care program for members, eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your benefits. You must use our providers.

Medicaid

When you have this Plan and Medicaid, we pay first.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 13.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 13.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Day to day care that can be provided by a non-medical individual.

Medical necessity

Medical necessity refers to medical services or hospital services that are determined by us to be:

- Rendered for the treatment or diagnosis of an injury or illness; and
- Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and
- Not furnished primarily for the convenience of the Member, the attending physician, or other provider of service; and
- Furnished in the most economically efficient manner which may be provided safely and effectively to the Member.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance by our contracted rate with the participating provider.

Us/We

Us and we refer to *PacifiCare Health Plans.*

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans,* brochures for other plans, and other materials you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as temporary continuation of coverage (TCC).

When you lose benefits

• When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

•• Your enrollment ends, unless you cancel your enrollment, or

•• You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

• Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

• TCC

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert;
- You decided not to receive coverage under TCC or the spouse equity law, or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-800-531-3341 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE – 202-418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Department of Defense/FEHB Demonstration Project

What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 open season for the year 2000. Open season enrollments will be effective January 1, 2001. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible

DoD determines who is eligible to enroll in the FEHB Program. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

The demonstration areas

- Dover AFB, DE
- Fort Knox, KY
- Dallas, TX
- New Orleans, LA
- Adair County, IA
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA

When you can join

You may enroll under the FEHB/DoD Demonstration Project during the 2000 open season, November 13, 2000, through December 11, 2000. Your coverage will begin January 1, 2001. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877-DOD-FEHB (1-877-363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during the 2000 and 2001 open seasons. Your coverage will begin January 1 of the year following the open season during which you enrolled.

If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2001 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at www.opm.gov.

TCC eligibility

See Section 11, FEHB Facts; it explains temporary continuation of coverage (TCC). Under this DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

Other features

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration Project.

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

Summary of benefits for the *PacifiCare Health Plans* – 2001

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist	15-22
Services provided by a hospital:		
• Inpatient	Nothing per admission	27-28
• Outpatient	$10 copay per office visit	28
Emergency benefits:		
• In-area	$50 per visit	31
• Out-of-area	$50 per visit	31
Mental health and substance abuse treatment	Regular benefits	32-33
Prescription drugs	$5 copay for generic formulary prescriptions $15 for brand formulary prescriptions	34-37
Dental Care	Nothing for preventive services; scheduled allowance for other services	39-40
Vision Care	Discounts for frames and lenses through the PacifiCare Perks℠ program.	19 & 41
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $1,500/Self Only or $3,000/Family enrollment per year Some costs do not count toward this protection	13

2001 Rate Information for PacifiCare Health Plans

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contract the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Arizona: Most of Arizona

Self Only	**A31**	**$66.70**	**$22.23**	**$144.51**	**$48.17**	**$78.93**	**$10.00**
Self and Family	**A32**	**$186.74**	**$62.25**	**$404.61**	**$134.87**	**$220.98**	**$28.01**

California

Self Only	**CY1**	**$60.20**	**$20.06**	**$130.43**	**$43.47**	**$71.23**	**$9.03**
Self and Family	**CY2**	**$156.98**	**$52.32**	**$340.11**	**$113.37**	**$185.75**	**$23.55**

Nevada: Las Vegas/Carson City/Reno

Self Only	**K91**	**$67.69**	**$22.56**	**$146.66**	**$48.88**	**$80.10**	**$10.15**
High Option Self and Family	**K92**	**$171.50**	**$57.16**	**$371.57**	**$123.86**	**$202.94**	**$25.72**

Oklahoma: Okla Cty and Tulsa area

Self Only	**2N1**	**$66.65**	**$22.22**	**$144.41**	**$48.14**	**$78.87**	**$10.00**
Self and Family	**2N2**	**$174.14**	**$58.04**	**$377.30**	**$125.76**	**$206.06**	**$26.12**

Oregon: Counties along I-5 Corridor and Clark County

Self Only	**7Z1**	**$86.59**	**$40.13**	**$187.61**	**$86.95**	**$102.22**	**$24.50**
Self and Family	**7Z2**	**$195.82**	**$84.95**	**$424.28**	**$184.06**	**$231.17**	**$49.60**

Texas: S Ant/Hston/Glvston/Da/Ft Wor/Glf Coast

Self Only	**GF1**	**$65.84**	**$21.95**	**$142.66**	**$47.55**	**$77.91**	**$9.88**
Self and Family	**GF2**	**$171.98**	**$57.33**	**$372.63**	**$124.21**	**$203.51**	**$25.80**

Washington: Puget Sound/Most West WA

Self Only	**WB1**	**$70.66**	**$23.55**	**$153.09**	**$51.03**	**$83.61**	**$10.60**
Self and Family	**WB2**	**$184.51**	**$61.50**	**$399.77**	**$133.25**	**$218.33**	**$27.68**