

A Health Maintenance Organization

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

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See pages 8-9 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 2002 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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RETIREMENT AND INSURANCE SERVICE
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Federal Employees
Health Benefits Program

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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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; “we” means PacifiCare.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to the OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street NW, Washington, DC 20415-3650.

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 or write

**THE HEALTH CARE FRAUD HOTLINE
(202) 418-3300**

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.

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.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. 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 in this Plan, you must live or work in our service area. This is where our providers practice.

Our service areas are:

ARIZONA

Serving: Maricopa and Pima counties and Apache Junction identified by the following zip codes:
85217, 85219, 85278 and 85220

CALIFORNIA

Serving Northern and Southern California:

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

El Dorado: 95682, 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, 91785-816, 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

NEVADA

Serving Clark County Nevada identified by the following cities and zip codes:

Blue Diamond, Boulder City, Bunkerville, Cal/Nev/Ari, Henderson, Jean, Indian Springs, Las Vegas, Logandale, Mesquite, Moapa, Mt.Charleston North Las Vegas, Nellis AFB, Overton and Searchlight.

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

OKLAHOMA

Serving Central and Northeastern Oklahoma:

The counties of: Canadian, Cleveland, Creek, Logan, Oklahoma, Pottawatomie, Rogers, Tulsa and Wagoner.

And portions of the following counties identified by zip code:

Muskogee: 74436

Osage: 74002, 74035, 74054, 74060

Washington: 74061, 74082

OREGON

Serving Metropolitan Portland, Salem, Corvallis, Eugene and Southwest Washington:

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

TEXAS

Serving San Antonio and Dallas/Ft. Worth:

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

WASHINGTON

Serving the Puget Sound area and most of Western Washington.

Grays Harbor, King, Lewis, 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 pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

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 2002

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- We increased speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))

Changes to this Plan

- **Code A3** Your share of the non-Postal premium will increase by 30.5% for Self Only or 63.3% for Self and Family
- **Code CY** Your share of the non-Postal premium will increase by 16.4% for Self Only or 16.3% for Self and Family
- **Code GF** Your share of the non-Postal premium will increase by 13.4% for Self Only or 13.6% for Self and Family
- **Code K9** Your share of the non-Postal premium will increase by 30.9% for Self Only or 35.2% for Self and Family
- **Code WB** Your share of the non-Postal premium will increase by 40.2% for Self Only or 94.6% for Self and Family
- **Code 2N** Your share of the non-Postal premium will increase by 15.3% for Self Only or 15.4% for Self and Family
- **Code 7Z** Your share of the non-Postal premium will increase by 72.1% for Self Only or 72.3% for Self and Family
- We now cover certain intestinal transplants.
- We now cover injectable medications and supplies under Home Health care. You pay nothing (Section 5(a)). We previously covered these services under the Prescription drug benefit.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card. 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 website.

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. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, women may see an OB/Gyn without a referral.

If you are enrolled in Plans WB or GF you may see any Woman’s Healthcare provider within the network for maternity care, reproductive health services, gynecological care and general examinations 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. If you do not receive prior approval you may be responsible for charges. Always return to your primary care physician for prior approval.

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, facility or pharmacy 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**

We do not have coinsurance.

Your Catastrophic Protection out-of-pocket maximum for copayments

After your copayments total \$1,500 per person or \$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 10 for how our benefits changed this year and page 58 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. For more information about our benefits, contact us at 1(800) 531-3341 or at our website at www.pacificare.com.

(a) Medical services and supplies provided by physicians and other health care professionals	16 - 23
• Diagnostic and treatment services	• Speech Therapy
• Lab, X-ray, and other diagnostic tests	• Hearing services (testing, treatment, and supplies)
• Preventive care, adult	• Vision services (testing, treatment, and supplies)
• Preventive care, children	• Foot care
• Maternity care	• Orthopedic and prosthetic devices
• Family planning	• Durable medical equipment (DME)
• Infertility services	• Home health services
• Allergy care	• Chiropractic
• Treatment therapies	• Educational classes and programs
• Physical and occupational therapies	
(b) Surgical and anesthesia services provided by physicians and other health care professionals.	24 - 27
• Surgical procedures	• Oral and maxillofacial surgery
• Reconstructive surgery	• Organ/tissue transplants
	• Anesthesia
(c) Services provided by a hospital or other facility, and ambulance services	28 - 29
• Inpatient hospital	• Extended care benefits/skilled nursing care
• Outpatient hospital or ambulatory surgical center	facility benefits
	• Hospice care
	• Ambulance
(d) Emergency services/accidents.	30 - 31
• Accidental injury	• Medical emergency
	• Ambulance
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Section 5 (a) Medical services and supplies provided by physicians and other health care professionals

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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.

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Benefit Description	You pay After the calendar year deductible
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In a physicians office • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion 	\$10 per office visit Nothing for inpatient services.
At home doctors house calls or visits by nurses and health aides	\$10 per visit
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • 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.

Preventive care, adult	You pay
Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including <ul style="list-style-type: none"> - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50 	Nothing if you receive these services during your office visit; otherwise, \$10 per office visit \$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 <i>Diagnosis and Treatment</i> , above.	\$10 per office visit
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • 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 	Nothing if you receive these services during your office visit; otherwise, \$10 per office visit
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i> <ul style="list-style-type: none"> • Immunizations for travel 	<i>All charges.</i>
Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations). • Influenza/Pneumococcal vaccines, annually, age 65 and over. • Eye exams to determine the need for vision correction. 	Nothing if you receive these services during your office visit; otherwise, \$10 per office visit
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing if you receive these services during your office visit; otherwise, \$10 per office visit
<ul style="list-style-type: none"> • Examinations, such as: <ul style="list-style-type: none"> - 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
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 28 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). 	<p>A single \$10 copay for the entire pregnancy.</p>
<p><i>Not covered: Routine sonograms to determine fetal sex.</i></p>	<p><i>All charges.</i></p>
Family planning	
<p>A broad range of family services such as:</p> <ul style="list-style-type: none"> • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: we cover oral contraceptives under the prescription drug benefit.</p>	<p>\$10 per office visit. Nothing for hospital visits or Outpatient Surgical Center.</p>
<p><i>Not covered: Reversal of voluntary surgical sterilization and genetic counseling.</i></p>	<p><i>All charges.</i></p>
Infertility services	
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • Fertility drugs <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	<p>50% of all charges</p>

Infertility services continued on next page.

Infertility services (Continued)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer gamate GIFT and zygote ZIFT</i> - <i>Zygote transfer</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<p><i>All charges.</i></p>
Allergy care	
<p>Testing and treatment Allergy injection</p>	<p>\$10 per office visit</p>
<p>Allergy serum</p>	<p>Nothing</p>
<p><i>Not covered: provocative food testing and sublingual allergy desensitization.</i></p>	<p><i>All charges.</i></p>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 26.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>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.</p>	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <p><i>Other treatment services not listed as covered.</i></p>	<p><i>All charges.</i></p>

Foot care	You pay
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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.</i> • <i>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).</i> 	<p><i>All charges.</i></p>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose. • Foot Orthotics when medical criteria is met. • 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: 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. • Prosthetic Replacements when the device is beyond repair or the patient requires a new device because of a physical change. 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>orthopedic and corrective shoes</i> • <i>arch supports</i> • <i>heel pads and heel cups</i> • <i>lumbosacral supports</i> • <i>corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Prosthetic replacements provided less than three years after the last one we covered</i> 	<p><i>All charges.</i></p>

Durable medical equipment (DME)	You pay
<p>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:</p> <ul style="list-style-type: none"> • Orthopedic Brace; • hospital beds; • wheelchairs; • crutches; • walkers; • insulin pumps. <p>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.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Specialized wheelchairs for comfort and convenience.</i> 	<p><i>All charges.</i></p>
Home health services	
<ul style="list-style-type: none"> • 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 such as injectables. • Injectable medications for home use and self-administration by patient when approved by the Plan or your Medical Group. 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic,therapeutic or rehabilitative.</i> 	<p><i>All charges.</i></p>
Chiropractic Care	
<p>Chiropractic services – You may self refer to a participating chiropractor for up to 30 visits each calendar year</p> <ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	<p>\$10 per office visit</p>

Alternative treatments	You pay
<p><i>Note: See page 37 for the PacifiCare PerksSM program for discounts on these services.</i></p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>acupuncture</i> • <i>naturopathic services</i> • <i>hypnotherapy</i> • <i>biofeedback</i> 	<p><i>All charges.</i></p>
Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking Cessation – including all related expenses such as Nicotine Replacement* • Taking Charge of Your Heart Health® • Diabetes self-management (Taking Charge of Diabetes®) • Healthy PregnancySM • Managing Depression 	<p>Nothing</p> <p>(Note: There is a \$20 Prescription Drug copayment for smoking cessation products)</p>

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

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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.)
- **YOUR PHYSICIAN 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.

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Benefit Description	You pay
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • 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 and prosthetic devices for device coverage information. • Voluntary sterilization • Treatment of burns <p>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.</p>	<p>\$10 per office visit; nothing for hospital visits or outpatient surgical centers</p>

Surgical procedures continued on next page.

Surgical procedures (Continued)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care.</i> 	<p><i>All charges.</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - 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. 	<p>Nothing</p>
<ul style="list-style-type: none"> • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - 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) <p>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.</p>	<p>See above.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges.</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • 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. • TMJ surgery and related non-dental treatment. 	<p>Nothing</p>

Oral and maxillofacial surgery continued on next page.

Oral and maxillofacial surgery <i>(Continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Oral implants and transplants • Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone) 	<p><i>All charges.</i></p>
Organ/tissue transplants	
<p>Limited to:</p> <ul style="list-style-type: none"> • 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 • Intestinal Transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as liver, stomach and pancreas • National Transplant Program (NTP) • 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. <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	<p><i>All charges.</i></p>

Anesthesia	You pay
Professional services provided in <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing
Professional services provided in <ul style="list-style-type: none"> • 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

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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).

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Benefit Description	You pay
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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
Not covered: <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes and schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care 	All charges.

<p>Outpatient hospital or ambulatory surgical center</p>	
<ul style="list-style-type: none"> • 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 <p>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.</p>	<p>Nothing</p>
<p>Extended care benefits/skilled nursing care facility benefits</p>	
<p>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. The Plan must also approve this service.</p> <p>All necessary services are covered up to 100 days per calendar year, including:</p> <ul style="list-style-type: none"> • 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. 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Homemaker Services</i> 	<p><i>All charges.</i></p>
<p>Hospice care</p>	
<p>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:</p> <ul style="list-style-type: none"> • Inpatient and outpatient care • Family counseling <p>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.</p>	<p>Nothing</p>
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<p><i>All charges.</i></p>
<p>Ambulance</p>	
<ul style="list-style-type: none"> • Local professional ambulance service when medically appropriate 	<p>Nothing</p>

Section 5 (d). Emergency services/accidents

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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.
- We have no 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.

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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 approved 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 Plan.

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • After hours care in your doctors office • Emergency care at an urgent care center • Emergency care at a hospital, including doctors’ services 	<p>\$10 per office visit</p> <p>\$10 per visit</p> <p>\$50 per visit</p> <p>Note: You pay nothing if you are admitted to the hospital.</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>
Emergency outside our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care at a hospital, including doctors’ services 	<p>\$10 per office visit</p> <p>\$10 per visit</p> <p>\$50 per visit</p> <p>Note: You pay nothing if you are admitted to the hospital.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area.</i> • <i>Medical and hospital costs resulting from a full-term delivery of a baby outside the service area.</i> 	<i>All charges.</i>
Ambulance	
<p>Professional ambulance service, including air ambulance services when medically appropriate.</p> <p>See 5(c) for non-emergency service.</p>	Nothing

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

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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.
- We do not have a 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.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

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Benefit Description	You pay
Mental health and substance abuse benefits	
<p>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.</p> <p>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.</p>	<p>Your cost sharing responsibilities are no greater than for other illness or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, Psychologists, or clinical social workers • Medication management 	<p>\$10 per visit</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>\$10 per visit or test</p>
<ul style="list-style-type: none"> • 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 	<p>Nothing</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>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.</i></p>	<p><i>All charges.</i></p>

Mental health and substance abuse benefits (Continued)

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow the authorization processes:

If you are enrolled in CY,2N,7Z,GF or WB Call PacifiCare Behavioral Health at 1(800) 999-9585. If you are enrolled in A3 you can call Contact Behavioral Health at 1(800) 888-1477. If you are enrolled in K9 call Harmony Behavioral Health at 1(800) 363-4874. Customer Service department.

If you are enrolled in CY,2N,7Z,GF or WB you can call PacifiCare Behavioral Health at 1(800) 999-9585 to get a list of providers or visit their website at www.pbhi.com.

If you are enrolled in A3 you can call Contact Behavioral Health at 1(800) 888-1477 if you are enrolled in K9 you can call Harmony Behavioral Health at 1(800) 363-4874 to get a list of providers or visit their websites at www.contact.com or www.harmony.com.

Section 5 (f). Prescription drug benefits

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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.

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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 pharmacists 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. We cover non-Formulary drugs prescribed by a Plan doctor.

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.

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.
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- **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.

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 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.

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) 531-3341 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) 531-3341.
 - **Why use generic drugs?** To reduce your out-of-pocket expenses! A generic drug is the chemical equivalent of a corresponding brand name drug. Generic drugs are less expensive than brand name drugs; therefore, you may reduce your out-of-pocket costs by choosing to use a generic drug.
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Benefit Description	You pay
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as not covered • 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 22) • Prenatal vitamins • Oral medications prescribed to treat infertility, or the underlying cause of infertility including Clomiphene Citrate, Bromocriptine Mesylate and Dexamethasone (Injectable infertility are covered under Section 5(a) Infertility Services) <p>Limited benefits</p> <ul style="list-style-type: none"> • 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. 	<p>\$5 per generic formulary prescription unit or refill.</p> <p>\$15 per brand formulary prescription unit or refill.</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Non-prescription medicines</i> • <i>Drugs obtained at a non-Plan pharmacy except for out of area emergencies.</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers [them(except prenatal Vitamins)]</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Diet Pills</i> • <i>Drugs for and supplies for cosmetic purposes (such as diet pills)</i> • <i>Drugs to enhance athletic performance</i> • <i>Smoking cessation drugs and medication, including nicotine patches unless you are enrolled in our Smoking Cessation program. (See page 37)</i> • <i>Diabetic supplies, except those shown above</i> • <i>Injectable medications prescribed for the treatment of infertility</i> 	<p><i>All Charges.</i></p>

Section 5 (g). Special features

Feature	Description
PacifiCare PerksSM Program	A PacifiCare members only program which offers discounts for health clubs, alternative care, vitamins and much more!
Hearing Aids for Children	The Oklahoma Plan (2N) covers hearing aids for children up to the age of 13 years old.
Immunizations	<ul style="list-style-type: none"> • 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. • If you are enrolled in the California Plan (CY) or the Washington Plan (WB) you may receive the influenza or pneumococcal vaccine regardless of your age. • In Arizona all members can have routine DPT, Tetanus Toxoid, Oral Polio, MMR, Smallpox and Hepatitis B immunizations/Vaccines regardless of age.
Dental anesthesia and anesthesiologist costs	The Oklahoma Plan (code 2N) covers these expenses for certain dental procedures for children up to age 8 or for severely emotionally or physically disabled individuals.
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 or contact lenses.
Health Improvement Programs	<p>You pay nothing for the following PacifiCare Health Improvement Programs:</p> <p>Managing your Heart Health, Managing Diabetes,* Smoking Cessation, Healthy Pregnancy and Managing Depression.</p> <p>*There is a \$20 Prescription Drug copayment for smoking cessation products.</p>
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

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

- For more information call PacifiCare Dental 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.
- There is no waiting period for eligibility
- There is a \$1,000 calendar year maximum
- 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.
- For treatment or therapy of Temporal Mandibular Joint (TMJ) disorders See section 5 (a) Medical benefits
- 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.

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Accidental injury benefit	You pay
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

Service	We pay (Scheduled Amount)	You pay
Dental benefits		
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% UCR	All charges in excess of the scheduled amounts listed to the left
Intraoral X-rays (one bitewing series of four every six months, one full mouth per five years)	For all preventive and diagnostic services.	
Prophylaxis (one every six months)		

Service	We pay (Scheduled Amount)	You pay
Dental benefits <i>(Continued)</i>		
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	
Extractions	\$15	

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, Healthy baby, Weight Watchers and much more through the **PacifiCare PerksSM** 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 and/or a PPO 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. The Non-FEHB dental benefits will not be coordinated with the dental benefits included with your medical plan.

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 Vision's 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.

Medicare prepaid plan enrollment – This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 4, 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.

*Not available in California due to regulatory requirements.

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 and hospital, prescription drugs, and Durable Medical Equipment (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 of the 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	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: 5995 Plaza Drive MS. CY 20-303, Cypress, CA 90630; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial – go to step 4; orAsk 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	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us — if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street NW, Washington, D.C. 20415-3630.</p>

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 include 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 or the year in which you were denied precertification or prior approval. 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 3 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 . If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. . Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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

When you are enrolled in Original Medicare along with this Plan, 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 Payer chart begins on next page.)

The following chart illustrates whether the Original Medicare Plan 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 for 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, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

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

- 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 website at www.pacificare.com, you can fax us at (714) 226-3575.

We do not waive any costs when you have Medicare.

• **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare + Choice Plan – 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 provide all the benefits that Original Medicare covers. 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 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.

If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care Plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in 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.

• **If you do not enroll in Medicare Part A or Part B**

Note: If you do not have one or both parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

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 illness 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 care. 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 14.
Coinsurance	We do not have Coinsurance.
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.
Experimental or Investigational Services	Our National and Regional Medical Committees determine whether or not treatments, procedures and drugs are no longer considered experimental or investigational. Our determinations are based on the safety and efficacy of new medical procedures, technologies, devices and drugs.
Medical necessity	Medical necessity refers to medical services or hospital services that are determined by us to be: <ul style="list-style-type: none">• 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 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 joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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.

- **Temporary Continuation of Coverage (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, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

Enrolling In TCC 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. It explains what you have to do to enroll

- **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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group 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.

For more information get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the “TCC and HIPAA” frequently asked question. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

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.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think their health plan and/or Medicare covers long-term care. Unfortunately, they are **WRONG!**
- How are YOU planning to pay for the future custodial or chronic care you may need? Consider buying long term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for care in a nursing home, in an assisted living facility, in your home, adult day care, hospice care, and more. LTC insurance can supplement care provided by family members, reducing the burden you place on them.

I'm healthy. I won't need long term care. Or, will I?

- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but you should have a plan just in case. LTC insurance may be vital to your financial and retirement planning.

Is long term care expensive?

- Yes. A year in a nursing home can exceed \$50,000 and only three 8- hour shifts a week can exceed \$20,000 a year, that's before inflation!
- LTC can easily exhaust your savings but LTC insurance can protect it.

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look under "Not covered" in sections 5(a) and 5(c) of your FEHB brochure. Custodial care, assisted living, or continuing home health care for activities of daily living are not covered. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care after a hospitalization with a 100 day limit.
- Medicaid covers LTC for those who meet their state's guidelines, but restricts covered services and where they can be received. LTC insurance can provide choices of care and preserve your independence.

When will I get more information?

- Employees will get more information from their agencies during the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- A toll-free telephone number will begin in mid-2002. You can learn more about the program now at www.opm.gov/insure/ltc.

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 2002. Open season enrollments will be effective January 1, 2002. 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 2001 open season, November 12, 2001, through December 10, 2001. Your coverage will begin January 1, 2002. 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 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 2002 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at www.opm.gov.

Temporary Continuation of Coverage (TCC)

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.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for the *PacifiCare Health Plans – 2002*

- **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: <ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office • Eye Exams 	Office visit copay: \$10 primary care; \$10 specialist	16-23
Services provided by a hospital: <ul style="list-style-type: none"> • Inpatient • Outpatient 	Nothing per admission \$10 copay per office visit	28 29
Emergency benefits: <ul style="list-style-type: none"> • In-area • Out-of-Area 	\$50 per emergency room visit \$50 per emergency room visit	31 31
Mental health and substance abuse treatment	Regular benefits	32-33
Prescription drugs	\$5 copay for generic formulary prescriptions \$15 for brand formulary prescriptions	34-36
Dental Care	Nothing for preventive services; scheduled allowance for other services	38-39
Vision Care	Discounts for frames and lenses through the PacifiCare Perks SM program.	37
Eye Exams	\$10 copayment per office visit	20-21
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after \$1,500/Self Only or \$3,000/Family enrollment per calendar year Some costs do not count toward this protection	14

2002 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 contact 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, 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 who are not career postal employees. Refer to the applicable FEHB Guide.

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

Arizona: Maricopa, Pima County and Apache Junction

Self Only	A31	\$86.99	\$29.00	\$188.48	\$62.83	\$102.94	\$13.05
Self and Family	A32	\$223.41	\$101.66	\$484.06	\$220.26	\$263.75	\$61.32

California: Northern and Southern California

Self Only	CY1	\$70.04	\$23.34	\$151.74	\$50.58	\$82.87	\$10.51
Self and Family	CY2	\$182.63	\$60.87	\$395.69	\$131.89	\$216.11	\$27.39

Nevada: Las Vegas/Clark County

Self Only	K91	\$88.57	\$29.52	\$191.90	\$63.96	\$104.80	\$13.29
High Option Self and Family	K92	\$223.41	\$77.30	\$484.06	\$167.48	\$263.75	\$36.96

Continued on next page.

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

Oklahoma: Central and Northeastern Oklahoma

Self Only	2N1	\$76.82	\$25.61	\$166.45	\$55.48	\$90.91	\$11.52
Self and Family	2N2	\$200.87	\$66.95	\$435.21	\$145.07	\$237.69	\$30.13

Oregon: Metro Portland, Salem, Corvallis, Eugene and Southwest Washington

Self Only	7Z1	\$97.86	\$69.05	\$212.03	\$149.61	\$115.52	\$51.39
Self and Family	7Z2	\$223.41	\$146.40	\$484.06	\$317.20	\$263.75	\$106.06

Texas: San Antonio, Dallas/Ft. Worth

Self Only	GF1	\$74.71	\$24.90	\$161.87	\$53.95	\$88.40	\$11.21
Self and Family	GF2	\$195.32	\$65.10	\$423.18	\$141.06	\$231.12	\$29.30

Washington: Puget Sound/Most West Washington

Self Only	WB1	\$97.86	\$33.01	\$212.03	\$71.52	\$115.52	\$15.35
Self and Family	WB2	\$223.41	\$119.68	\$484.06	\$259.30	\$263.75	\$79.34