PacifiCare of Nevada

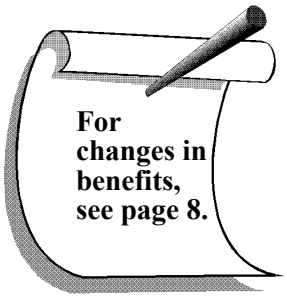
http://www.uhcfeds.com

2009

A Health Maintenance Organization

Serving: Clark County

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 6 for requirements.



Enrollment codes for this Plan:

Nevada
K91 Self Only
K92 Self and Family

This plan has Commendable Accreditation from the NCQA. See the 2009 FEHB Guide for more information on NCQA.

Authorized for distribution by the:

United States
Office of Personnel Management

Center for
Retirement and Insurance Services
http://www.opm.gov/insure

RI 73-832

Important Notice from PacifiCare About
Our Prescription Drug Coverage and Medicare

OPM has determined that PacifiCare's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048

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Introduction

This brochure describes the benefits of PacifiCare of Nevada, under our contract (CS 2899) with the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for PacifiCare's administrative offices is:

PacifiCare of Nevada
P.O. Box 30975
Salt Lake City, UT 84130

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in 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, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language 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 United States 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 fehbwebcomments@opm.gov. You may also write to the OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning and Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider 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 866/546-0510 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1.Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2.Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3.Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4.Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5.Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - Exactly what will you be doing?
  - About how long will it take?
  - What will happen after surgery
  - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

- www.talkaboutrx.org/. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

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.

General Features of our High Option

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, and our providers. OPM's FEHB Web site (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 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 866/546-0510, or write to P.O. Box 30975, Salt Lake City, UT 84130. You may also contact us by fax at 480/303-7678 or visit our Web site at www.uhcfeds.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies

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:

Nevada

Serving: Clark County identified by the following cities:

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

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 2009

Do not rely only on these change descriptions; this Section 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.

Changes to this Plan

- Your share of the non-Postal premium will increase for Self Only or increase for Self and Family. See page 70.

- **Surgical treatment of morbid obesity** - The Plan will now cover the following two surgical procedures for treatment of morbid obesity: *Rouxen-Y bypass and Lap Band Surgery*. The Plan no longer covers vertical banded gastroplasty as treatment for morbid obesity.
- **Catastrophic protection** - The Plan will decrease the out of pocket maximum to $2,500 for self only and $7,500 for self and family enrollment.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as 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 866/546-0510 or write to us at PacifiCare, P.O. Box 30975, Salt Lake City, UT 84130. You may also request replacement cards through our Web site at www.uhcfeds.com.

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 Web site, which you can also access at www.uhcfeds.com.

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

- **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 within their primary medical group once every twelve months for the well-woman exam, 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 hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 866/546-0510. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

How to get approval for…

- **Your hospital stay** — Your primary care Physician will prearrange any medically necessary hospital or facility care, including inpatient Transitional Care or care provided in a Subacute/Skilled Nursing Facility. If you've been referred to a Specialist and the Specialist determines you need hospitalization, your Primary Care Physician and Specialist will work together to prearrange your hospital stay.
- **How to precertify an admission** — Your primary care Physician will prearrange any medically necessary hospital or facility care, including inpatient Transitional Care or care provided in a Subacute/Skilled Nursing Facility.
- **Maternity care** — Your OB/GYN or your contracted Medical Group will pre-arrange your hospital stay.
- **What happens when you do not follow the precertification rules when using non-network facilities** — You will be financially responsible for these services except emergency or urgently needed services.

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 but not limited to:

- Cardiovascular bypass surgery
- Septoplasty
- Cholecystectomy
- Hysterectomy
- Arthroplasty
- Specialized scanning diagnostic exams
- Growth Hormone Treatment (GHT)
- Bariatric surgery

PacifiCare 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 Interpretation Committee and Technology Assessment and Guideline 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

This is what you will pay out-of-pocket for covered care.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility or pharmacy when you receive certain services.

Example: When you see your primary care physician you pay a copayment of $15 per office visit and when you go in the hospital, you pay $150 per day up to 5 days per inpatient admission.

Note: If the billed amount or the Plan allowance that providers we contract with have agreed to accept as payment in full is less than your copayment, you pay the lower amount.

Cost-Sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. deductible, coinsurance, and copayments) for the covered care you receive.

Deductible

We do not have a deductible.

Coinsurance

Coinsurance is the percentage that you must pay for your care.

Example: You pay 50% for covered infertility services.

Waivers

In some instances, a PacifiCare provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the content of the contracts that the Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at 866/546-0510.

Your catastrophic protection out-of-pocket maximum

After your copayments and coinsurance total $2,500 per person or $7,500 per self and 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 catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription Drugs
- Dental services
- Vision services
- Chiropractic services

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

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

When Government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

High Option Benefits

See page 8 for how our benefits changed this year.

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Section 5. High Option Benefits Overview

This Plan offers a High Option. The benefit package is described in Section 5. Make sure that you review the benefits.

Please read *Important things you should keep in mind* at the beginning of the sections. Also read the General exclusions in Section 6, they apply to the benefits in the following sections. To obtain claim forms, claims filing advice, or more information about High Option benefits, contact us at 866/546-0510 or at our Web site at www.uhcfeds.com.

High Option

Office visit copay	**$15**
Specialist visit copay	**$30**
Prescription drugs	**$10 for generic formulary drugs** **$30 for brand-name formulary** **$50 for non-formulary drugs** **Mail order prescription drugs require 2 copayments for a 90-day supply**
Inpatient hospital copay	**$150 per day up to 5 days per inpatient admission**
Outpatient hospital/ambulatory surgical center	**$150 per outpatient surgery or procedure**
Chiropractic services	**$15 per visit.** **20 visits each calendar year to chiropractors when authorized by the Plan.**
Dental services	**Covered at 100% for diagnostic & preventive services, and up to a maximum allowable fee for basic and major services**
Vision exam	**$15 per PCP office visit** **$30 per specialist vist** **You receive one annual eye refraction in a twelve month period. Your annual eye refraction must be performed by an optometrist or ophthalmologist contracted with your medical group or IPA.**
Vision hardware	**After you pay a $25 copayment toward vision hardware, you will receive either a $100 allowance toward frames and lenses every 24 months or an $85 allowance toward contact lenses every 24 months at a participating UnitedHealthcare Vision provider.**

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

Important things you should keep in mind about these benefits:

- Please remember 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.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- 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.

Benefit Description	You Pay
Diagnostic and treatment services	**High Option**
Professional services of physicians • In a physician's office • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion	$15 per primary care physician (PCP) office visit $30 per specialist office visit $45 copayment per urgent care center Nothing for inpatient services
At home doctors house calls or visits by nurses and health aides	$15 per visit
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Electrocardiogram • EEG	Nothing
Specialized scanning diagnostic exams	**High Option**
• CT Scans • PET Scans • SPECT Scans • MRI • Nuclear Scans • Angiograms (including heart catherizations) • Arthrograms • Myelograms	$200 copayment per scan. **Note**: There will be a separate copay per body part scanned per visit.

Specialized scanning diagnostic exams - continued on next page

Benefit Description	You Pay
Specialized scanning diagnostic exams (cont.)	**High Option**
• Ultrasounds not associated with maternity care **Note**: Preauthorization is required for specialized scanning diagnostic exams.	$200 copayment per scan. **Note**: There will be a separate copay per body part scanned per visit.
Preventive care, adult	**High Option**
Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy, screening – every five years starting at age 50. - Double contrast barium enema - every five years starting at age 50. - Colonoscopy screening - every ten years starting at age 50.	Nothing if you receive these services during your office visit; otherwise, $15 per PCP office visit, $30 per specialist office visit
Routine Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	$15 per PCP office visit, $30 per specialist office visit
Routine pap test **Note**: The office visit is covered if pap test is received on the same day; see Diagnosis and Treatment, above.	$15 per PCP office visit, $30 per specialist office visit
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): • Influenza vaccines, annually, including women who are pregnant. • Pneumococcal vaccine, age 65 and over. • Varicella (Chickenpox) - all persons age 19 to 49 years • Tetanus Diptheria and Pertussis (Tdap) - ages 19 to 64, with booster every ten years. • Tetanus-diptheria (Td) - booster once every ten years, ages 65 and over.	Nothing if you receive these services during your office visit; otherwise, $15 per PCP office visit, $30 per specialist office visit
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* • *Immunizations for travel*	*All charges*

Benefit Description	You Pay
Preventive care, children	**High Option**
• Childhood immunizations recommended by the American Academy of Pediatrics and the ACIP • Meningococcal vaccines	Nothing if you receive these services during your office visit; otherwise; $15 per PCP office visit, $30 per specialist office visit
• Well-child care charges for routine examinations, immunizations and care (up to age 22 years). • Examinations, such as: - Eye exams to determine the need for vision correction. - Ear exams to determine the need for hearing correction. - Examinations done on the day of immunizations (up to age 22 years).	$15 per PCP office visit, $30 per specialist office visit
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care **Note**: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see below 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, you do not need to precertify the normal length of stay. We will extend your inpatient stay for you or your baby 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. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	A single $30 copayment for the entire pregnancy.
Not covered: Routine sonograms and genetic testing to determine fetal sex.	*All charges*
Family planning	**High Option**
A broad range of family planning services such as: • Voluntary sterilization (See Surgical procedures Section 5(b) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) **Note**: We cover oral contraceptives, contraceptive patches and rings, contraceptive diaphragms and cervical caps under the prescription drug benefit.	$15 per PCP office visit, $30 per specialist office visit. $150 copayment if done at an outpatient surgical center.

Family planning - continued on next page

Benefit Description	You Pay
Family planning (cont.)	**High Option**
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling, unless part of authorized genetic testing.*	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of infertility, such as: • Artificial insemination: (Up to **three** cycles per pregnancy attempt) - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI)	50% of all covered charges
Not covered: • *Advanced reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote* - *intra-fallopian transfer (ZIFT)* • *Services and supplies related to excluded ART procedures* • *Fertility drugs* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Allergy care	**High Option**
• Testing and treatment • Allergy injection	$15 per PCP office visit, $30 per specialist office visit
Allergy Serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization.	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy **Note**: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 27. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) **Note**: We will only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$30 per treatment

Treatment therapies - continued on next page

Benefit Description	You Pay
Treatment therapies (cont.)	**High Option**
Not covered: Other treatment services not listed as covered.	*All charges*
Physical and occupational therapies	**High Option**
Physical therapy, occupational therapy • Unlimited visits for the services of each of the following: - qualified physical therapists; - occupational therapists **Note**: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function or due to illness or injury. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided with no day limit. • Pulmonary Rehabilitation	$30 copayment per treatment or therapy visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Cognitive Behavioral Therapy except initial neuropsychological testing* • *Development and Neuroeducational testing and treatment beyond initial diagnosis* • *Hypnotherapy* • *Vocational Rehabilitation* • *Psychological testing*	*All charges*
Speech therapy	**High Option**
Unlimited visits for the services of: • Qualified speech therapists **Note**: All therapies are subject to medical necessity	$30 per visit
Hearing services (testing, treatment, and supplies)	**High Option**
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing (see Preventive care)	$15 per PCP office visit, $30 per specialist visit
Not covered: • *All other hearing testing* • *All other hearing aids*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	$15 per PCP office visit, $30 per specialist visit
• You receive one annual eye refraction in a twelve month period. Your annual eye refraction must be performed by an optometrist or ophthalmologist contracted with your medical group or IPA.	$15 per PCP office visit, $30 per specialist visit

Vision services (testing, treatment, and supplies) - continued on next page

Benefit Description	You Pay
Vision services (testing, treatment, and supplies) (cont.)	**High Option**
• Medically necessary contact lenses are covered at no charge after your copayment when required for Anisometropia or Keratoconus, or following cataract surgery, or when visibly acuity can not be corrected to 20/70 in the better eye, and conventional type lenses will not improve visual acuity to 20/70 or better. **Note**: See preventive care children for eye exams for children	$15 per PCP office visit, $30 per specialist visit
• You will receive a $100 allowance towards eyeglass frames at a participating UnitedHealthcare Vision provider in a 24 consecutive month period. • After your copayment, you pay nothing for eyeglass lenses purchased at a participating UnitedHealthcare Vision provider. • You will receive an $85 allowance towards contacts in lieu of eyeglasses at a participating UnitedHealthcare Vision provider. **Note:** Eye examinations are not covered through UnitedHealthcare Vision providers, but are a benefit of your medical plan. Please see coverage for eye examinations stated above.	$25 copayment
Not covered: • *Eyeglasses or contact lenses except as mentioned above* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Contact lens fitting*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. **Note**: See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$15 per PCP office visit, $30 per specialist visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above.* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery).*	*All charges*
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes; stump hose. • Foot orthotics when medical criteria is met. • Custom or standard orthopedic shoes for diabetic foot disease or when permanently attached to a medically necessary orthopedic brace. • 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.	Nothing

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You Pay
Orthopedic and prosthetic devices (cont.)	**High Option**
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.	Nothing
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than three years after the last one we covered*	*All charges*
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Under this benefit, we also cover durable medical equipment prescribed by your Plan physician such as, but not limited to: • Oxygen; • Dialysis equipment; • Orthopedic brace; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Insulin pumps. **Note**: Call us at 866/546-0510 as soon as your Plan physician prescribes this equipment. We will advise you of the appropriate provider to contact to arrange rental or purchase of this equipment.	20% of the cost up to $1,500 per calendar year and all charges above $1,500
Not covered: • *Specialized wheelchairs for comfort and convenience.* • *Any item not medically necessary*	*All charges*
Home health services	**High Option**
• 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 for members who are homebound or confined to an institution that is not a hospital. Homebound members are those who have a physical condition such that there is a normal inability to leave the home. • Services include oxygen therapy, intravenous therapy and medications.	Nothing

Home health services - continued on next page

Benefit Description	You Pay
Home health services (cont.)	**High Option**
• Injectable medications for home use and self-administration by patient when approved by the Plan or your Medical Group. **Note**: Self- injectable drugs are covered under the prescription drug benefit. Please see Section *5(f)*.	$50 copayment per prescription
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative.* • *24 hour nursing care*	*All charges*
Chiropractic care	**High Option**
Chiropractic services – You may self refer to a participating chiropractor for your first visit. A treatment plan must be approved for all follow up visits. When authorized by the Plan, you will receive: • 20 visits each calendar year to chiropractors. • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application.	$15 copayment per visit
Alternative treatments	**High Option**
No benefit	*All charges*
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Massage therapy* • *Acupuncture*	*All charges*
Educational classes and programs	**High Option**
Coverage is limited to: • Smoking cessation – including all related expenses such as Nicotine Replacement* • Taking Charge of Your Heart Health • Diabetes self-management (Taking Charge of Diabetes®) • Pregnancy to Pre-School • Managing Depression For health improvement programs offered in your area and for costs associated with those programs, call 866/546-0510.	***Note**: There is a $20 prescription drug copayment for smoking cessation products.

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

Important things you should 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.
- 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 FOR 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.

Benefit Description	You Pay
Surgical procedures	**High Option**
A comprehensive range of services, such as: • 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 • Circumcision • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity (bariatric surgery). Surgery is limited to Rouxen-Y bypass and Lap Band Surgery. **Note**: The following conditions must be met: > Eligible members must be age 18 or over. > Eligible members must weigh 100 pounds or 100% over their normal weight according to current underwriting standards. > Eligible members must meet the National Institute of Health guidelines, which can be found at http://www.nlm.nih.gov/medlineplus/ > We may require you to participate in a non-surgical multidisciplinary program approved by us for six months prior to your bariatric surgery. > We will determine the provider for the non-surgical program and surgery based on quality and outcomes. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy)	$15 per PCP office visit, $30 per specialist office Nothing for surgery - $150 copayment per day up to 5 days per inpatient admission or $150 copayment for outpatient surgery.

Surgical procedures - continued on next page

Benefit Description	You Pay
Surgical procedures (cont.)	**High Option**
• Treatment of burns **Note**: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$15 per PCP office visit, $30 per specialist office Nothing for surgery - $150 copayment per day up to 5 days per inpatient admission or $150 copayment for outpatient surgery.
Not covered: • *Reversal of voluntary sterilizationRoutine treatment of conditions of the foot; see Foot care.*	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: – the condition produced a major effect on the member's appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: – surgery to produce a symmetrical appearance on the other breast; – treatment of any physical complications, such as lymphedemas; – breast prostheses and surgical bras and replacements (see Prosthetic devices) **Note**: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure..	Nothing for surgery - $150 copayment per day up to 5 days per inpatient admission or $150 copayment for outpatient surgery
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance of a normal body part through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and	Nothing for surgery - $150 copayment per day up to 5 days per inpatient admission or $150 copayment for outpatient surgery.

Oral and maxillofacial surgery - continued on next page

Benefit Description	You Pay
Oral and maxillofacial surgery (cont.)	**High Option**
• Other surgical procedures that do not involve the teeth or their supporting structures. • TMJ surgery and related non-dental treatment.	Nothing for surgery - $150 copayment per day up to 5 days per inpatient admission or $150 copayment for outpatient surgery.
Not covered: • *Oral implants and transplants* • *Procedures associated with oral and dental implants, such as skin or bone grafting.* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*
Organ/tissue transplants	**High Option**
Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to *Other services* in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description. • Cornea • Heart • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas	Nothing for surgery - $150 copayment per day up to 5 days per inpatient admission.
Blood or marrow stem cell transplants limited to the stages of the following diagnoses: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myelogenous leukemia - Hemoglobinopathy (i.e. Fanconi's, Thalessemia major) - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis • Autologous transplants for	Nothing for surgery - $150 copayment per day up to 5 days per inpatient admission.

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	**High Option**
- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Neuroblastoma - Amyloidosis • Autologous tandem transplants for - Recurrent germ cell tumors (including testicular cancer) - Muliple myeloma - De-novo myeloma	Nothing for surgery - $150 copayment per day up to 5 days per inpatient admission.
Blood or marrow stem cell transplants for • Allogeneic transplants for - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced neuroblastoma - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies - Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer - Ependymoblastoma - Ewing's sarcoma - Medulloblastoma - Pineoblastoma - Waldenstrom's macroglobulinemia	Nothing for surgery - $150 copayment per day up to 5 days per inpatient admission.
Mini-transplants (non-myeloblative, reduced intensity conditioning) for covered transplants: Subject to medical necessity	
Tandem transplants for covered transplants: Subject to medical necessity	

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	**High Option**
Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for. • Allogeneic transplants for - Chronic lymphocytic leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Myelodysplasia/Myelodysplastic syndromes - Multiple myeloma - Multiple sclerosis • Nonmyeloablative allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Myelodysplasia/myelodysplastic syndromes - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Multiple myeloma - Multiple sclerosis - Myeloproliferative disorders - Sarcomas • Autologous transplants for - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Small cell lung cancer - Multiple sclerosis - Systemic lupus erythematosus - Systemic sclerosis • National Transplant Program (NTP) **Limited Benefits** • Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in a National Cancer Institute or National Institute of Health-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.	Nothing for surgery - $150 copayment per day up to 5 days per inpatient admission.

Organ/tissue transplants - continued on next page

Benefit Description	You Pay
Organ/tissue transplants (cont.)	**High Option**
• Bone marrow stem cell donor search and testing for compatible unrelated donors up to $15,000 per procedure at a National Preferred Transplant Facility when you are the intended recipient. **Transportation, food and lodging -** If you live over 60 miles from the transplant center and the services are pre-authorized by us: • Transportation limited to you and one escort to a National Preferred Transplant Network or other Company Approved Transplant Facility. • Lodging and food; you receive a $125 allowance per day for housing and food. This allowance excludes liquor and tobacco. **Note**: We cover related medical and hospital expenses of the donor when we cover the recipient. We also cover donor screening charges for immediate family members to include spouses, parents, children, siblings and, if appropriate, grandparents.	Nothing for surgery - $150 copayment per day up to 5 days per inpatient admission.
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**High Option**
Professional services provided in: Hospital (inpatient)	Nothing after your $150 copayment per day up to 5 days per inpatient admission.
Professional services provided in: • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing after your $150 copayment per outpatient surgery or $75 copayment per day up to 5 days per admission to skilled nursing facility

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

Important things you should 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).

• **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You Pay
Inpatient hospital	**High Option**
Room and board, such as: • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. • Operating, recovery, maternity, and other treatment rooms **Note**: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$150 copayment per day up to 5 days per inpatient admission.
Other hospital services and supplies, such as: •Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • 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: *• Custodial care* *• Non-covered facilities, such as nursing homes and schools*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	**High Option**
Not covered continued: *• Personal comfort items, such as telephone, television, barber services, guest meals and beds* *• Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery, and other treatment rooms • 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 • 23 hour observation • Non-surgical medical services **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.	$150 copayment per outpatient surgery or procedure.
Extended care benefits/Skilled nursing care facility benefits	**High Option**
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. All necessary services are covered up to 100 days per calendar year, including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	$75 copayment up to 5 days per admission
Not covered: • *Custodial care* • *Homemaker Services* • *24 hour nursing* • *Private Duty Nursing*	*All charges*

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

Section 5(d). Emergency services/accidents

Important things you should 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.

• 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.

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 physician. 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 a non-Plan facility 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 plan 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	**High Option**
• Emergency care at a doctor's office	$15 per PCP office visit, $30 per specialist visit
• After hours care in your doctor's office	$15 per PCP office visit, $30 per specialist visit
• Emergency care at an urgent care center	$45 per visit

Emergency within our service area - continued on next page

Benefit Description	You pay
Emergency within our service area (cont.)	**High Option**
• Emergency care at a hospital, including doctors' services	$100 copayment per emergency room visit **Note**: We waive the $100 copayment if you are admitted to the hospital.
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	**High Option**
• Emergency care at a doctor's office	$15 per PCP office visit, $30 per specialist visit
• Emergency care at an urgent care center	$45 per urgent care center visit
• Emergency care at a hospital, including doctors' services	$100 copayment per emergency room visit **Note**: We waive the $100 copayment if you are admitted to the hospital.
Not covered: *•Elective care or non-emergency care* *• Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area.* *• Medical and hospitalcosts resulting from a full-term delivery of a baby outside the service area.*	*All charges*
Ambulance	**High Option**
Professional ambulance service, including air ambulance services when medically appropriate. See 5(c) for non-emergency services.	Nothing

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

- 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.

Important things you should 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.

- 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 FOR THESE SERVICES** (See the instructions after the benefits description below).**YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You Pay
Mental health and substance abuse benefits	**High Option**
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. **Note**: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by Behavioral Health providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$30 per visit
Diagnostic tests such as routine lab work and X-rays	Nothing
Specialized scanning • CT Scans • PET Scans • MRI's • SPECT Scans • Nuclear Scans • Angiograms (including heart catherizations) • Arthrograms • Myelograms • Ultrasounds not associated with maternity care	$200 copayment per scan. **Note**: There will be a separate copay per body part scanned per visit.
• 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	$150 per day up to 5 days per admission.
Not covered: Services we have not approved.	*All charges*

Mental health and substance abuse benefits - continued on next page

Benefit Description	You Pay
Mental health and substance abuse benefits (cont.)	**High Option**
***Note**: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Preauthorization	To receive these benefits you must obtain a treatment plan and follow the authorization processes. Please call the following customer service department in your area to access benefits or to obtain a list of providers: PacifiCare Behavioral Health at 1 (800) 999-9585 (Web site www.pbhi.com)
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a 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.

- **There are important features you should be aware of. These include:**
- **Who can write your prescription.** A plan physician must write the prescription including medically necessary prescriptions authorized for dental treatment.
- **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 over 1,600 prescription drugs that physicians use as a guide when prescribing medications for patients. The formulary plays an important role in providing safe, effective and affordable prescription drugs to PacifiCare members. It also allows us to work together with physicians and pharmacists to ensure that our members are getting the drug therapy they need. A Pharmacy and Therapeutics Committee evaluates prescription drugs for safety, effectiveness, quality treatment and overall value. The committee considers first and foremost the safety and effectiveness of a medication before they review the cost. The formulary is updated on a regular basis. You may obtain a copy of the formulary by calling Customer Service or by logging on to the PacifiCare Web site at www.uhcfeds.com. PacifiCare uses a generic based formulary. Prescriptions will be filled with generics whenever possible. If you or your physician prefer a brand name product when a formulary generic equivalent is available, you will pay the applicable copayment.
- **These are the dispensing limitations.** Prescription drugs prescribed by a Plan PCP or specialist and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. For medications that come in trade size packages, you will be responsible for one applicable copayment per prepackaged unit. Non-formulary drugs will be covered when prescribed by a Plan doctor. Clinical edits (limitations) can be used for safety reasons, quantity limitations, age limitations and benefit plan exclusions and may require prior authorization. We may require you to update prior authorizations for certain medications.
- You will get up to a **30-day supply**, 2 vials of the same kind of insulin or one commercially prepared unit (i.e., one inhaler, one vial of ophthalmic medication, topical ointment or cream) for a $10 copayment per prescription unit or refill for generic formulary drugs or a $30 copayment for name brand formulary drugs or a $50 copayment for generic or brand name non-formulary drugs. Some drugs may be dispensed in quantities other than a 30-day supply. They are;
  - Medications with quantity limits that may be set at a smaller amount to promote appropriate medication and patient safety.
  - Pre-packaged medications such as inhalers, eye drops, creams or other types of medications that are normally dispensed in pre packaged units of 30 days or less will be considered one prescription unit.
  - Medications that are manufactured in prescription units to exceed a 30-day supply may be subject to more than one copayment.
- **Mail Order**. The most convenient and affordable way to obtain your prescriptions is to take advantage of our mail service program. In the event of a national emergency, please contact your pharmacist about obtaining an override. Should you need assistance with your medications, please contact our Customer Service Department at 1 (800) 624-8822 or TDHI 1 (800) 442-8833. Prescription drugs may also be dispensed 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 $20 copayment per prescription unit or refill for generic formulary drugs, a $60 copayment for name brand formulary maintenance medications or a $100 copayment for generic or brand non-formulary medications.

- **Active Military Duty**. If you are called to active military duty or in the event of a National emergency and you are in need of prescription medications call 1 (800) 562-6223.
- **When you have to file a claim.** Please refer to Section 7 for information on how to file a pharmacy claim, or contact our Customer Service Department at 1 (800) 562-6223.
- **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.

Benefit Description	You Pay
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require unit or refill. • 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 the following contraceptive devices: diaphragms, cervical caps and patches and rings. • Intravenous fluids and medications for home use (covered under Section 5(a) Home Health Services) – see page 23 • Prenatal vitamins • Drugs for the treatment of morbid obesity when medically necessary, criteria is met and authorized by the plan	$10 per generic formulary prescription unit or refill. $30 per brand formulary prescription unit or refill. $50 per non-formulary brand or generic medication. **Note**: If there is no generic equivalent available, you will still have to pay the brand-name copayment.
Limited benefits • Drugs to treat sexual dysfunction are covered when Plan's medical criteria is met. Contact the plan for dose limits.	50% of the cost of the medication per prescription unit or refill up to the dosage limit; You pay all charges above that.
• Self injectable drugs (except insulin) when preauthorized	$50 copayment per prescription unit or refill
Not covered: • *Non-prescription medicines* • *Drugs obtained at a non-Plan pharmacy except for out of area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them (except prenatal Vitamins)* • *Medical supplies such as dressings and antiseptics*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You Pay
Covered medications and supplies (cont.)	**High Option**
Not covered continued: • *Diet pills* • *Drugs and/or supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Smoking cessation drugs and medication, including nicotine patches unless you are enrolled in our Smoking Cessation program (see pages 24 & 43).* • *Diabetic supplies, except those shown above* • *Fertility drugs* • *Drugs prescribed by a dentist* • *Replacement of lost, stolen or destroyed medication*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- For more information call PacifiCare Dental at 1 (800) 229-1985.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payer of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- 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. For a full list of benefits, exclusions and limitations please refer to the Plan information pamphlet for the 2008 PacifiCare Dental Indemnity Plan for Federal Employees.
- You do not need to see plan providers, you may self refer to any dentist for dental services.
- There is no waiting period for eligibility to access these dental benefits; however, there are waiting periods to obtain bridges and dentures.
- There is a $1,000 calendar year maximum.
- Your PacifiCare medical plan covers 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.
- For medically necessary prescriptions authorized for dental treatment see Section 5 (f) Prescription drug benefits.

Benefit Description	You Pay
Accidental injury benefit	**High Option**
We cover immediate (within 48 hours) stabilization and emergency services for trauma/injury to jawbone, or surrounding oral structures, which includes treatment of severe pain, swelling or bleeding. This does not include the restoration, extraction or replacement of teeth.	$15 PCP office visit copayment, $30 specialist visit copayment $100 copayment if you receive services in an emergency room **NOTE**: The emergency room copayment is waived if you are admitted to the hospital.

Benefit Description	
Preventive and Diagnostic	**High Option**
ADA code **D0150** Comprehensive Oral exam **D0210** Intraoral X-rays (one bitewing series of four every twelve months, one full mouth per two years) and diagnostic services. **D1110** Prophylaxis (two times per calendar year)	100% Usual, customary and reasonable (UCR).

Benefit Description	
Basic and Major	**High Option**
D2140 Amalgam fillings (one tooth surface, primary or permanent teeth)	$18
D2150 Amalgam fillings (two tooth surfaces, primary or permanent teeth)	$23
D2751 Porcelain with metal crown	$200
D2740 Porcelain Crown	$125
D3310 Single root canal	$90
D3320 Bicuspid root canal	$115
D4341 Periodontal root planing and scaling (four or more teeth)	$30
D5110 Full mouth dentures (upper)	$232.50
D5120 Full mouth dentures (lower)	$232.50
D5213 Partial dentures	$225
D6250 Pontic- resin with high nobel metal	$82.50
D7140 Extractions	$15

Note: There is a waiting period for bridges and dentures. Initial dentures or bridges are covered after a 36- month deferment period if all the teeth being replaced were missing before the covered person's coverage became effective under this plan. If you were covered under another dental plan immediately before enrolling in this plan, that time will be applied to your deferment period. Replacement dentures are covered only if we have written proof that your existing bridge or denture cannot be made fit for use and it is at least 5 years old.

Section 5(h). Special features

Feature	Description
Feature	**High Option**
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Health Improvement Programs	Through **Health A to Z**, PacifiCare plan members have access to the following health improvement programs: **Managing your Heart Health, Managing Diabetes, Smoking Cessation*, and Managing Depression**. For health improvement programs offered in your area and costs associated with these programs call 866/546-0510. Available to PacifiCare medical members, Health A to Z provides you with tools that can help contribute to your overall health and well-being. It offers premier motivational and interactive tools that allow you to make better health and lifestyle management choices. Find out ways to improve your emotional well-being and create a plan to help motivate your children. And along the way, why not be rewarded for your healthful lifestyle choices? With Health A to Z, you can earn credits that can be used to get discounts on fitness items. *There is a $20 Prescription Drug copayment for smoking cessation products..
Member discount programs	10% - 50% discount on many health and wellness purchases such as: **Vision Care** – Laser Eye Surgery **Alternative Medicine** – such as Chiropractic and Acupuncture **Health supplies** – vitamins, supplements, family household medical items and Hearing Devices Call 866/546-0510 for a complete list of special services, or visit www.uhcfeds.com

Feature - continued on next page

Feature	Description
Feature (cont.)	**High Option**
Travel benefit/services overseas	Covered for emergencies only.
Services for deaf and hearing impaired	TTY phone line - 877/777-6534
Centers of excellence	Services performed at Centers of Excellence are covered when medically necessary and preapproved. You pay $15 for outpatient PCP visits, $30 for specialist visits and $150 per day up to 5 days per admission for inpatient hospitalization.

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 catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan and all appeals must follow their guidelines. For additional information contact the Plan at 866/546-0510 or visit their website at www.uhcfeds.com.

Medicare Managed Care and Medicare Supplement plans

If you are Medicare eligible and are interested in enrolling in a Medicare HMO or a Medicare Supplement policy offered by this Plan without dropping your enrollment in this FEHB plan, call your group plan administrator at 800/637-9284, TDHI 800/387-1074 for information. Medicare Advantage –With over 1.4 million members*, SecureHorizons is the nation's largest provider of **Medicare Advantage** and related plans. SecureHorizons focuses on the health and well-being of Medicare beneficiaries, including seniors 65 and older and people with disabilities age 21 and older. As a member of SecureHorizons, you benefit from low or no plan copayments, low or no deductibles, and virtually no paperwork. SecureHorizons helps offer peace of mind for Medicare beneficiaries residing throughout the United States by offering more services than original Medicare for little additional cost. For more information, call toll free at 800/637-9284, TDHI 800/387-1074.

Medicare Supplement – SecureHorizons Medicare Supplement Plans pick up where Medicare leaves off, so you have less worry about overwhelming medical bills. As a Medicare beneficiary you can choose the level of coverage you feel best suits your needs. Choices range from a plan that covers some basic hospitalization and medical coinsurance expenses, to plans with richer benefit packages including foreign travel emergency and at-home recovery. For more information, call toll free (800/637-9284, TDHI 800/387-1074).

SecureHorizons® Direct!

If you have Medicare Parts A and B you may be eligible to enroll in this Medicare Advantage Private Fee-For-Service Plan. To find out more information on SecureHorizons Direct, call 800/776-8876, TDHI 800/387-1074.

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

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **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 services/accidents*);
- 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 (see specifics regarding transplants);
- 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.
- Services, drugs, or supplies you receive without charge while in active military service.

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, coinsurance, or deductible.

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. Your facility will file on the UB-92form. For claims questions and assistance, call us at 866/546-0510.

When you must file a claim – such as for services you received outside of the Plan's service area – 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.
- Be sure to keep a copy for your records.

Submit your claimsto:

PacifiCare of Nevada
P.O. Box 30975
Salt Lake City, UT 84130

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 benefits for 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/prior approval required by Section 3:

1 Ask us in writing to reconsider our initial decision. You must:

(a) Write to us within 6 months from the date of our decision; and

(b) Send your request to us at: P.O. Box 30975, Salt Lake City, UT 84130**;** and

(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and

(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

2 We have 30 days from the date we receive your request to:

(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or

(b) Write to you and maintain our denial – go to step 4; or

(c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.

3 You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

4 If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

• 90 days after the date of our letter upholding our initial decision; or

• 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or

• 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, D.C. 20415-3630.

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 more than one claim, 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.

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 866/546-0510 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 may call OPM's Health Insurance Group 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 or a covered family member has coverage under any other another group health plan or has 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 or older;
- Some people with disabilities under 65 years of age; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) 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.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) 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 Part A and Part 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.

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.

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

Claims process when you have the Original Medicare Plan – You will probably not need 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 provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claims, call us at 1 866/546-0510, visit us on our Web site at www.uhcfeds.com, or you can fax us at 925/602-1626.

We do not waive any costs if the Original Medicare Plan is your primary payer.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

	Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage 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 Advantage plan's service area.
• **Medicare prescription drug coverage (Part D)**	When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payer for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) 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) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payer before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payer before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) 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 under TRICARE or CHAMPVA.

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.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB 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 under the State program.

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.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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.

Coinsurance

Coinsurance is the percentage that you must pay for your care.

Example: You pay 50% for covered infertility services. See page 20.

Copayment

A copayment is a fixed amount of money You pay when you receive covered services. See page 12.

Cost-Sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. deductible, coinsurance, and copayments) for the covered care you receive.

Covered services

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

Experimental or investigational service

A drug, device, treatment or procedure is considered experimental is:

• It is not recognized, in accordance with generally accepted medical standards, as being safe and effective for your condition;

• It requires approval by a governmental authority (including the U.S. Food and Drug Administration) before you can use it, but they have not granted that approval; or

• It is the subject of a written protocol used by the treating facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity, or maximum tolerated does.

We evaluate Investigational/experimental treatments on a case-by-case basis as well as on a continual basis as new and emerging treatments become available. Our Medical Director or his/her designee determine whether or not treatments, procedures, devices and drugs are no longer considered experimental and investigational. We use a variety of resources in deciding if a service is experimental/investigational. Resources include, specific database searches of the National Institutes of Health (NIH) and the Health Care Financing Administration (HCFA). 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:

- 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

You

You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition 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/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- 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 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.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **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**. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2009 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2008 benefits until the effective date of your coverage with your new plan. 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.

- **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 (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce**

  If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). 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 Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **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 Federal 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 Benefits 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. 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.

  For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program.* See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. 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 information about Federal and State agencies you can contact for more information.

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents, which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

Where can I get more information about FSAFEDS?

Visit **www.FSAFEDS.com** or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877- 889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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

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Summary of benefits for PacifiCare of Nevada- 2009

- **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.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copayment: $15 primary care; $30 specialist	17
Services provided by a hospital:		
• **Inpatient**	$150 per day up to 5 days per hospital admission	31
• **Outpatient**	$150 copayment per outpatient surgery or procedure	32
Emergency benefits:		
• **In-area**	$100 per emergency room visit	34
• **Out-of-area**	$100 per emergency room visit	35
Note: Emergency room copay is waived if you are admitted to the hospital.		
Mental health and substance abuse treatment:	$150 per day up to 5 days per hospital admission.	36
Prescription drugs:	$10 copayment for generic formulary prescriptions $30 for brand formulary $50 non-formulary prescriptions	38-40
Dental care:	Covered at 100% for diagnostic & preventive services, and up to a maximum allowable fee for basic and major services	41-42
Eye Exams	$15 per Primary Care Physician office visit $30 per Specialist office visit	21
Vision Hardware	$25 copayment – After you pay a $25 copayment toward vision hardware, you will receive either a $100 allowance toward frames and lenses every 24 months or an $85 allowance toward contact lenses every 24 months.	22
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $2,500/Self Only or $7,500/ Family enrollment per calendar year. Some costs do not count toward this protection.	12

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2009 Rate Information for PacifiCare of Nevada

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the Guide to Federal Benefits 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 Guide to Benefits *for Career* UnitedStates Postal Service Employees, RI 70-2, and to the rates shown below.

The rates shown below do not apply to *Post*al Service Inspectors, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

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 Guide to Federal Benefits.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Clark County							
High Option Self Only	K91	144.48	48.16	313.04	104.35	166.63	26.01
High Option Self and Family	K92	327.98	109.32	710.61	236.87	378.26	59.04