

PacifiCare of Colorado

<http://www.pacificare.com>

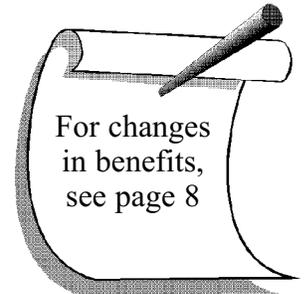
PacifiCare®
of Colorado

2004

A Health Maintenance Organization

Serving: The Front Range of Colorado

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 7 for requirements.



This plan has Excellent accreditation from the NCQA. See the 2004 Guide for more information on accreditation.

Enrollment codes for this Plan:

D61 Self Only

D62 Self and Family

Special Notice – We will no longer offer the high option benefit in 2004. We now offer an enhanced standard option. See page 8.

Authorized for distribution by the:



**United States
Office of Personnel Management**

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



RI 73-049



**UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001**

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this 2004 Federal Employees Health Benefits (FEHB) Program plan brochure. The brochure describes the benefits this plan offers you for 2004. Because benefits vary from year to year, you should review your plan's brochure every Open Season – especially Section 2, which explains how the plan changed.

It takes a lot of information to help a consumer make wise healthcare decisions. The information in this brochure, our FEHB Guide, and our web-based resources, make it easier than ever to get information about plans, to compare benefits and to read customer service satisfaction ratings for the national and local plans that may be of interest. Just click on www.opm.gov/insure!

The FEHB Program continues to be an enviable national model that offers exceptional choice, and uses private-sector competition to keep costs reasonable, ensure high-quality care, and spur innovation. The Program, which began in 1960, is sound and has stood the test of time. It enjoys one of the highest levels of customer satisfaction of any healthcare program in the country.

I continue to take aggressive steps to keep the FEHB Program on the cutting edge of employer-sponsored health benefits. We demand cost-effective quality care from our FEHB carriers and we have encouraged Federal agencies and departments to pay the full FEHB health benefit premium for their employees called to active duty in the Reserve and National Guard so they can continue FEHB coverage for themselves and their families. Our carriers have also responded to my request to help our members to be prepared by making additional supplies of medications available for emergencies as well as call-up situations and you can help by getting an Emergency Preparedness Guide at www.opm.gov. OPM's HealthierFeds campaign is another way the carriers are working with us to ensure Federal employees and retirees are informed on healthy living and best-treatment strategies. You can help to contain healthcare costs and keep premiums down by living a healthy life style.

Open Season is your opportunity to review your choices and to become an educated consumer to meet your healthcare needs. Use this brochure, the FEHB Guide, and the web resources to make your choice an informed one. Finally, if you know someone interested in Federal employment, refer them to www.usajobs.opm.gov.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay Coles James".

Kay Coles James
Director



Notice of the Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).

- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
United States Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

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Introduction

This brochure describes the benefits of PacifiCare of Colorado under our contract (CS 1761) with the United States Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for PacifiCare of Colorado's administrative offices is:

PacifiCare of Colorado
6455 South Yosemite Street
Greenwood Village, CO 80111

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, 2004, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2004, and changes 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 of Colorado.
- 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 fehwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 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 (FEHB) 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 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 1-800-877-9777 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 or with OPM if you are retired.
- 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.

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of test 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 reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.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 healthcare providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.talkaboutrx.org/consumer.html. 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 healthcare 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 healthcare 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.

HMOs 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 and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. These payment arrangements include capitation, discounted fee-for-service and case rates, as well as additional financial incentives including bonuses and withholds.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence – PacifiCare of Colorado (and its predecessors) began offering health care coverage in Colorado in 1974.
- Profit status – We are a for-profit organization.

If you want more information about us, call 1-800-877-9777, or write to 6455 South Yosemite Street, Greenwood Village, CO 80111. You may also contact us by fax at 1-303-714-3977 or visit our website at www.pacificare.com.

Service Area

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

Our service area is: the Colorado counties of Adams, Arapahoe, Boulder, Broomfield, Clear Creek, Denver, Douglas, Elbert, El Paso, Gilpin, Jefferson, Larimer, Morgan, Park, Teller and Weld.

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 received outside the 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 2004

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

Program-wide changes

- We added information regarding two new Federal Programs that complement FEHB benefits, the Federal Flexible Spending Account Program – FSAFEDS and the Federal Long Term Care Insurance Program. See page 52.
- We added information regarding Preventing Medical Mistakes. See page 5.
- We added information regarding enrolling in Medicare. See page 42.
- We revised the Medicare Primary Payer Chart. See page 44.

Changes to this Plan

- We will no longer offer the high option benefit in 2004. However, we have merged the standard and high options to offer an enhanced standard option for 2004.
- If you were enrolled in the High Option in 2003 your non-postal premium will increase by 7.4% for Self Only coverage or decrease by 25.3% for Self and Family coverage.
- If you were enrolled in the Standard Option in 2003 your non-postal premium will increase by 50.35% for Self Only coverage or 41.94% for Self and Family coverage.
- **Office visits** – You now pay a \$10 copayment for office visits to a primary care physician (PCP) and a \$40 copayment for office visits to specialists, including behavioral health specialists.
- **Prescriptions drugs** – You now pay \$10 for generic formulary drugs and, \$35 for brand name formulary drugs and \$50 for non-formulary drugs. You pay two copayments for a mail order 90-day supply.
- **Maternity care** – You now pay a single \$10 copayment for the entire pregnancy.
- **Allergy injections** – When not in conjunction with an office visit, you now pay a \$10 copayment in a PCP's office and \$20 in a specialist's office.
- **Physical, occupational and speech therapies** – You now pay a \$20 copayment for physical, occupational and speech therapy.
- **Cardiac rehabilitation** – You now pay a \$20 copayment for each visit.
- **Inpatient hospital** – You now pay \$150 per day up to 5 days per admission.
- **Outpatient hospital or ambulatory surgical center** – You now pay a \$150 copayment per outpatient surgery.
- **Outpatient hospital or ambulatory surgical center** – You now pay a \$50 copayment for medical, non-surgical services, performed in these settings.
- **Skilled nursing facility** – You now pay a \$50 copayment per day up to 5 days per admission.
- **Emergency services (within the service area)** – You now pay a \$40 copayment for emergency care received in a PCP's office after regular office hours, specialist's office or urgent care center.
- **Emergency services (outside the service area)** – You now pay a \$40 copayment for emergency care received in a PCP's office, specialist's office or urgent care center.
- **Emergency services** – The Plan will no longer waive your \$100 emergency room copayment if you are admitted to the hospital.
- **Ambulance** – You now pay a \$75 copayment per trip.
- **Catastrophic out-of-pocket maximum** – Your out of pocket maximum has increased to \$5,000 per self only enrollment. It remains \$10,000 per self and family enrollment.
- **Dental** – We will now offer a Preferred Provider Option (PPO) dental plan, which is subject to a calendar year deductible of \$50 per person or \$150 per family. We pay a maximum \$1,000 in benefits per person per year. We pay a percentage of the contracted provider reduced rate for in-network providers. In-network providers will not balance bill members. We will pay a percentage of our scheduled fee allowance for out-of-network providers.
- **Orthodontic services** – The Plan will no longer cover orthodontic services. Members who are currently in a treatment plan or begin a new treatment plan prior to the end of the 2003 contract year can continue to receive the current orthodontia benefits until the treatment plan is completed.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-877-9777.

Where you get covered care

- **Plan providers**

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.

Plan providers are physicians and other health care professionals in our 16-county service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

The physicians that we contract with are either in private practice in their own office, or participating in medical groups, practicing in conveniently located group practice centers.

We list Plan providers in the provider directory, which we update periodically. The list of primary care physicians is also on our Web site at www.pacificare.com.

- **Plan facilities**

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

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 (PCP). This decision is important since your PCP provides or arranges for most of your health care.

Some of our participating physicians are organized into groups of primary care physicians and specialists who have joined together to provide services. For physicians affiliated in this manner, PCPs belong to just one group, but some specialists may have more than one affiliation. When you need specialty care, your PCP will most likely refer you to a specialist with whom he or she is affiliated. PCPs typically have established relationships with other doctors to whom they'll most likely refer patients when specialized care is needed. Referring to specialists your PCP is familiar with makes it easy for your PCP to communicate with both you and your specialist and coordinate your care. Our policy is to encourage PCPs to consider patients' input in care decisions.

- **Primary care**

Your primary care physician can be a family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist. We contract with approximately 1,500 primary care physicians.

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

• **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, you may access care for the following benefits without a referral from your PCP:

- mental health and substance abuse benefits – refer to Section 5(e) for information on how to access these benefits.
- vision care – contact.
 - Prior to the new contract year, contact VSP at 1-888-426-4877
 - After the beginning of the 2004 contract year, contact Eye Specialists, A Block Vision Company at 1-800-879-6901
- chiropractic care – go directly to a participating American Specialty Health Networks provider.
- obstetrical or gynecological care – access care through your primary care physician or go directly to a participating OB/GYN physician.

We contract with over 3,000 referral specialists.

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 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, you may discuss whether or not it is appropriate to continue to see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause; or
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
 - reduce our service area and you enroll in another FEHB Plan,you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-877-9777. If you are new to the FEHB Program, we will arrange for you to receive care.

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

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. 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 case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

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 review and approval process preauthorization. Your physician must obtain preauthorization for services such as:

- Septoplasty
- Hysterectomy
- MRIs, CT, PET and SPECT scans.
- Upper GI endoscopy
- Colonoscopy
- Knee arthroscopy

PacifiCare of Colorado 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 procedures 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 Guidelines and are reviewed and revised on a regular basis. Criteria are available for review by the member's participating physician, the member or the member's representative.

Section 4. Your costs for covered services

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

- **Copayments**

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

Example: When you see your primary care physician you pay a copayment of \$10 per office visit.

- **Deductible**

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them.

We do not have any deductibles on our medical benefits. Under the dental benefits, we have a \$50 individual deductible and a \$150 family deductible.

- **Coinsurance**

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

Example: In our Plan, you pay 50% of our allowance for infertility services, or drugs for the treatment of sexual dysfunction.

Your catastrophic protection out-of-pocket maximum for copayments and coinsurance

After your copayments, coinsurance or deductibles total \$5,000 per person or \$10,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, your out-of-pocket expenses for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription drugs
- Dental services
- Non-authorized/non-covered services

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

Section 5. Benefits — OVERVIEW

(See page 8 for how our benefits changed this year and page 60 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsection. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-877-9777 or at our website at www.pacificare.com.

(a) Medical services and supplies provided by physicians and other health care professionals	14-21
• Diagnostic and treatment services	• Hearing services (testing, treatment, and supplies)
• Lab, X-ray and other diagnostic tests	• Vision services (testing, treatment, and supplies)
• Preventive care, adult	• Foot care
• Preventive care, children	• Orthopedic and prosthetic devices
• Maternity care	• Durable medical equipment (DME)
• Family planning	• Home health services
• Infertility services	• Chiropractic
• Allergy care	• Alternative treatments
• Treatment therapies	• Educational classes and programs
• Physical and occupational therapy	
• Speech therapy	
(b) Surgical and anesthesia services provided by physicians and other health care professionals	22-24
• Surgical procedures	• Oral and maxillofacial surgery
• Reconstructive surgery	• Organ/tissue transplants
	• Anesthesia
(c) Services provided by a hospital or other facility, and ambulance services	25-27
• Inpatient hospital	• Extended care benefits/skilled nursing care facility benefits
• Outpatient hospital or ambulatory surgical center	• Hospice care
	• Ambulance
(d) Emergency services/accidents	28-29
• Medical emergency	• Ambulance
(e) Mental health and substance abuse benefits	30-31
(f) Prescription drug benefits	32-34
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• Services for deaf and hearing impaired	• Women’s Health Solutions
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• 24-Hour Health Information	
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Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office • Office medical consultations • Second surgical opinion 	\$10 per PCP office visit \$40 per specialist office visit
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • At home when medically necessary 	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Physical examinations that are not medically necessary, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel</i> • <i>Obesity treatment, except for surgical treatment of morbid obesity</i> • <i>Total Parenteral Nutrition (TPN)</i> 	<i>All charges</i>

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Ultrasound • Electrocardiogram • EEG 	Nothing
<ul style="list-style-type: none"> • MRIs, CT, PET and SPECT scans 	\$75 copayment per test
Preventive care, adult	
We cover periodic health appraisals for adults. These visits include coverage for routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol • Colorectal Cancer Screening, including: <ul style="list-style-type: none"> — Fecal occult blood test — Sigmoidoscopy, screening • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Routine pap test Note: The office visit is covered if pap test is received on the same day; see <i>Diagnostic and treatment services</i> , above.	\$10 per PCP office visit \$40 per specialist office visit
Routine mammogram — covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every year • At age 65 and older, one every two years 	Nothing
Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster — once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and over 	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Physical examinations that are not medically necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel.</i> 	<i>All charges</i>

Preventive care, children	You pay
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	\$10 per office visit
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (up to age 22 years) • Examinations, such as: <ul style="list-style-type: none"> — Eye exams to determine the need for vision correction — Ear exams to determine the need for hearing correction — Examinations done on the day of immunizations (up to age 22 years) 	\$10 per PCP office visit \$40 per specialist office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical examinations that are not medically necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel.</i> 	<i>All charges</i>
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 25 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	\$10 copayment for the entire pregnancy
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Any procedure intended solely for sex determination</i> • <i>Birthing classes</i> • <i>Normal delivery outside of our service area</i> 	<i>All charges</i>

Family planning	You pay
<p>A range of voluntary family planning services, such as:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5(b)) • Family planning counseling • Information on birth control • Injectable contraceptive drugs • Intrauterine devices (IUDs) and implantable contraceptive devices, including their insertion and removal • Diaphragms and cervical caps, including their fitting 	<p>\$10 per PCP office visit \$40 per specialist office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary, surgical sterilization</i> • <i>Genetic counseling</i> • <i>Pregnancy test kits and ovulation kits</i> 	<p><i>All charges</i></p>
Infertility services	
<ul style="list-style-type: none"> • Diagnosis and treatment of infertility • Artificial insemination <ul style="list-style-type: none"> — intravaginal insemination (IVI) — intracervical insemination (ICI) — intrauterine insemination (IUI) <p>This coverage is limited to members who have been diagnosed as biologically infertile in accordance with accepted medical practice.</p>	<p>50%</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Fertility drugs</i> • <i>Assisted reproductive technology (ART) procedures</i> <ul style="list-style-type: none"> — <i>in vitro fertilization</i> — <i>embryo transfer, GIFT and ZIFT</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost related to donor sperm and donor ova</i> • <i>Infertility services for members who have undergone a voluntary sterilization procedure</i> 	<p><i>All charges</i></p>
Allergy care	
<p>Comprehensive diagnostic allergy evaluation including testing</p>	<p>\$10 per PCP office visit \$40 per specialist office visit</p>
<p>Allergy injection</p>	<p>When not in conjunction with an office visit, \$10 per PCP office visit; \$20 per specialist office visit</p>
<p>Allergy serum</p>	<p>Nothing</p>

Treatment therapies	You pay
<ul style="list-style-type: none"> • 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 24. • 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. Your plan physician will handle this preauthorization process. 	Nothing
Physical and occupational therapy	
<p>Physical therapy and occupational therapy:</p> <ul style="list-style-type: none"> • Up to 20 visits or two months per condition, whichever is greater, if significant improvement can be expected within two months <p>Physical/occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.</p> <p>Note: We provide physical and occupational up to 20 sessions for each type of therapy per year, for the care and treatment of congenital defects and birth abnormalities for children up to age five (5). This is without regard to whether the condition is acute or chronic or whether the purpose of the therapy is to maintain or to improve functional capacity.</p>	\$20 per office visit Nothing for inpatient
<p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided at an approved facility for up to 90 sessions for short-term follow-up care. Coverage of cardiac rehabilitation for stable angina pectoris will be limited to one course of treatment per plan year.</p>	\$20 per office visit Nothing for inpatient
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Special evaluation and/or therapy for conditions such as behavior disorders and pulmonary rehabilitation</i> 	<i>All charges</i>
Speech therapy	
<p>Up to 20 visits or two months per condition, whichever is greater.</p> <p>Speech therapy is provided when medically necessary without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.</p>	\$20 per office visit Nothing for inpatient
Hearing services (testing, treatment, and supplies)	
<p>Examinations to determine the need, if any, for hearing correction.</p>	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, and evaluation for them</i> 	<i>All charges</i>

Vision services (testing, treatment, and supplies)	You pay
<ul style="list-style-type: none"> • Diagnosis and treatment of diseases of the eye • Routine eye exams including refraction, once every 12 months, to determine the prescription for corrective lenses, eyeglasses or contact lenses. You may go directly to a PacifiCare participating provider without a referral or authorization. Prior to the new contract year, contact VSP at 1-888-426-4877. After the beginning of the 2004 contract year, contact Eye Specialists, A Block Vision Company at 1-800-879-6901. • Routine visual acuity exams as part of covered periodic health exams 	\$10 per PCP office visit \$40 per specialist office visit
<p>We cover eyeglasses when prescribed following cataract surgery with an intra ocular lens implant. Eyeglasses must be obtained through participating providers, and are covered up to \$125 per pair, with a limit of one pair per surgery and two pairs per lifetime.</p>	All cost over \$125
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Fitting contact lenses</i> • <i>Vision therapy</i> • <i>Radial keratotomy, keratomileusis and excimer laser surgery</i> • <i>Eyeglasses or contact lenses, other than following cataract surgery as described above</i> 	<i>All charges</i>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p>	\$10 per PCP office visit \$40 per specialist office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting or trimming of the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> 	<i>All charges</i>

Orthopedic and prosthetic devices	You pay
<ul style="list-style-type: none"> • Orthopedic braces and podiatric shoe inserts meeting criteria are covered up to a combined maximum of \$500 per member per calendar year. Podiatric shoe inserts are covered for persons with historical ulcers or pre-ulcerous lesions and documented neuropathy, persistent plantar facitis or documented neuropathy who have had documented failure of using commercial over-the-counter inserts prior to, or instead of surgery. • Externally worn breast prostheses and surgical bras, including necessary replacements will be covered following a mastectomy up to \$500 per member per calendar year. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, lenses following cataract removal, and surgically implanted breast implants following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See 5(b) for coverage of the surgery to insert the device. • External extremity prosthetics – please refer to the Durable Medical Equipment benefit for coverage information. 	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Foot orthotics</i> • <i>Orthotic devices for podiatric use except as described for podiatric shoe inserts above.</i> • <i>Arch support</i> • <i>Prostheses for cosmetic purposes</i> • <i>Experimental/investigational or cosmetic implants</i> 	<i>All charges</i>
Durable medical equipment (DME)	
<p>We cover rental or purchase, at our option, of durable medical equipment (DME) Intended to be used repeatedly and in the home to assist in the treatment of an injury or illness. Replacement, repair and adjustments to DME is limited to normal wear and tear or because of a significant change in the member's physical condition. DME coverage will be based on medical necessity and Medicare guidelines.</p> <p>We cover items, such as, but not limited to:</p> <ul style="list-style-type: none"> • Hospital beds • Lymphedema pumps • Nebulizers • Oxygen • Positive airway pressure devices (C-PAP, Bi-PAP) • Suction machines • Traction equipment • Ventilators • Wheelchairs 	Nothing up to the annual \$1,500 benefit limit; all charges thereafter
<p><i>Not covered, items such as:</i></p> <ul style="list-style-type: none"> • <i>medical supplies</i> • <i>replacement of lost or stolen items</i> • <i>optional attachments and modifications for comfort and convenience</i> 	

Home health services	You pay
<ul style="list-style-type: none"> • Home health services of nurses and therapists, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative</i> 	<i>All charges</i>
Chiropractic	
<p>Chiropractic services – up to 20 outpatient visits with a participating chiropractor.</p> <p>Note: You may self refer to a participating chiropractor for the 1st visit per neuromusculoskeletal condition or injury; however the Plan must approve any additional treatment.</p>	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Chiropractic services for maintenance care</i> • <i>Biofeedback</i> 	<i>All charges</i>
Alternative treatments	
<p><i>Not covered, services such as:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> • <i>Biofeedback</i> 	<i>All charges</i>
Educational classes and programs	
<p>Smoking cessation – a self-directed, self-paced smoking cessation program for our members who would like to stop smoking. After enrollment in the program, a letter is sent to your PCP to inform him or her of your participation.</p> <p>The program includes:</p> <ul style="list-style-type: none"> • Regularly scheduled motivational phone calls with a trained smoking cessation specialist. • Educational materials to guide smokers to quit. • One of two smoking cessation aid products; a transdermal patch for nicotine replacement therapy, or an approved prescription drug. Coverage of these aids is available for up to 90 days per year, limited to 3 years per lifetime. <p>To enroll in the smoking cessation program, or for more information, please call 1-800-877-9777.</p>	<p>\$20 enrollment fee for smoking cessation program</p> <p>\$20 copayment per 30-day supply</p>
<p><i>Not covered: special service clinics, centers, or programs on an inpatient or outpatient basis, such as:</i></p> <ul style="list-style-type: none"> • <i>Education clinics, such as premenstrual (PMS), lactation, headache, eating disorder, senior services and stress management</i> 	<i>All charges</i>

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

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

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

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Benefit Description	You pay
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Surgical services including normal pre- and post-operative care by the surgeon • Services of a surgical assistant and anesthesiologist when medically necessary • Correction of amblyopia and strabismus • Treatment of fractures, including casting • Removal of tumors and cysts • Endoscopy procedure • Biopsy procedure • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity based on criteria established by us • Insertion of internal prosthetic devices. Note: See Section 5 (a) for device coverage information. • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns 	<p>\$10 per PCP office visit \$40 per specialist office visit</p> <p>Nothing after your \$150 per day up to 5 days per admission or \$150 outpatient surgery copayment.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary, surgically-induced sterility</i> • <i>Surgery primarily for cosmetic purposes</i> 	<p><i>All charges</i></p>

Reconstructive surgery	You pay
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or surgery if: <ul style="list-style-type: none"> — the condition produced a major effect on the member’s appearance and — the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Some examples of congenital anomalies are cleft lip and cleft palate. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> — surgery to produce a symmetrical appearance on the other breast; — treatment of any physical complications, such as lymphedemas; — breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to, have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>Nothing after your \$150 copayment per day up to 5 days per inpatient admission or \$150 copayment per surgery for outpatient surgery.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury.)</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Treatment of congenital conditions of the jaw that may be demonstrated to cause actual significant deterioration in the member’s physical condition because of inadequate nutrition or respiration; • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • TMJ surgery and related non-dental treatment. 	<p>Nothing after your \$150 copayment per day up to 5 days per inpatient admission or \$150 copayment per surgery for outpatient surgery.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthodontic treatment, or other dental related services for treatment of TMJ.</i> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges</i></p>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Liver • Allogeneic (donor) bone marrow and stem cell transplants • Autologous bone marrow and stem cell transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>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.</p>	<p>Nothing after your \$150 copayment per day up to 5 days per inpatient admission or \$150 copayment per surgery for outpatient surgery.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Transplants not listed as covered</i> • <i>Implants of artificial organs</i> 	<p><i>All charges</i></p>
Anesthesia	
<p>Professional services provided in:</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>Nothing</p>

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

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Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by 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 PREAUTHORIZATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require preauthorization.

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Benefit Description	You pay
Inpatient hospital	
<p>Room and board, such as:</p> <ul style="list-style-type: none"> • Semiprivate, or specialized care units, such as intensive care or cardiac care units; • General nursing care; and • Meals and special diets. <p>NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	\$150 copayment per day up to 5 days
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood, blood plasma, and blood products if not donated or replaced, including processing and administration • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia service when medically necessary 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Special blood handling fees, wound healing products and storage of cord blood</i> • <i>Personal comfort items, such as telephone, television, articles for personal hygiene, guest meals and beds</i> • <i>Private duty nursing care</i> • <i>Take-home drugs and supplies</i> • <i>Hospitalization for any dental procedures, except for children under certain circumstances</i> 	<i>All charges</i>

Outpatient hospital or ambulatory surgical center	You pay
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Blood, blood plasma, and blood products if not donated or replaced, including processing and administration • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service when medically necessary <p>NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment and meeting criteria. We do not cover the dental procedures.</p>	<p>\$150 copayment for outpatient surgery in a hospital or ambulatory surgical center; \$50 copayment for non-surgical services or 23-hour observation in an outpatient hospital setting or ambulatory surgical center.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Special blood handling fees, wound healing products and storage of cord blood</i> • <i>Hospitalization for any dental procedures, except for children under certain circumstances</i> 	<p><i>All charges</i></p>
Extended care benefits/skilled nursing care facility benefits	
<p>Subacute care facility services following hospitalization is covered up to 60 days per calendar year at an approved subacute care facility. This coverage includes:</p> <ul style="list-style-type: none"> • Accommodations • Meals 	<p>\$50 copayment per day up to 5 days</p>
<ul style="list-style-type: none"> • General nursing care • Medical supplies and equipment ordinarily furnished by the facility • Prescribed drugs and biologicals 	<p>Nothing</p>
<p>Skilled nursing facility (SNF): We cover up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by us. This coverage includes:</p> <ul style="list-style-type: none"> • Accommodations • Meals • General nursing care • Medical supplies and equipment ordinarily furnished by the facility • Prescribed drugs and biologicals 	<p>\$50 copayment per day up to 5 days</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Care for chronic conditions</i> • <i>Private room, except when medically necessary</i> • <i>Personal comfort items, such as telephone, television, articles for personal hygiene, guest meals and beds</i> • <i>Private duty nursing care</i> 	<p><i>All charges</i></p>

Hospice care	You pay
<p>Supportive and palliative care for a terminally ill member is covered in the home or hospice facility when approved by our Medical Director. Services include:</p> <ul style="list-style-type: none"> • Inpatient and outpatient care • Family counseling <p>These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.</p>	Nothing
<i>Not covered: services such as independent nursing and homemaker services</i>	<i>All charges</i>
Ambulance	
<ul style="list-style-type: none"> • Medically necessary air or ground ambulance service ordered or authorized by a Plan doctor 	\$75 per trip

Section 5 (d). Emergency services/accidents

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

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

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What is a medical emergency?

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

What to do in case of emergency:

In a life or limb threatening emergency, call 911 or go to the nearest hospital emergency room or other facility for treatment. You do not need authorization from your primary care physician before you go. True emergency care is covered no matter where you are.

Emergencies within our service area:

If you receive emergency care and are in our service area, notify your PCP on the first business day following your admission, so that he or she can coordinate any follow-up treatment.

When you need urgent care while you're in our service area, call your primary care physician. All physician offices have a 24-hour answering service that will contact your PCP or his or her on-call partner. Your physician can assess the situation and decide what type of care you need. Ask your PCP about after-hours and "on-call" procedures now, before you need these services.

Emergencies outside our service area:

If you receive emergency or urgent care outside our service area, contact PacifiCare Customer Service within 48 hours, unless it was not reasonably possible to do so, to let us know what has happened and where you went for care.

We also cover follow-up treatment to emergency care up to \$400 per person per calendar year when that care is delivered outside our service area.

Emergency services/accidents benefits begin on the next page.

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office <ul style="list-style-type: none"> • During normal business hours • After normal business hours • Emergency care at an urgent care center • Emergency room setting 	<p>\$10 per PCP office visit \$40 per specialist office visit \$40 per visit \$40 per visit \$100 per visit</p> <p>Note: We do not waive the \$100 copayment if you are admitted to the hospital</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Follow-up care in the emergency facility • Emergency visits made in non-life or limb threatening situations without your PCP’s authorization • Emergency room services obtained during normal physician office hours, except in the event of a life or limb threatening emergency or when preauthorized by your PCP 	<p><i>All charges</i></p>
Emergency outside our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency room setting 	<p>\$40 per visit \$40 per visit \$100 per visit</p> <p>Note: We do not waive the \$100 copayment if you are admitted to the hospital</p>
<p>We cover up to \$400 per person per calendar year for follow-up care to emergency services received outside the service area. These services are covered when needed in order to prevent serious deterioration of your health that would result from an unforeseen illness or injury if you are temporarily absent from our service area and receipt of your health care cannot be delayed until your return to the service area.</p>	<p>You pay the appropriate emergency benefit copayment listed in the box directly above</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Elective care or non-emergency care • Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area • Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area 	<p><i>All charges</i></p>
Ambulance	
<p>Ground or air ambulance service approved by us</p>	<p>\$75 per trip</p>

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

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

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Benefit Description	You pay
Mental health and substance abuse benefits	
<p>Diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illness or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$10 per PCP office visit \$40 per specialist office visit</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>Nothing</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility 	<p>\$150 copayment per day up to 5 days</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Psychiatric evaluation or therapy, or substance abuse treatment, on court order or as a condition of parole or probation, unless determined by us to be necessary and appropriate</i> • <i>Services we have not approved</i> <p><i>Note: The same exclusions contained in this brochure that apply to other benefits apply to these mental health and substance abuse benefits, unless the services are included in a treatment plan that we approve. OPM's review of disputes about network treatment plans will be based on the treatment plan's clinical appropriateness. OPM will generally not order one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All charges</i></p>

Preauthorization

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

PacifiCare members receive mental health or substance abuse services through PacifiCare Behavioral Health. Simply call toll-free at 1-888-777-2735 and PacifiCare Behavioral Health will put you in touch with the right mental health professional and authorize needed services.

To seek our mental health or substance abuse services, you do not need a referral from your primary care physician. However, please identify yourself as a PacifiCare member when contacting PacifiCare Behavioral Health. Also, be sure to present your PacifiCare ID card each time you visit your mental health professional.

Section 5 (f). Prescription drug benefits

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

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

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

- **Who can write your prescription.** A Plan physician, an approved non-Plan physician, or a licensed dentist must write your prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy or through our mail-order program.
- **We use a formulary.** PacifiCare covers most FDA-approved generics and a broad selection of brand name drugs. 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 pharmacies to ensure that our members are getting the drug therapy they need. A Pharmacy and Therapeutics Committee consisting of physicians and pharmacists evaluates prescription drugs based on safety, effectiveness, quality treatment and overall value. The committee considers first and foremost the safety and effectiveness of a medication before reviewing 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 onto the PacifiCare website at www.pacificare.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 non-formulary copayment.
- **These are the dispensing limitations.** Drugs are dispensed in accordance with the Plan’s drug formulary. Prescription drugs prescribed by a Plan or referral doctor 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. You do not need prior authorization for non-formulary because there are different copayments for formulary and non-formulary medications. Clinical edits (limitations) can be used for safety reasons, quantity limitations, age limitations, and benefit plan exclusions.

A 90-day supply of maintenance medications can be filled through our mail-order prescription drug program. You pay 2 applicable copayments per 90-day supply of tablets and capsules, or up to 4 prepackaged units, for a covered medication. Contact PacifiCare of Colorado’s Customer Service Department at 1-800-877-9777 for more information – and to receive a mail-order form.

If you are called to active military duty or in the event of National emergency and you are in need of prescription medications, call us at 1-800-877-9777!

- **Why use generic drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you less money than a brand name drug.
- **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 1-800-877-9777.

Please Note: We do not coordinate benefits for outpatient prescription drugs.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail-order program:</p> <ul style="list-style-type: none"> • Drugs for which a prescription is required by law • Disposable needles and syringes for the administration of covered prescribed medications • Commercially prepared progesterone and estrogen products • Intravenous fluids and medication for home use are covered under “Home health services”. See page 21. • Oral contraceptive drugs; contraceptive diaphragms; and cervical caps • Coverage for implantable and injectable contraceptives is listed under the “Family planning section” located in 5(a) <p>The following benefit is covered, but limited:</p> <ul style="list-style-type: none"> • Diabetic glucose and ketone test strips and lancets dispensed in the manufacturer’s prepackaged unit, up to 200 test strips, or 200 lancets, per 30-days. 	<p>Per prescription unit or prepackaged unit, up to a 30-day supply:</p> <p>Formulary Generic – \$10</p> <p>Formulary Brand – \$35</p> <p>Non-Formulary – \$50</p>
<ul style="list-style-type: none"> • Insulin 	<p>A copayment is applied to every two vials of the same kind of insulin.</p> <p>You can receive up to six vials of the same kind of insulin through the mail-order program for two applicable copayments.</p>
<p>Injectable drugs (except insulin) when preauthorized</p>	<p>\$50 copayment per prescription unit or refill</p>
<p>Medical Foods (prescription metabolic formulas and their modular components) obtained from a pharmacy for inherited enzymatic disorders caused by single gene defects for diagnosed conditions, such as:</p> <ul style="list-style-type: none"> • Phenylketonuria (up to age 21) • Maternal phenylketonuria (for women through age 35) • Maple syrup urine disease • Tyrosinemia • Homocystinuria • Urea cycle disorders • Hyperlysinemia • Glutaric acidemias • Methylmalonic acidemia • Propionic acidemia 	<p>50% of the cost</p>
<p>The following benefit is covered, but limited:</p> <ul style="list-style-type: none"> • Drugs to treat sexual dysfunction are covered when plan criteria is met. Contact us for dose limits. 	<p>50% of the cost of the medication per prescription unit or refill up to the dosage limit; you pay all charges above that.</p>

Covered medications and supplies (<i>continued</i>)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs available without a prescription or for which there is a nonprescription equivalent available</i> • <i>Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies</i> • <i>Vitamins and nutritional substances that can be purchased without a prescription</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Smoking cessation drugs and medication, including nicotine patches, except through the smoking cessation programs provided</i> • <i>Drugs for weight reduction</i> • <i>Lifestyle enhancement drugs, including but not limited to drugs to enhance hair growth, anti-aging and mental performance</i> • <i>Fertility drugs</i> • <i>Drugs for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Convenience packaged medications, including but not limited to Insulin penfill</i> 	<p><i>All charges</i></p>

Section 5 (g). Special features

Feature	Description										
Services for deaf and hearing impaired	TDD phone line – 1-800-659-2656										
Health Management Programs	<p>PacifiCare offers health management programs to members meeting specific criteria, for the following disease states or illnesses:</p> <ul style="list-style-type: none"> • Cancer Care Program • Congestive Heart Failure (CHF) • Coronary Artery Disease (CAD) • End-Stage Renal Disease (ESRD) • Diabetes Management • Taking Charge of Depression <p>If you are interested in any of these programs, please contact your physician.</p>										
24-Hour Health Information Program	<p>Members can visit the PacifiCare website at www.pacificare.com and click on the 24-Hour Health Information icon to view a wide-range of health-related information. There are detailed sections on women’s and men’s health, parenting, wellness centers, healthy lifestyles, exercise demos and more. The program combines two features: Interactive Web Health content, with a real-time Live Assist and 24-Hour Health Information Audio Library with Nurse Line.</p> <p>The Health Information Audio Library can be accessed by calling 1-866-747-4325 on a touch-tone phone.</p>										
Women’s Health Solutions	<p>Internet-based information for health and wellness for yourself and your family. The following modules are currently available by accessing www.pacificare.com.</p> <ul style="list-style-type: none"> • Pregnancy to Preschool • Menopause: Understanding Your Options 										
National Pharmacy Network	<p>PacifiCare of Colorado has contracted with a network of nationally known pharmacies and several independent pharmacies throughout the United States, for members needing to fill prescriptions when outside of Colorado for the appropriate copayment.</p> <p>How to use these pharmacies:</p> <ul style="list-style-type: none"> • You must ask the pharmacy if they are contracted to process prescriptions for PacifiCare members. • You must present your PacifiCare ID card at the time you are filling your prescription. • The pharmacy must process the prescription electronically. <p>Some of the major pharmacy chains included in the network are:</p> <table style="width: 100%; border: none;"> <tr> <td>Albertson’s</td> <td>Long’s</td> <td>K-Mart</td> <td>Safeway</td> <td>Vons</td> </tr> <tr> <td>Eckerd</td> <td>King Sooper’s</td> <td>Kroger</td> <td>Target</td> <td>Walgreens</td> </tr> </table> <p>Call customer service at 1-800-877-9777 for more information.</p>	Albertson’s	Long’s	K-Mart	Safeway	Vons	Eckerd	King Sooper’s	Kroger	Target	Walgreens
Albertson’s	Long’s	K-Mart	Safeway	Vons							
Eckerd	King Sooper’s	Kroger	Target	Walgreens							

Section 5 (h). Dental benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary. For a full list of benefits, exclusions and limitations, please refer to the Plan information pamphlet for the 2004 PacifiCare Preferred Provider Dental Plan for Colorado Federal Employees.
- You have the option of choosing in-network dentists or out-of-network dentists. PacifiCare pays a higher benefit when you use in-network dentists.
- The calendar year deductible is \$50 per person/\$150 per family. The deductible is waived for preventive services.
- There is a maximum benefit of \$1,000 per member per year.
- 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 more information call PacifiCare Dental Administrators at 1-800-591-5915.

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Dental Benefits

Service	In-network – we pay	Out-of-network – we pay
Preventive and diagnostic services, such as: Periodic oral evaluation Intraoral X-rays – (one bitewing series of four every six months)	100% of the provider’s contracted rate.	100% of the Plan’s fee allowance or the dentist’s charge, whichever is less.
Basic services, such as: Amalgam fillings Root canals Periodontal scaling and root planing, per quad Removal of impacted tooth – soft tissue	90% of the provider’s contracted rate.	80% of the Plan’s allowance, or the dentist’s charge, whichever is less.
Major services, such as: Complete denture Maxillary partial denture Pontic Crown	60% of the provider’s contracted rate.	50% of the Plan’s allowance, or the dentist’s charge, whichever is less.

Note: There is a 12 month waiting period for major procedures; there is an additional waiting period for bridges and dentures. Initial dentures or bridges are covered after a 36-month waiting period. If you were covered under PacifiCare’s FEHB High Option indemnity, Standard Option dental HMO, or another dental plan immediately before enrolling in this Plan, that time will be applied to your waiting 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 (i). Non-FEHB benefits available to Plan members

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

PacifiCare Has A Plan To Help Keep Your Smile Healthy...and Your Vision Sharp!

Dental

Take advantage of significant savings with the Non-FEHB PacifiCare Dental Plan. This dental HMO plan offers low copayments and out-of-pocket costs at your Assigned Contracting Dental Office, with savings on more than 100 common dental procedures. Even better, most oral examinations, teeth cleanings and X-rays are available at no cost. The plan has no deductible or annual maximum. Available to **all** Federal Employees, you don't have to be a member of the medical plan to join! For more information, please call 1-800-229-1985 from 7 a.m. to 6 p.m., PST, Monday through Friday.

The Non-FEHB dental benefits will not be coordinated with the dental benefits included with the PacifiCare medical plan.

Vision

Also, take advantage of significant savings with the new Non-FEHB vision plan, now available from PacifiCare Dental and Vision. This Full Service Vision Plan offers the following when you use network vision providers:

- Annual comprehensive eye exam
- Standard lenses at NO cost (single vision, bifocal, trifocal)
- Frames up to \$100
- Contact lenses
- Choice of: Independent doctors, Sears Optical, Target Optical, JCPenney Optical and Pearle Vision
- Laser vision surgery discount available

With the Full Service Vision Plan, you can have your vision exam and choose your eyewear at the same location. You do not have to be a member of the medical plan to enroll in the vision plan.

For more information, please call 1-800-229-1985 from 7 a.m. to 6 p.m., PST, Monday through Friday.

PacifiCare PerksSM Program

The PacifiCare Perks Program offers members discounts to:

- **Complementary & Alternative Care** – such as massage therapy and acupuncture, health and wellness products offered at 40% below the suggested retail price, including: vitamins, minerals and daily formulas, herbal and dietary supplements, sports nutrition products, natural body care products, and audio and video tapes on Yoga, Tai Chi, Massage and more
- **Healthy Moms/Kids** – discounts for Gymboree Play and Music programs, Safe Beginnings family safe products, ClearPlan Easy fertility monitor rebate, breastfeeding accessories
- **Fitness & Weight Management** – discounts with health club memberships, DietMate weight loss aids, Spa Wish gift certificates and more
- **Pharmacy and Personal Care** – discounts on nearly 500 top-selling name brand pharmacy and personal care products, free shipping with a mail-order prescription

Call 1-800-877-9777 for a complete list of special services, or visit www.pacificare.com.

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition and we agree, as discussed under services requiring our prior approval on page 11.**

We do not cover the following:

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

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800-877-9777.

When you must file a claim – such as for services you receive outside of the Plan’s service area – submit it on the HCFA-1500 or be sure to provide documentation that includes all of the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to: PacifiCare
Attn: Customer Service, CO84-416
P.O. Box 6770
Englewood, CO 80155

Prescription Drugs

Please mail your prescription receipts with your name and ID number to:

Prescription Solutions Claims Department
P.O. Box 6037
Cypress, CA 90630

Dental services

Please provide the same information detailed in the bullets above.

Submit your claims to: PacifiCare Dental
P.O. Box 483
Tustin, CA 92781

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
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- | | |
|----------|--|
| 1 | <p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">(a) Write to us within 6 months from the date of our decision; and(b) Send your request to us at: PacifiCare
Attn: Member Appeals
P.O. Box 4306
Englewood, CO 80155-4306 <p>Or you can fax us your request at 1-303-714-2643; and</p> <ul style="list-style-type: none">(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 | <p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none">(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 | <p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p> |
| 4 | <p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">• 90 days after the date of our letter upholding our initial decision; 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. <p>Write to OPM at: United States Office of Personnel Management, Insurance Service Programs, Health Insurance Group 3, 1900 E Street NW, Washington, D.C. 20415-3630.</p> |

Send OPM the following information:

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

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

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

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

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

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 from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

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

- (a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-877-9777 and we will expedite our review; or
- (b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You can call OPM's Health Insurance Group 3 at 1-202-606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and older
- Some people with disabilities, under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- **Part A (Hospital Insurance).** Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- **Part B (Medical Insurance).** Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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

• **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 both 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+Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

**• The Original Medicare Plan
(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 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. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in Original Medicare along with this plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be coordinated by your Plan PCP, and preauthorization rules still apply.

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-800-877-9777.

We waive some costs if the Original Medicare Plan is your primary payer – we will waive some out-of-pocket costs, as follows:

- Physician office visit copayments are waived if you are enrolled in Medicare Part B.
- Hospital copayments are waived if you are enrolled in Medicare Part A.

(Primary payer chart begins on next page.)

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.

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) Are an active employee with the Federal government 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	✓	
2) Are an annuitant and... • You have FEHB coverage on your own or through your spouse who is also an annuitant	✓	
• You have FEHB coverage through your spouse who is an active employee		✓
3) 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)	✓*	
4) 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	✓	
5) 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)	✓*	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty)	✓**	
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	✓	
C. When you or a covered family member have FEHB and...		
1) Are an active employee with the Federal government 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	✓	
2) Are an annuitant and... • You have FEHB coverage on your own or through your spouse who is also an annuitant	✓	
• You have FEHB coverage through your spouse who is an active employee		✓
D. Are covered under the FEHB Spouse Equity provision as a former spouse	✓	

* Unless you have FEHB coverage through your spouse who is an active employee

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

- **Medicare+Choice**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare+Choice plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare+Choice plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare+Choice plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare+Choice plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and our Medicare+Choice Plan: You may enroll in our Medicare+Choice and also remain enrolled in our FEHB plan. In this case, we do not waive cost-sharing for your FEHB coverage.

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

Suspended FEHB coverage and a Medicare+Choice Plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare+Choice plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare+Choice 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+Choice plan's service area.

TRICARE & 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 both TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

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 the program.

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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.

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 of our allowance that you must pay for your care. See page 12.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 12.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Any skilled or non-skilled health services, or personal comfort or convenience related services, which provide general maintenance, supportive, preventive and/or protective care. Custodial care that lasts for 90 days or more is sometimes known as Long Term Care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.
Experimental or investigational services	Our National and Regional Medical Committees determine whether or not treatments, procedures and drugs are no longer considered experimental or investigational. Our determinations are based on the safety and efficacy of new medical procedures, technologies, devices and drugs.
Medical necessity	Medical necessity refers to medical services or hospital services which are determined by us to be: <ul style="list-style-type: none">• Rendered for the treatment or diagnosis of an injury or illness; and• Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and• Not furnished primarily for the convenience of the Member, the attending physician, or other provider of service; and• Furnished in the most economically efficient manner which may be provided safely and effectively to the Member.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance by our contracted rate with the participating provider.
Usual Customary and Reasonable (UCR)	Providers usual charge for furnishing treatment, service or supply; or the charge the company determines to be the general rate charged by others who render or furnish such treatment, services or supplies to persons who reside in the same geographical area.
Us/We	Us and we refer to PacifiCare of Colorado.

Section 11. FEHB facts

Coverage Information

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about 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 health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

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 Federal Employees Health Benefits (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 option of the Blue Cross and Blue Shield Service Benefit Plan that provides the lower level of coverage;
- 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 2004 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 the plan's 2003 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).

• **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under 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 Employees Health Benefits Plans 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 website, 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 job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

• **Converting to individual coverage**

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

- Your coverage under TCC or the spouse equity law ends (if you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law ends; 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 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 (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 have information about Federal and State agencies you can contact for more information.

Two new Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you know about two new Federal programs that complement the FEHB Program. First, the **Flexible Spending Account (FSA)** Program, also known as **FSAFEDS**, lets you set aside tax-free money to pay for health and dependent care expenses. The result can be a discount of 20 to more than 40 percent on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** covers long term care costs not covered under the FEHB.

The Federal Flexible Spending Account Program – *FSAFEDS*

- **What is an FSA?**

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%!*

There are two types of FSA's offered by the FSAFEDS Program:

- **Health Care Flexible Spending Account (HCFSA)**

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal income tax return, even if you don't have self and family health benefits coverage.
Note: The IRS has a broader definition than that of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum amount that can be allotted for the HCFSA is \$3,000 annually. The minimum amount is \$250 annually.

- **Dependent Care Flexible Spending Account (DCFSA)**

- Covers eligible dependent care expenses incurred so you can work, or if you are married, so you and your spouse can work, or your spouse can look for work or attend school full-time.
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified IRS dependent and/or with whom you jointly file your Federal income tax return.
- The maximum that can be allotted for the DCFSA is \$5,000 annually. The minimum amount is \$250 annually. *Note:* The IRS limits contributions to a Dependent Care FSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive

- **Enroll during Open Season**

You **must make an election** to enroll in an FSA during the FEHB Open Season. Even if you enrolled during the initial Open Season for 2003, you must make a new election to continue participating in 2004. Enrollment is easy!

- Enroll online anytime during Open Season (November 10 through December 8, 2003) at www.fsafeds.com.

- Call the toll –free number 1-877-FSAFEDS (372-3337) Monday through Friday, from 9 a.m. until 9 p.m. eastern time and a FSAFEDS Benefit Counselor will help you enroll.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and will be responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the flexible spending accounts. If you are not eligible for FEHB, you are not eligible to enroll for a Health Care FSA. However, almost all Federal employees are eligible to enroll for the Dependent Care FSA. The only exception is intermittent (also called when actually employed [WAE]) employees expected to work less than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers signed on. Under IRS law, FSAs are not available to annuitants. In addition, the U.S. Postal Service and the Judicial Branch, among others, are Federal agencies that have their own plans with slightly different rules, but the advantages of having an FSA are the same no matter what agency you work for.

• How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits of an FSA, the IRS places strict guidelines on them. You need to estimate how much you want to allocate to an FSA because current IRS regulations require you forfeit any funds remaining in your account(s) at the end of the FSA plan year. This is referred to as the “use-it-or-lose-it” rule. You will have until April 29, 2004 to submit claims for your eligible expenses incurred during 2003 if you enrolled in FSAFEDS when it was initially offered. You will have until April 30, 2005 to submit claims for your eligible expenses incurred from January 1 through December 31, 2004 if you elect FSAFEDS during this Open Season.

The **FSAFEDS Calculator** at www.fsafeds.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

• What can my HCFSA pay for?

Every FEHB health plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 12 and detailed throughout this brochure. Your HCFSA will reimburse you for such costs when they are for tax deductible medical care for you and your dependents that is NOT covered by this FEHB Plan or any other coverage that you have.

Under this plan, typical out-of-pocket expenses include:

- Infertility services
- Custodial home health care
- Experimental or investigational procedures and treatments not covered by this Plan
- Care received by non-plan providers

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. If you do not see your service or expense listed in Publication 502, please call a FSAFEDS Benefit Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA** An FSA lets you allot money for eligible expenses before your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will also be lower. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into a FSA:	\$ 2,000	\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$ 2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon in which retirement system you are enrolled (CSRS or FERS), as well as your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424, a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal income tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

Health care expenses

The HCFSA is tax-free from the first dollar. In addition, you may be reimbursed from the HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal income tax return. Using the example listed in the above chart, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal income tax return. In addition, money set aside through a HCFSA is also exempt from FICA taxes. This exception is not available on your Federal income tax return.

Dependent care expenses

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.fsafeds.com and download the Dependent Care Tax Credit Worksheet from the Quick Links box to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

• **Does it cost me anything to participate in FSAFEDS?**

Probably not. While there is an administrative fee of \$4.00 per month for an HCFSAs and 1.5% of the annual election for a DCFSA, most agencies have elected to pay these fees out of their share of employment tax savings. To be sure, check the [FSAFEDS.com](http://www.fsafeds.com) web site or call 1-877-FSAFEDS (372-3337). Also, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the plan year and wind up forfeiting your end of year account balance, per the IRS "use-it-or-lose-it" rule.

• **Contact us**

To find out more or to enroll, please visit the **FSAFEDS Web site at www.fsafeds.com**, or contact SHPS by email or by phone. SHPS Benefit Counselors are available from 9:00 a.m. until 9:00 p.m. eastern time, Monday through Friday.

- E-mail: fsafeds@shps.net
- Telephone: 1-877-FSAFEDS (372-3337)
- TTY: 1-800-952-0450 (for hearing impaired individuals that would like to utilize a text messaging service)

The Federal Long Term Care Insurance Program

It's important protection

Here's why you should consider enrolling in the Federal Long Term Care Insurance Program:

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive when you need assistance performing activities of daily living – such as bathing or dressing yourself. This need can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you control over the type of care you receive and where you receive it. It can also help you remain independent, so you won't have to worry about being a burden to your loved ones.
- **It's to your advantage to apply sooner rather than later.** Long term care insurance is something you must apply for, and pass a medical screening (called underwriting) in order to be enrolled. Certain medical conditions will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a change in health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. If you marry, your new spouse will also have a limited opportunity to apply using abbreviated underwriting. Qualified relatives are also eligible to apply with full underwriting.

To find out more and to request an 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 the terms appear.

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Summary of benefits for PacifiCare of Colorado – 2004

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

Benefits	You Pay	Page
Medical services provided by physicians:		
<ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office 	PCP office visit copayment: \$10 Specialist office visit copayment: \$40	14
Services provided by a hospital:		
<ul style="list-style-type: none"> • Inpatient 	\$150 copayment per day up to 5 days per admission	25
<ul style="list-style-type: none"> • Outpatient 	\$150 copayment for outpatient surgery; \$50 copayment for non-surgical services or 23-hour observation in an outpatient hospital setting or ambulatory surgical center	26
Emergency benefits:		
<ul style="list-style-type: none"> • In-area 	\$100 per visit; not waived if admitted	29
<ul style="list-style-type: none"> • Out-of-area 	\$100 per visit; not waived if admitted	29
Mental health and substance abuse treatment	Same as any other illness or condition	30
Prescription drugs	For a 30-day supply or trade-size package – \$10 copayment for generic formulary prescriptions; \$35 copayment for brand formulary prescriptions; \$50 copayment for non-formulary prescriptions	32–34
Dental Care	Dental PPO Plan, with \$50 self/\$150 self and family deductible; \$1,000 calendar year maximum payable benefit per person. In-network dentists charge reduced contracted rates. You pay a percentage of that contracted rate. In-network dentists do not balance bill. Out-of-network dentists are paid a percentage of the contracted fee allowance by the plan. You pay anything above that amount.	36
Chiropractic Care	\$10 copayment per visit; based on medical necessity; maximum of 20 visits per year	21
Vision Care	\$10 copayment per refraction; one refraction every 12 months.	19
Special features: Health management programs		35
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after \$5,000/person or \$10,000/family per year Some costs do not count toward this protection and you must continue to pay for some services.	12

2004 Rate Information for PacifiCare of Colorado, Inc.

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	D61	\$116.99	\$39.00	\$253.49	\$84.49	\$138.44	\$17.55
Self and Family	D62	\$277.09	\$95.74	\$600.36	\$207.44	\$327.12	\$45.71