Prudential HealthCare HMO® — Central Florida

Prudential HealthCare®
A member company of Aetna U.S. Healthcare®

2001

http://www.aetnaushc.com/pruhealthcare

A Health Maintenance Organization

Serving: Central Florida

For changes in benefits see page 9.

Enrollment in this Plan is limited; see page 8 for requirements.

4/99
This plan has commendable accreditation from the NCQA. See the *2001 Guide* for more information on NCQA.

Enrollment codes for this Plan:
EH1 Self Only
EH2 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

Federal Employees Health Benefits Program

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Introduction

Prudential Health Care Plan, Inc.,
dba Prudential HealthCare HMO® — Central Florida
1425 Union Meeting Road,
P.O. Box 1126, Mail Stop U32A
Blue Bell, PA 19422

This brochure describes the benefits of Prudential HealthCare HMO® — Central Florida under our contract (CS 1978) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

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

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 9. Rates are shown at the end of this brochure.

Plain language

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

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

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

Section 1. Facts about this HMO plan

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

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

- **Provider Compensation**

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.

This is a direct contract prepayment Plan, which means that plan providers are neither agents nor employees of the Plan. Rather, they are independent doctors and providers who practice in their own offices or facilities. The Plan arranges with licensed providers and hospitals to provide medical services for both the prevention of disease and the treatment of illness and injury for benefits covered under the Plan.

Plan providers in our network have agreed to be compensated in various ways. Many Plan primary care physicians are paid by capitation every month. Under capitation, a physician receives payment for a patient whether he sees that patient that month or not. Specialists, hospitals, primary care physicians and other providers in our network are paid in the following ways:

- Per individual service (fee-for-service at contracted rates),
- Per hospital day (per diem contracted rates), and
- Under other capitation methods (a certain amount per member, per month)

You are encouraged to ask your physicians and other providers how they are compensated for their services. Members should ask their treating provider about the method by which the provider is compensated for providing services to the member.

Who provides my health care?

When you first join the Plan, you must choose a primary care doctor for you and each covered member of your family. You may select your primary care physician from a list of family or general practitioners, pediatricians or medical internists. For women, open access to Plan gynecologists is available for the diagnosis and treatment of gynecological problems and one routine gynecological exam and Pap smear each calendar year.

Patients' Bill of Rights

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

Direct Access Ob/Gyn Program

This program allows female members to visit any Plan gynecologist for a routine well-woman exam, including a Pap smear (if appropriate) and an unlimited number of visits for gynecologic problems and follow-up care as described in your benefits plan. Gynecologists may also refer a woman directly for covered gynecologic services without the patient's having to go back to her Plan primary care physician. If your Ob/Gyn is part of an Independent Practice Association (IPA), a Physician Medical Group (PMG) or a similar organization, covered care must be coordinated through the IPA, the PMG or the similar organization.

Mental Health/Substance Abuse

Behavioral health care services (e.g., treatment or care for mental disease or illness, alcohol abuse and/or substance abuse) are managed by an independently contracted organization. This organization makes initial coverage determinations and coordinates referrals; any behavioral health care referrals will generally be made to providers affiliated with the organization, unless your needs for covered services extend beyond the capability of the affiliated providers. You can receive information regarding the appropriate way to access the behavioral health care services that are covered under your specific plan by calling Member Services at 1-800-856-0764. As with other coverage determinations, you may appeal behavioral health care coverage decisions in accordance with the provisions of your Plan.

Ongoing Reviews

We conduct ongoing reviews of those services and supplies which are recommended or provided by health professionals to determine whether such services and supplies are covered benefits under this Plan. If we determine that the recommended services and supplies are not covered benefits, you will be notified. If you wish to appeal such determination, you may then contact us to seek a review of the determination.

Authorization

Certain services and supplies under this Plan may require authorization by us to determine if they are covered benefits under this Plan.

Patient Management

We have developed a patient management program to assist in determining what health care services are covered under the health plan and the extent of such coverage. The program assists members in receiving the appropriate health care and maximizing coverage for those health care services.

Only medical directors make decisions denying coverage for services for reasons of medical necessity. Coverage denial letters delineate any unmet criteria, standards and guidelines, and inform the provider and member of the appeal process.

Our patient management staff uses national guidelines and resources to guide the precertification, concurrent review and retrospective review processes. Using the information obtained from providers, patient management staff utilize Milliman & Robertson Health Care Management Guidelines when conducting concurrent review. If there is no applicable Milliman & Robertson Guideline, patient management staff utilizes InterQual ISD criteria. To the extent certain patient management functions are delegated to integrated delivery systems, independent practice associations or other provider groups ("Delegates"), such Delegates utilize criteria that they deem appropriate.

- **Precertification** — Certain health care services, such as hospitalization or outpatient surgery, require precertification by us to ensure coverage for those services. When a member is to obtain services requiring precertification through a Plan provider, this provider should precertify those services prior to treatment.

• **Concurrent Review**	The concurrent review process assesses the necessity for continued stay, level of care, and quality of care for members receiving inpatient services. All inpatient services extending beyond the initial certification period will require Concurrent Review.
• **Discharge Planning**	Discharge planning may be initiated at any stage of the patient management process and begins immediately upon identification of post-discharge needs during precertification or concurrent review. The discharge plan may include initiation of a variety of services/benefits to be utilized by the member upon discharge from an inpatient stay.
• **Retrospective Record Review**	The purpose of retrospective review is to retrospectively analyze potential quality and utilization issues, initiate appropriate follow-up action based on quality or utilization issues, and review all appeals of inpatient concurrent review decisions for coverage and payment of health care services. Our effort to manage the services provided to members includes the retrospective review of claims submitted for payment, and of medical records submitted for potential quality and utilization concerns.

Member Services
Representatives from Member Services are trained to answer your questions and to assist you in using the Prudential HealthCare plan properly and efficiently. After you receive your ID card, you can call the Member Services toll-free number on the card when you need to:

- Ask questions about benefits and coverage.
- Notify us of changes in your name, address or telephone number.
- Change your primary care physician or office.
- Obtain information about how to file a grievance.

Confidentiality
We protect the privacy of confidential member medical information. We contractually require that Plan providers keep member information confidential in accordance with applicable laws. Furthermore, you have the right to access your medical records from Plan providers, at any time. Prudential HealthCare (including its affiliates and authorized agents, collectively "Prudential HealthCare") and Plan providers require access to member medical information for a number of important and appropriate purposes, including claims payment, fraud prevention, coordination of care, data collection, performance measurement, fulfilling state and federal requirements, quality management, utilization review, research and accreditation activities, preventive health, early detection and disease management programs. Accordingly, for these purposes, members authorize the sharing of member medical information about themselves and their dependents between Prudential HealthCare and Plan providers and health delivery systems.

If you want more information about us, call 1-800-856-0764, or write to 1425 Union Meeting Road, P.O. Box 1126, Mail Stop U32A, Blue Bell, PA 19422. You may also contact us by fax at 215-775-6550 or visit our website at www.aetnaushc.com/pruhealthcare**.**

Service Area

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area includes the Florida counties of Orange, Osceola, Seminole, Lake, Polk, Brevard and Volusia counties.

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. We will not pay for any other health care services.

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

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed higher patient cost sharing and shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling Customer Service at 1-800-856-0764, **or** checking our website at **www.aetnaushc.com/pruhealthcare.** You can find out more about patient safety on the OPM website, **www.opm.gov/insure**. To improve your healthcare, take these five steps:
  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the Prudential HealthCare HMO — Central Florida non-postal premium will increase 5.5% for Self and decreases by 7.2% for Self and Family.
- You must contact Merit Behavioral Care Corporation before obtaining mental conditions or substance abuse services. You do not need a referral from your primary care physician. See Section 5(e).
- The copayment for an office visit to a specialist has increased from $10 to $15 per visit. See Sections 5(a), 5(b), 5(d) and 5(e).
- We have eliminated the mental health 20 outpatient office visits calendar year maximum. Office visits will now be based on medical necessity. Copayments have been increased from $5 to $15 per office visit. See Section 5(e).
- We have eliminated the 30 day mental health hospitalization and also 60 days in a Day Treatment Facility calendar year maximum. The mental health hospital copay of $90 per day and the $45 per day copay for Day Treatment Facility have also been eliminated. We will treat mental health hospitalizations and Day Treatment Facility as any other illness based on medical necessity. See Section 5(e).
- If we deny your claim or services, you may be able to request an External Review. See page 41.
- Coverage for increase routine mammogram is available for women above a certain age. See page 16.

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 covered 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 1-800-856-0764.

Where you get covered care

You get covered care from "plan providers" and "Plan facilities." You will only pay copayments or coinsurance, and you will not have to file claims.

- **Plan providers**

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

We list plan providers in the provider directory, which we update periodically. The list is also on our website at **www.aetnaushc.com/pruhealthcare**.

- **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 facilities in the provider directory, which we update periodically. The list is also on our website at **www.aetnaushc.com/pruhealthcare**.

What you must do to get covered care

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

- **Primary care**

Your primary care physician can be a general practitioner, family practitioner, internist or pediatrician. Your primary care physician will provide or coordinate most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us or visit our website. We will change your primary care physician to a newly-selected primary care physician.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, you may see a network OB/GYN, chiropractor, Dermatologist (up to 5 visits annually), or Podiatrist without a referral.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause; or
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
  - reduce our service area and you enroll in another FEHB Plan,

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

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

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise covered 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 1-800-856-0764. 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 hospital benefits of the hospitalized person.

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process precertification. Your Plan physician must obtain approval for certain services such as hospitalization or surgery and the following services:

- For certain prescription drugs
- For covered transplant surgery
- For certain diagnostic tests
- For ambulance transportation
- For coverage of follow-up care by a non-Plan provider.

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 when you receive services.

  Example: When you see your primary care physician you pay a copayment of $10 or $15 if you see a plan specialist.

- **Coinsurance** — We do not have coinsurance.

Your out-of-pocket maximum

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

- Prescription drugs

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

Section 5. Benefits – OVERVIEW

(See page 9 for how benefits changed this year and page 55 for benefit 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 benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-856-0764 or at our website at **www.aetnaushc.com/pruhealthcare**.

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office	$10 per PCP visit $15 per specialist visit
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion • Treatment of diseases of the eye	$10 per PCP visit $15 per specialist visit
At home	Nothing
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during your office visit; otherwise, $10 per PCP visit $15 per specialist visit

Preventive care, adult	You pay
Routine screenings, such as: • Periodic check-ups • Blood lead level • Total blood cholesterol • Colorectal Cancer Screening, including •• Fecal occult blood test	$10 per PCP visit $15 per specialist visit
•• Sigmoidoscopy, screening — every five years starting at age 50	Nothing
Prostate Specific Antigen (PSA test)	Nothing
Routine pap test **NOTE**: There is no copay for the pap test if performed during the office visit.	$10 per PCP visit $15 per specialist visit
Routine mammogram — covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • At age 40 and older, one every calendar year.	$10 per PCP visit $15 per specialist visit
• Routine Immunizations	$10 per PCP visit $15 per specialist visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Preventive care, children	
Childhood immunizations recommended by the American Academy of Pediatrics	Nothing if these services are received during your office visit, otherwise $10 per PCP visit $15 per specialist visit
• Examinations, such as: •• Eye exams through age 17 to determine the need for vision correction. •• Ear exams through age 17 to determine the need for hearing correction •• Examinations done on the day of immunizations (through age 22) • Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per PCP visit $15 per specialist visit

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care **NOTE**: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. 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 for the first PCP visit only $15 for the first specialist visit only
Family planning	
• Voluntary sterilization • Surgically implanted contraceptives **NOTE**: We will give no refund of any portion of the office visit copay if an implanted time-release medication is removed before the end of its expected life. Coverage is limited to one implanted time-release medication within the expected lifetime of the product. • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per PCP visit $15 per specialist visit
Not covered: • Reversal of voluntary surgical sterilization, genetic counseling • More than one implanted time-release medication within the expected lifetime of the product	*All charges*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: •• intravaginal insemination (IVI) •• intracervical insemination (ICI) •• intrauterine insemination (IUI) • Injectable Fertility drugs **NOTE**: We cover oral fertility drugs under the prescription drug benefit.	$15 per specialist visit
Not covered: • *Any procedures which involve harvesting, storage and/or manipulation of eggs and sperm* • *Assisted reproductive technology (ART) procedures, such as:* •• *in vitro fertilization* •• *embryo transfer* •• *embryo freezing* •• *GIFT procedures* •• *ZIFT procedures* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm*	*All charges*
Allergy care	
Testing and treatment Allergy injection	$10 per PCP visit $15 per specialist visit
Allergy serum	Nothing
Treatment therapies	
• Chemotherapy and radiation therapy **NOTE**: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 24. • Respiratory and inhalation therapy • Dialysis — Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy — Home IV and antibiotic therapy • Growth hormone therapy (GHT)	$15 per visit

Rehabilitative therapies	You pay
Physical therapy, occupational therapy and speech therapy — • Up to two months per condition if significant improvement can be expected within two months for the services of each of the following: •• qualified physical therapists; •• speech therapists; and •• occupational therapists. **NOTE**: We only cover speech therapy for certain speech impairments of organic origin. We only cover occupational therapy services that assist the member to achieve and maintain self-care and improved functioning in other areas of daily living.	Nothing
Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction — • Up to 60 consecutive days from the day therapy begins in a Plan facility	$10 per PCP visit $15 per specialist visit
• Physical therapy to treat temporomandibular joint (TMJ) dysfunction syndrome	$10 per PCP visit $15 per specialist visit
Not covered: • *long-term rehabilitative therapy*	*All charges*
Hearing services (testing, treatment, and supplies)	
• Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per PCP visit $15 per specialist visit
Not covered: • *all other hearing testing at age 18 and older, unless medically necessary* • *hearing aids*	*All charges*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	$15 per office visit, nothing for the eyeglasses or contact lenses
• Annual eye refractions (which include a written lens prescription for eyeglasses) obtained from Plan providers)	$15 per office visit
Not covered: • *All other eyeglasses or contact lenses* • *Eye exercises* • *Contact lens prescriptions* • *Radial keratotomy and other refractive surgery*	*All charges*

Foot care	You pay
• Coverage for routine foot care when you are under active treatment for a metabolic or peripheral vascular disease or of a neurological condition.	$15 per specialist visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• Internal prosthetic devices, such as artificial joints, pacemakers and surgically implanted breast implant following mastectomy. **NOTE**: See 5(b) for coverage of the surgery to insert the device. • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Orthopedic devices, such as braces or foot orthotics • Prosthetic devices, such as artificial limbs or initial eye glasses or lenses following cataract removal • Corrective orthopedic appliance for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	$15 per visit
Durable medical equipment (DME)	
• Rental or purchase (determined by the Plan) of durable medical equipment, such as hospital beds and wheelchairs. • Replacement, repair and maintenance of durable medical equipment not provided under a manufacturer's warranty or purchase agreement.	All charges over $100,000 in your lifetime
Not covered: • *Exercise equipment, including, but not limited to, exercycles*	*All charges*
Home health services	
• Home health services of nurses and health aides, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need.	Nothing
Not covered: • *Homemaker services*	*All charges*

Alternative treatments	You pay
Chiropractic services	$10 per PCP visit or $15 per specialist visit
Dermatology services - you may see a Plan Dermatologist without a referral from your PCP for up to 5 visits annually. You will need to obtain a referral from your PCP, if more than 5 visits are required.	$15 per visit
Educational classes and programs	
Outpatient diabetes self-management training and educational services given by certified educators or board certified endocrinologists	$10 per PCP visit or $15 per specialist visit
Not covered: • *Services and supplies to the extent that they are determined by us to be educational. "Educational" means:* *(a) That the primary purpose of the service or supply is to provide the person with any of the following: training in the activities of daily living; instruction in scholastic skills such as reading and writing; preparation for an occupation; or treatment for learning disabilities; or* *(b) That the service or supply is being provided to promote development beyond any level of function previously demonstrated.*	*All charges*

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- 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 facility (i.e. hospital, surgical center, etc.).
- Plan physicians must get precertification of surgical procedures.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity — Surgical treatment of morbid obesity — a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. This procedure must be approved in advance by us. • Insertion of internal prosthetic devices. See 5(a) — Orthopedic braces and prosthetic devices for device coverage information. • Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUD's) **NOTE**: Devices are covered under 5(a). • Treatment of burns	Nothing

Surgical Procedures — *Continued on next page*

Surgical procedures (*continued*)	You pay
Not covered: • *Reversal of voluntary surgically-induced sterilization* • *Blood and blood derivatives replaced by or for the member* • *Eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperpia) and astigmatism* • *Cosmetic surgery furnished mainly to change your appearance. This includes surgery to treat a mental, psychoneurotic or personality disorder through change in appearance* • *Services or supplies for sex changes* • *Treatment of non-morbid obesity in the absence of concurrent disease*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) **NOTE**: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Oral and maxillofacial surgery	
Oral surgical procedures, such as: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip or cleft palate or severe functional malocclusion; • Removal of stones from salvary ducts; • Excision of leukoplakia or malignancies; • Excision of tumors; • Other surgical procedures that do not involve the teeth or their supporting structures.	$15 per office visit, Nothing for surgical procedures

Oral and maxillofacial surgery — *Continued on next page*

Oral and maxillofacial surgery (*continued*)	You pay
Not covered: • *All other procedures involving the teeth or intra-oral areas surrounding the teeth* • *Any dental care involved with the treatment of temporomandibular joint (TMJ) pain dysfunction syndrome*	*All charges*
Organ/tissue transplants	
Limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Lung: Single — Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors **NOTE**: Transplants are covered when approved by the Medical Director. • The Institutes of Quality (IQ) Program —.The Institutes of Quality (IQ) Program provides coverage for sophisticated medical treatments and procedures offered by a network of hospitals and physicians known for their demonstrated accomplishment in patient outcomes. The IQ Program includes a nationwide network for organ transplants, bone marrow transplants, and brain and spinal cord injury rehabilitation. Under the IQ Program, your primary care physician initiates a referral to an institute of quality for covered procedures. You must meet certain pre-screening criteria. Your participation is strictly subject to approval by Prudential HealthCare. You may contact us at 1-800-856-0764 for further information about the program. **NOTE**: We cover related medical and hospital expenses of the donor when we cover the recipient.	$15 per office visit, Nothing for surgical procedures
Not covered: • *Transplants not listed as covered*	*All charges*

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

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

IMPORTANT

Here are some important things to remember about these benefits:

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

IMPORTANT

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

Outpatient hospital or ambulatory surgical center	You pay
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service **NOTE**: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: blood and blood derivatives replaced by or for the member	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Extended care benefit: Up to 100 days per condition for all confinements which are due to the same or related causes and which are separated by less than three months. **NOTE**: Coverage is provided 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 the Plan. All necessary services are covered, including; • Bed, board and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	Nothing
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Personal comfort items, such as telephone and television*	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member in the home or hospice facility. Covered services include inpatient and outpatient care and family counseling. Hospice 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 six months or less. **NOTE**: Counseling must be provided within three months after the death of the patient.	All charges over : $7,400 for the patient and $200 for family counseling
Ambulance	
• Ambulance service ordered or authorized by a Plan doctor	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

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

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

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, call you primary care doctor. In extreme emergencies or if you are unable to contact your doctor, contact the local emergency system (e.g. the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify your primary care doctor. You or a family member must notify your primary care doctor as soon as possible after receiving emergency care. It is your responsibility to ensure that your primary care doctor has been timely notified.

If you need to be hospitalized, the Plan must be notified as soon as possible. If you are hospitalized in non-Plan facilities and a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by us or provided by plan providers.

Emergencies outside our service area: Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified as soon as possible. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by us or provided by plan providers.

Portability:

If you are away from home and require medical care other than routine physicals, immunizations and non-emergency maternity care, you can use any Prudential HealthCare network facility in the area you are visiting. You will receive this care at a maximum benefit level as if you were at home, free of bills and claim forms.

To obtain these benefits you must do one of two things:

- Contact your primary care doctor at home to obtain permission for out-of-area care. In life-threatening emergencies, we recommend that you seek appropriate treatment immediately. However, you or a family member must notify your primary care doctor within 48 hours concerning the emergency care you received.

- Contact the Prudential HealthCare office in the city you are visiting or the National Hotline (1-800-526-2963) to obtain a referral to a local Plan doctor. This toll free number is also located on the back of your member ID card and is answered 24 hours a day.

Your home Plan is responsible for reimbursing the providers in the out-of-area Prudential HealthCare HMO plan. You should not be asked to make payments, except applicable copays, or file a claim form unless you receive authorized treatment from a non-Plan provider.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center with referral	$10 per PCP visit $15 per specialist visit
• Emergency care in a hospital emergency room, including doctors' services **NOTE**: If the emergency results in admission to a hospital, we waive the copay.	$50 per visit
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center **NOTE**: Urgent care services rendered outside our service area must be coordinated through the Prudential National Service Hotline (1-800-526-2963) for the $15 copay to apply.	$15 per visit
• Emergency care in a hospital emergency room, including doctors' services **NOTE**: If the emergency results in admission to a hospital, we waive the copay.	$50 per visit
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
Ambulance service approved by the Plan. See 5(c) for non-emergency service.	Nothing

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

Network Benefit		
IMPORTANT	**Parity** Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past. When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions. **Here are some important things to keep in mind about these benefits:** • All benefits are subject to the definitions, limitations, and exclusions in this brochure. • Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. • **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.	IMPORTANT

Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. **NOTE**: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$15 per visit
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, residential treatment, full-day hospitalization, facility based intensive outpatient treatment.	Nothing
Not covered: Services we have not approved. **NOTE**: *OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Network mental health and substance abuse benefits — *Continued on next page.*

Preauthorization

To be eligible to receive these enhanced mental health and substance abuse benefits you must follow your treatment plan and all of our network authorization processes. These include:

You must call Merit Behavioral Care Corporation at 1-800-210-6280 prior to obtaining mental health or substance abuse services.

We may limit your benefits if you do not follow your treatment plan.

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following conditions:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you, we will allow you reasonable time to transfer your care to a network mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage. The transitional period will last for up to 90 days from the date you receive notice of the change. You may receive this notice prior to January 1, 2001, and the 90 day period begins with receipt of the notice.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

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

IMPORTANT

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

- **Who can write your prescription.** A Plan or referral physician must write the prescription
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy for up to a 30-day supply, or by mail for a 30-90 day supply of medication (if authorized by your physician). Please call Member Services at 1-800-856-0764 for more details on how to use the mail order program. In an emergency or urgent care situation, you may fill your covered prescription at any retail pharmacy. If you obtain your prescription at a non-Plan pharmacy, you will need to pay the pharmacy the full price of the prescription and submit a claim for reimbursement subject to the terms and conditions of the Plan.
- **We use a formulary.** The plan uses a formulary. A formulary is a list of medications generally available under the plan subject to applicable terms and conditions. Coverage under the plan is not limited to medications included on the formulary, however a higher copayment may apply. Non-formulary drugs will be covered when prescribed by a licensed physician or dentist, but at the highest copay level. Visit our website at **www.aetnaushc.com/pruhealthcare** to review our Formulary Guide or call 1-800-856-0764.
- **Precertification.** Your pharmacy benefits plan includes our precertification program. Precertification helps encourage the appropriate and cost-effective use of certain drugs. These drugs must be pre-authorized by our Pharmacy Management Precertification Unit before they will be covered. Only your physician or pharmacist in the case of an antibiotic or analgesic can request prior authorization for a drug.

  The precertification program is based upon current medical findings, manufacturer labeling, FDA guidelines and cost information.

  The drugs requiring precertification are subject to change. Visit our website for the current Precertification List.
- **These are the dispensing limitations.** Prescription drugs will be dispensed for up to a 30-day supply or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin) or up to a 90-day supply by mail order, when permitted by a licensed physician or dentist. We follow FDA dispensing guidelines. For example, Diflucan VC is FDA indicated as a single-dose treatment and a copay will be charged for each tablet. The treatment usage for many antibiotics will be for a 10-day supply or less for which one copay would apply.

  Only maintenance medications and contraceptives can be obtained by mail order. Maintenance drugs are used for the treatment of the following chronic medical conditions: chronic obstructive pulmonary disease; clotting drugs; congestive heart failure; coronary artery disease (angina); diabetes; glaucoma; hypertension; thyroid disease; and seizure disorders. We may also include other conditions.
- **When you have to file a claim.** Call us at 1-800-856-0764 to obtain a claim form.
  Mail the completed claim form with your itemized bills to: Prudential HealthCare Pharmacy Services, Member Reimbursement Department, P.O. Box 34860, Louisville, KY 40232-4860.

Prescription drug benefits— *Continued on next page*

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. • Disposable needles and syringes for the administration of covered medications • Insulin, with a copay applied to each vial • Contraceptive drugs and devices, including diaphragms. • Oral fertility drugs (injectables are covered under Medical Services and Supplies. See Section 5(a).) The following are examples of what a copay applies to: • Up to a 30-day supply of tablets, capsules and liquids to be taken orally; or as indicated for use by the Food and Drug Administration (FDA). For example, Diflucan VC is FDA indicated as a single-dose treatment and copay will be charged for each tablet. The treatment usage for many antibiotics will be for a 10-day supply or less for which one copay would apply. • a manufacturer's standard 10 milliliter vial of insulin; • insulin syringes, a copay applies to each package of 100; • a package of no more than 15 milliliters of any optic or ophthalmic product; • a manufacturer's smallest standard package of nasal or oral inhaler; • a manufacturer's smallest standard package of nebulizer solution; • 1 manufacturer's smallest standard package of liquid or solid rectal or vaginal medication; • 1 manufacturer's smallest standard package containing no more than 60milliliters of topical solutions or lotions; • 1 manufacturer's smallest standard package containing no more than 60 grams of topical ointments or creams; • Up to a 30 day supply of patches, a copay applies to each manufacturer's standard package; • 1 package of oral contraceptives; • 1 diaphragm unit; • Diabetic supplies (except insulin), disposable needles and syringes, contraceptive devices other than diaphragms, intravenous fluids and medications for home use, implantable drugs (such as Norplant®), and injectable drugs (such as Depo Provera® or some fertility drugs) are covered under the Medical Benefits. **Limited benefits** Drugs to treat sexual dysfunction have dispensing limitations. Contact Member Services at (800) 856-0764 for specific details.	**In a Plan pharmacy (per 30-day supply or commercially prepared unit/refill):** $5 per prescription unit/refill for generic formulary drugs $10 per prescription unit/refill for brand name formulary drugs $20 per prescription unit/refill for non-formulary drugs

Covered medications and supplies —*Continued on the next page.*

Covered medications and supplies (*Continued)*	You pay
Maintenance medications and oral contraceptives may also be obtained through a Plan Mail Order drug program for up to a 90 day supply per refill or order. Maintenance drugs are used for the treatment of the following chronic medical conditions: chronic obstructive pulmonary disease; clotting drugs; congestive heart failure; coronary artery disease (angina); diabetes; glaucoma; hypertension; thyroid disease; and seizure disorders. We may also include other conditions.	**By mail order for a 90-day supply** $5 per prescription unit/refill for generic formulary drugs $10 per prescription unit/refill for brand name formulary drugs $20 per prescription unit/refill for non-formulary drugs
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements which can be obtained without a prescription* • *Nonprescription medicines* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Medical supplies, such as dressings and antiseptics* • *Drugs, services and supplies provided in connection with any weight loss program or food supplements used to achieve weight loss, unless the member is morbidly obese or the obesity is shown to have an adverse effect on a concurrent sickness*	*All Charges*

Section 5 (g). Special Features

Feature	Description
High risk pregnancies	Prudential HealthCare's Starting Right Program includes components for both low-risk and high-risk maternity care. We have refined processes to make educational materials for low-risk members even more easy to access and member-satisfying. For high-risk members, we work closely with Plan obstetricians on providing case management by our registered nurses.
Centers of excellence for transplants/heart surgery, etc.	The Institutes of Quality (IQ) Program provides coverage for sophisticated medical treatments and procedures offered by a network of hospitals and physicians known for their demonstrated accomplishment in patient outcomes. The IQ Program includes a nationwide network for organ transplants, bone marrow transplants, and brain and spinal cord injury rehabilitation. Under the IQ Program, your primary care physician initiates a referral to an institute of quality for covered procedures. You must meet certain pre-screening criteria. Your participation is strictly subject to approval by Prudential HealthCare. You may contact us at 1-800-856-0764 for further information about the program.

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	You Pay
We cover restorative services and supplies necessary to promptly repair or replace sound natural teeth. The need for these services must result from an accidental injury.	$15 per visit
Not covered: • *Other dental services not shown as covered*	*All charges*
Dental benefits	
We have no other dental benefits.	*All charges*

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.

Dental Program

The Dental Program is a comprehensive dental plan with no claim forms or deductibles. It is not insurance; it's a discount dental program, with more than 10,000 Plan dentists across the country. These dentists have agreed to provide services to program participants at reduced rates — including periodic exams, cleanings … even orthodontia care.

For as little as $5.00 per month ($6.00 for families), you will have access to a full range of dental services at a substantial discount. The Schedule of Benefits has changed for 2001. You can enroll by submitting a completed application and a full year's premium, $60.00 for an individual and $72.00 for a family. (Please note, this is not a payroll deducted plan.) Applications and more details about the Dental Program are included in your Prudential HealthCare open enrollment packet. You may contact Benefit Network Systems at 1-800-391-9721 for more information.

Vision Program

As a Prudential HealthCare HMO member, you can obtain discounts on eyeglasses and frames at designated locations. Call customer service at 1-800-856-0764 for more details.

The Vitamin Advantage Program is no longer available.

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

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

We do not cover the following:

- Care by non-**Plan** providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Procedures, 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;
- Procedures, 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 and supplies provided by you, your spouse, or a child, brother, sister or parent of you or your spouse.

Section 7. Filing a claim for covered services

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

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

Medical and hospital 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 1-800-856-0764.

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

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

Submit your claims to: Prudential HealthCare, P.O. Box 45082, Jacksonville, FL 32232-5082.

Mental health and substance abuse benefits

Submit your claims to: Magellan Behavioral Health, Prudential Central Florida, P.O. Box 1626, Maryland Heights, MO 63043.

Prescription drugs

Call 1-800-856-0764 to obtain a claim form. Send the completed claim form and the original pharmacy receipt (no cash register receipts) which includes the pharmacy name, address and telephone number, drug name strength, number of units dispensed and the amount you paid.

Submit your claims to: Prudential HealthCare Pharmacy Services, Member Reimbursement Department, P.O. Box 34860, Louisville, KY 40232-4860.

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Prudential HealthCare, P.O. Box 44163, Jacksonville, FL 32231-4163; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: • Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or • Write to you and maintain our denial — go to step 4; or • Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request — go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us — if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. **NOTE**: If you want OPM to review different claims, you must clearly identify which documents apply to which claim. **NOTE**: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must provide a copy of your specific written consent with the review request. **NOTE**: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

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

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-856-0764 and we will expedite our review; or

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division III at 202-606-0755 between 8 a.m. and 5 p.m. eastern time.

External Review

You can seek an independent external review if:

1. The amount of your claim or service is more than $500; and
2. We denied your claim because we did not consider the treatment medically necessary or considered it experimental or investigational.

The independent external review will use a neutral, independent physician with related expertise to conduct the review. We will cover the professional fee for the review and you will pay the cost to compile and send your submission to the Plan.

To request an External Review Form, call 1-800-856-0764 within 60 days after receiving our written notification that we will uphold our original decision to deny your claim.

The external reviewer will make a decision within 30 days after you send us all the necessary information with the External Review Request Form. Your primary care physician can request an expedited review in cases of "clinical urgency" where your health would be seriously jeopardized if you waited the full 30 days. In this case, the external review organization or physician will make a decision within 72 hours.

To request a detailed description of the external review requirements, call us at 1-800-856-0764.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

- **What is Medicare?**

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

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

- **The Original Medicare Plan**

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

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover benefits. Your care must continue to be authorized by your **Plan** PCP, or precertified as required.

We will not waive any of our copayments, coinsurance, and deductibles.

(Primary payer chart begins on next page.)

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

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

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

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything unless your Plan physician does not participate in Medicare. To find out if you need to do something about filing your claims, call us at 1-800-856-0764.

We waive some costs when you have Medicare — When Medicare is the primary payer, we do not waive any out-of-pocket costs.

- **Medicare managed care plan**

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

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and /or service area (if you use our Plan providers), but we will not wave any of our copayments.

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

- **Enrollment in Medicare Part B**

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

TRICARE

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See pages 9 and 13.

Coinsurance

Coinsurance is the percentage of expenses that you must pay for your care. We do not have coinsurance on this Plan.

Covered services

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

Custodial care

Any type of care provided in accordance with Medicare guidelines, including room and board, that a) does not require the skills of technical or professional personnel; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-hospital Skilled Nursing Facility care; or c) is a level such that you have reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care where the primary purpose of the type of care provided is to attend to your daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of this includes, but is not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non infected, post operative or chronic conditions, preparation of special diets, supervision of medication which can be self-administered by the you, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of us, based on medically accepted standards, can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical or paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest cures, convalescent care.

Detoxification

The process whereby an alcohol or drug intoxicated or alcohol or drug dependent person is assisted, in a facility licensed by the appropriate regulatory authority, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol or drug, alcohol or drug dependent factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

Experimental or investigational services

We do not cover procedures, services, or supplies that are experimental or investigational. In order to determine whether or not a procedure, service, or supply is experimental or investigational, we gather appropriate information for a decision that will be made by medical professionals. The information we collect may include medical records, current reviews of medical literature and scientific evidence, results of current studies or clinical trials, research protocols, reports or opinions of authoritative medical bodies, opinions of independent outside experts and approvals granted by regulatory bodies. Your provider may sometimes ask that you sign a form acknowledging that the procedure, service, or supply is experimental or investigational. This form and any related protocol may also be part of the information we consider. After reviewing all pertinent information, we make our determination and notify you of our decision. Please contact customer service at 1-800-856-0764 for more specific information.

Medical necessity

Also known as medically necessary or medically necessary services. Services that are appropriate and consistent with the diagnosis in accordance with accepted medical standards as described in this document. Medical Necessity, when used in relation to services, shall have the same meaning as Medically Necessary Services. This definition applies only to the determination by us of whether health care services are Covered Benefits under this Plan.

Reasonable Charge

The charge for a Covered Benefit which is determined by us to be the prevailing charge level made for the service or supply in the geographic area where it is furnished. We may take into account factors such as the complexity, degree of skill needed, type or specialty of the Provider, range of services provided by a facility, and the prevailing charge in other areas in determining the Reasonable Charge for a service or supply that is unusual or is not often provided in the area or is provided by only a small number of providers in the area.

Referral

Specific directions or instructions from your PCP, in conformance with our policies and procedures, that direct you to a Plan provider for medically necessary care.

Respite Care

Care furnished during a period of time when your family or usual caretaker cannot, or will not, attend to the your needs.

Urgent Care

Covered benefits required in order to prevent serious deterioration of a your health that results from an unforeseen illness or injury if you are temporarily absent from the our service area and receipt of the health care service cannot be delayed until your return to the service area.

Us/We

Us and we refer to Prudential HealthCare HMO — Central Florida

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

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

Your medical and claims records are confidential

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

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

When you retire

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

When you lose benefits

- **When FEHB coverage ends**

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

  - Your enrollment ends, unless you cancel your enrollment, or
  - You are a family member no longer eligible for coverage.

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

- **Spouse equity coverage**

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

- **TCC**

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

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

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

- **Converting to individual coverage**

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

- **Inspector General Advisory**

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 1-800-856-0764 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE — 202-418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

- **Penalties for Fraud**

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

Index

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

NOTES:

NOTES:

Summary of benefits for Prudential HealthCare HMO®-Central Florida- 2001

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office ..... • Maternity	Office visit copay: $10 primary care; $15 specialist First visit only	15
Services provided by a hospital: • Inpatient ..... • Extended Care (up to 100 days) ..... • Outpatient.....	Nothing	26 26 27
Emergency benefits: • In-area ..... • Out-of-area.....	$50 per ER copay $15 per Urgent Care Center or physician visit	28 29
Mental health and substance abuse treatment	Same as medical and hospital benefits	30
Prescription drugs.....	$5 per prescription for a generic formulary drug, $10 per prescription for a brand name formulary drug, or a $20 per prescription for a non-formulary drug	32
Dental Care.....	$15 copay per visit for Accidental injury benefit only	36
Vision Care.....	$15 copay — one refraction annually	19
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $1,500/Self Only or $3,000/Family enrollment per year Copays for prescription drugs do not count towards these limits.	13
Special Features: High risk pregnancies and Centers of excellence for transplants/heart surgery, etc.	Contact Plan	35

2001 Rate Information for Prudential HealthCare HMO® — Central Florida

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

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

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Central Florida							
Self Only	EH1	$71.51	$23.83	$154.93	$51.64	$84.61	$10.73
Self and Family	EH2	$195.82	$70.98	$424.28	$153.79	$231.17	$35.63