UnitedHealthcare of North Carolina, Inc.

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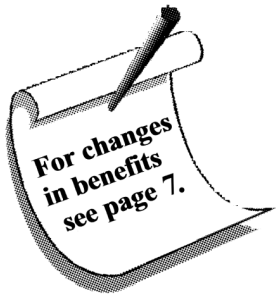
A UnitedHealth Group Company

2001

A Health Maintenance Organization



Serving: Central, Eastern and Western North Carolina.

Enrollment in this Plan is limited; see page 6 for requirements.

This Plan has commendable accreditation from the NCQA.
See the 2001 Guide for more information on NCQA.

Enrollment codes for this Plan:

XM1 Self Only
XM2 Self and Family

Authorized for distribution by the:

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

FEHB
Federal Employees
Health Benefits Program

RI 73-638

Table of Contents

Introduction

UnitedHealthcare of North Carolina, Inc.
2307 West Cone Blvd.
Greensboro, NC 27408

This brochure describes the benefits of UnitedHealthcare of North Carolina under our contract (CS 2702) 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 **7**. 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 UnitedHealthcare of North Carolina.

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

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 are only responsible for your copayments or coinsurance. Additionally, we will process claims according to regulatory standards.

Patients' Bill of Rights

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

- We are licensed by the State of North Carolina as a Health Maintenance Organization. We maintain compliance with all Federal and State laws, regulations, and mandates.

- UnitedHealthcare of North Carolina was formed in 1996 upon the purchase of PHP Inc. by United Healthcare, Inc. PHP Inc. (formerly Physicians Health Plan of North Carolina, Inc.) was licensed by the State of North Carolina as a Health Maintenance Organization in May 1985.

- Since 1985, we have experienced continued growth in membership and currently serving the needs of over 300,000 members. Annual income in 1998 and 1999 was $8,278,253 and $7,503,721 respectively.

If you want more information about us, call 800/999-1147, or write to UnitedHealthcare of North Carolina's Customer Service Department at P. O. Box 26303, Greensboro, NC 27438-6303. You may also contact us by fax at 336/286-3778 or visit our website at www.uhc.com or by email at nccstsvc@uhc.com.

Service Area

To enroll in our Plan, you must "live in or work in" our Service Area. This is where our providers practice. Our service area is: The Counties of Alamance, Alexander, Bladen, Brunswick, Buncombe, Burke, Caldwell, Caswell, Catawba, Cleveland, Columbus, Cumberland, Davidson, Davie, Duplin, Durham, Forsyth, Guilford, Harnett, Haywood, Henderson, Hoke, Iredell, Jackson, Lee, McDowell, Moore, New Hanover, Onslow, Orange, Pender, Person, Polk, Randolph, Richmond, Robeson, Rockingham, Rutherford, Sampson, Scotland, Stokes, Surry, Transylvania, Wake, Watauga, Wilkes, Wilson, and Yadkin.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will only cover you for urgent and emergent care. We will not pay for any other health care services without prior approval.

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

Section 2. How we change for 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, shorter day and 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 (800) 999-1147 and speaking with our Customer Service Representatives, **or** checking our website at www.uhc.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:

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

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

Changes to this Plan

- Your share of the non-postal Premium will increase 21% for Self Only or 16% for Self and Family.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800/999-1147.

Where you get covered care

You get 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 contract with hospitals, pharmacies, Primary Care physicians and specialists to provide health care services to you.

We list Plan providers in the provider directory, which we update periodically.

- **Plan facilities**

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

What you must do to get covered care

We are an open access network and do not require that you select a primary care physician. If you need medical attention, simply refer to your provider directory for a participating provider name and call to arrange for your office visit.

- **Primary care**

We encourage you to select a primary care physician for you and each member of your family. A primary care physician can be a family practitioner, internist, pediatrician, or OB/Gyn provider. We recognize the importance and value a primary care physician can bring to the coordination of your health care.

- **Specialty care**

You may self-refer to most specialists simply by selecting a provider from our provider directory and calling for an appointment.

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 participating physician will make arrangements for appropriate referrals and develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your participating 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 participating physician. Your participating 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 participating physician, who will assist you in choosing 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 participating physician or participating specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800/999-1147. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

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

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

Circumstances beyond our control

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

Services requiring our prior notification

Your participating physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us.

We call this review the pre-notification process. You, your provider, or your physician must always make notification to us for the following services:

- Any and all non-Plan providers
- Mental Health and Substance Abuse services must be pre-authorized through our MH/SA provider by calling into our toll free number of 800/559-5951.
- Some prescription drugs may need prior authorization. Generally, these are medications which requires you be closely monitored by your physician. See prescription drug benefits in Section 5 (f) on page 33.
- Durable Medical Equipment exceeding $1,000 in cost

Failure to make notification the above services will result in you being responsible for all charges for services to these providers. It is your responsibility to assure the notification has been approved prior to you seeking services from 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 to the provider when you receive services.

Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you would have no copayment due.

•Deductible

We do not have a deductible.

•Coinsurance

Coinsurance is the percentage of our negotiated fee that you must pay for your care. Our coinsurance doesn't require that you meet a deductible.

Example: In our Plan, you pay the following coinsurance:

- 40% for Biofeedback
- 50% for Diagnosis and treatment of infertility
- 40% for Implanted, time released medications
- 40% for Durable medical equipment, exceeding $100 in cost
- 40% for Ostomy supplies
- 20% for Ambulance services
- 20% for Accidental dental care

Your out-of-pocket maximum for Copayments and co-insurance

After your copayments and coinsurance total $2,500 per person or $5,000 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 and coinsurance since you are responsible for informing us when you reach the maximum.

Section 5. Benefits -- OVERVIEW

(See page 7 for how our benefits changed this year and page 55 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 800/999-1147 or at our website at www.uhc.com or at our email address at nccstsvc@uhc.com .

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office	$10 per office 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	$10 per office visit except as noted below: $20 per urgent care visit Nothing for hospital care Nothing for skilled nursing home
• At home	$50 per visit
Diagnostic and treatment services	**You pay**
Not covered: • Chiropractic services • Homemaker services	*All charges.*

Diagnostic and treatment services – Continued on next page

Lab, X-ray and other diagnostic tests (C*ontinued)*	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology	Nothing at a free standing outpatient facility.
• X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	$10 per office visit
Preventive care, adult	
Routine screenings, such as: • Blood lead level – One annually • Total Blood Cholesterol – One annually • Colorectal Cancer Screening, including ••Fecal occult blood test	$10 per office visit
••Sigmoidoscopy, screening – every five years starting at age 50	$100 per outpatient setting visit
Prostate Specific Antigen (PSA test) – one annually	$10 per office visit
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnostic and Treatment Services*, above.	$10 per office visit
Preventive care, adult	**You pay**
Routine mammogram –covered annually	$10 per office visit. Nothing at outpatient facility
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, sports, or travel.*	*All charges.*
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) and more frequent if you've had an accident. • Influenza/Pneumococcal vaccines, annually as suggested by your physician	$10 per office visit

Preventive care -- children continues on next page

Preventive care, children *(Continued)*	**You pay**
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit
• Examinations, such as: ••Eye exams ••Ear exams ••Examinations done on the day of immunizations • Well-child care charges for routine examinations, immunizations and care	$10 per office visit
Maternity care	**You pay**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery. • 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). See Special Features, Section 5 G, regarding our Healthy Pregnancy Program	$100 for pre and post-natal care.
Not covered: *Routine sonograms to determine fetal age, size or sex*	*All charges*

Family planning	
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per office visit $100 at outpatient facility 40% of charges for implanted contraceptives
Not covered: • *Reversal of voluntary surgical sterilization* • *Voluntary abortions except when the mother's life is endangered or if due to an act of rape or incest.*	*All charges.*
Infertility services	**You pay**
Diagnosis and treatment of infertility, such as: • Artificial insemination: ••intravaginal insemination (IVI)	50% of charges
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* ••*in vitro fertilization* ••*embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Fertility drugs*	*All charges.*
Allergy care	
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Not covered: • *Provocative food testing and sublingual allergy desensitization*	*All charges.*

Treatment therapies	You pay
• 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)	$10 per office visit. Nothing at outpatient facility or by a home health care provider
Rehabilitative therapies	**You pay**
Physical therapy, occupational therapy and speech therapy -- • Two consecutive months per condition for the services of each of the following: ••qualified physical therapists; ••speech therapists; and ••occupational therapists. Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to a maximum of $500 in charges during the entire time you are covered under the plan.	$10 per office visit Nothing for Cardiac Rehabilitation
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges.*
Hearing services (testing and treatment)	
• Hearing testing for adults • Hearing testing for children through age 17 (see Preventive care, children)	$10 per office visit.
Not covered: • *Hearing aids*	*All charges.*

Vision services (testing, treatment, and supplies)	You pay
• Eye refraction exam – annually	$10 per office visit
• Eye exam to determine the need for vision correction for children (see preventive care) • Annual eye refractions	$10 per office visit
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *External lenses following cataract surgery*	*All charges.*
Foot care	
Routine foot care See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Orthopedic and prosthetic devices	**You pay**
• Artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthodontic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. Note: Should you need orthopedic or prosthetic devices we suggest you call us at (800) 999-1147 to confirm which vendor you should purchase the items from. Additionally, we will tell you more about this benefit when you call. Note: For items with charges that exceed $1,000, call us at 800/999-1147 as soon as your Plan physician prescribes this equipment. Note: Devices exceeding $1,000 in cost requires pre-notification to Plan	40% of eligible charges

Orthopedic and prosthetic devices – continues on next page

Orthopedic and prosthetic devices *(Continued)*	**You pay**
Not covered: • *orthopedic and corrective shoes unless attached to a brace* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *prosthetic repair and replacements - except for breast prostheses and surgical bras*	*All charges.*
Durable medical equipment (DME)	**You pay**
Rental or purchase, at our option, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds; • wheelchairs; • crutches; • walkers; • blood glucose monitors; and • insulin pumps. Call us at 800/999-1147 and we will help direct you to a participating health care provider to rent or sell you the durable medical equipment at Plan contracted rates and will tell you more about this service when you call. Note: For items with charges that exceed $1,000, call us at 800/999-1147 as soon as your Plan physician prescribes this equipment.	Nothing for items of $100 or less when received within the physician's office 40% of eligible charges for items exceeding $100
Not covered: • *Repair, replacements, and duplicates*	*All charges.*

Home health services	You pay
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include: oxygen therapy, intravenous therapy, and medications.	Nothing
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges.*
Alternative treatments	
• Biofeedback for the treatment of headaches	40% of eligible charges
Not covered: • *acupuncture* • *chiropractic services* • *naturopathic services* • *hypnotherapy* • *biofeedback – except as shown above*	*All charges.*
Educational classes and programs	
Coverage is limited to: • Diabetes outpatient management	Nothing

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.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductibles
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. • Insertion of internal prostethic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information.	\$10 per office visit. Nothing at surgical facilities
• Voluntary sterilization	\$10 per office visit.
• Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a).	Nothing at outpatient facility.
• Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	**Norplant** – 40% of charges per implantation

Surgical procedures – continues on next page

Surgical procedures *(Continued)*	**You pay**
Not covered: • *Reversal of voluntary sterilization* • *Surgery primarily for cosmetic purposes.* • *Non network physicians unless prior approved*	*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.	$10 per office visit Nothing at outpatient or inpatient facility
• 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.	See above.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • TMJ • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$10 per office visit. Nothing for inpatient facility $100 at outpatient facility

Oral and maxillofacial surgery – continues on next page

Oral and maxillofacial surgery *(Continued)*	**You pay**
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*
Organ/tissue transplants	**You pay**
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allegeneic 'donor' bone marrow transplant • Autologous 'bone' marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. *Limited Benefits* – All transplant treatment must be coordinated through our transplant program - United Resource Network. Transplants not going through United Resource Network will not be covered. Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be limited to non-randomized clinical trials, based on recommendations by the National Cancer Institute. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	$10 per office visit. Nothing at inpatient or outpatient facility
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered* • *Non utilization of United Resource Network*	*All charges*

Anesthesia	You pay
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	$10 per office visit Nothing at outpatient facility

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

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma products • 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 • Special duty nursing	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds*	*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.	$100 copayment per occurrence to the facility
Not covered: • *Dental procedures*	*All charges*
Extended care benefits/skilled nursing care facility benefits	**You pay**
Extended care benefit: • Bed, board, general nursing care, drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor. • Up to 90 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate and approved by the Plan.	Nothing
Not covered: • *Custodial care*	*All charges*

Hospice care	You pay
Hospice: • Supportive and palliative care for the terminally ill. • Services provided in home or hospice unit • Includes inpatient and outpatient care and family counseling under the direction of a Plan doctor who has certified you are in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing
Not covered: • *Independent nursing, homemaker services*	*All charges*
Ambulance	
• Local or out of area professional ambulance service when medically appropriate	20% of eligible charges

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 a life threatening situation, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Should you desire to speak with someone regarding your current medical emergency, you can call your plan physician or our Care24 phone representatives. The Care24 phone is available 24 hours a day, 7 days a week. The Care24 phone number is listed on the back of your identification card. Be sure to tell the emergency room personnel you are a Plan member and present your identification card. Your emergency room copayment is $50 per visit. If you are admitted to the hospital, within 24 hours as a result of your emergency room visit, your emergency room copayment is waived.

If you have been directed to the emergency room by our representatives, it's a good idea to call our Customer Service number at 800/999/1147, so we can make a note in your records.

Follow up care, provided in an emergency room, is not a covered benefit. Follow up care must be provided by your network doctor.

Emergencies outside our service area:

Benefits are available for any health service that is immediately required because of injury or unforeseen injury. If you are in a life threatening situation, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. For other emergencies which cannot wait until you return to the service area, you might want to call our Care24 phone service noted on the back of your ID card. Care24 can assist you with direction to an urgent facility. Our Care24 representatives are available 24 hours a day, 7 days a week. The Care24 phone number is listed on the back of your identification card. Always be sure to tell the emergency room personnel you are a Plan member and present your identification card. Your emergency room copayment is $50 per visit. If you are admitted to the hospital, within 24 hours as a result of your emergency room visit, your emergency room copayment is waived. You or a family member must notify the Plan by calling 800/999-1147 unless it was not reasonably possible to do so.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$10 per office visit $20 per visit at urgent care center $50 per visit at hospital
Not covered: • *Elective care or non-emergency care received at an emergency room*	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$10 per office visit $20 per visit at urgent care center $50 per visit at hospital
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges.*
Ambulance	
Professional ground or air ambulance service when medically appropriate. See 5(c) for non-emergency service.	20% of charge per service

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

IMPORTANT

Parity

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

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

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

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

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
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	$10 per office visit
• Diagnostic tests	$10 per office visit Nothing at out patient facility
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, full-day hospitalization, facility based intensive outpatient treatment	Nothing

Mental health and substance abuse benefits *(Continued)*	**You pay**
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.*

Preauthorization

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

- Prior to receiving Mental Health or Substance Abuse care, you must call our provider at 800/559-5951. This number is also listed in your Federal Provider Directory.
- Provider information is only available by calling the 800 number noted above.
- Inpatient and outpatient treatment requires the coordination and approval of our network providers.
- When calling the 800 number, you will speak with an intake coordinator who will register you, verify your coverage, determine your medical need, and provide with a choice of network provider names and phone numbers.
- If the intake coordinator is unable to assist, you may be transferred to a care manager who will assist you in direction of a provider who can best fit the needs of your current problem.
- You will be given a choice of provider names and phone numbers from which you will call to arrange your own appointment.
- After setting up your appointment, you must call the Plan's Mental Health and Substance Abuse provider back to advise which provider you have made an appointment with and the date of the appointment.
- A specific number of visits will be authorized for you.
- You will receive an authorization letter, confirming your visit approval.
- You must take this letter with you when you visit our provider.
- If the Plan's provider recommends hospitalization, the Plan's provider will handle the necessary authorization.

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

Limitation

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

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.
- Some medications have a prior authorization (PA) requirement and the Plan provider must call Plan's pharmacy manager to authorize the medication before picking it up from the network pharmacy.
- 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 licensed physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan's network pharmacy except in emergency situations.
- **We use a formulary.** The Plan's formulary, also called a Preferred Drug List (PDL), is a list of commonly prescribed medications that have been chosen by the Plan's Pharmacy and Therapeutics Committee, based on a drug's effectiveness and cost. The Pharmacy and Therapeutics Committee will evaluate any additions or deletions to the PDL. If your provider prescribes a medication that is not on the PDL, your prescription cost will fall into the third level of coverage and cost you more.
- **These are the dispensing limitations.** Medications will be dispensed up to a 31-day supply limit unless quantity limits are established by the manufacturer. Medications can be presented to Plan's network pharmacy for refill no earlier than seven (7) days prior to the prescription running out. Your Plan provider may prescribe medications listed on the Plan formulary or not on the Plan formulary. If the medication is not on the Plan formulary, you will pay a higher cost for each prescription.
- **When you have to file a claim.** You should only have to file a claim for medications received in an emergency situation. Your process to file the emergency prescription would be to make a copy of the original prescription receipt which shows the medication name, number dispensed, prescribing doctor, and cost of medication. On the same page as the prescription receipt copy, place your name, address, and your member number as noted on the Plan's identification card. Mail to the address noted on the back of Plan's identification card. Reimbursement, less the applicable copayment, will be mailed to you.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy: • Up to a 31-day supply, unless limited by the drug manufacturer's packaging or appropriate use guidelines as approved by the Plan • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase. • Insulin • Disposable needles and syringes for the administration of covered medications • Diabetic supplies including: blood testing strips – glucose; urine testing strips – glucose; ketone testing strips and tablets; lancets; and lancet devices. • Injectable drugs • Intravenous fluids and medications for home use • Contraceptive drugs and devices • Growth Hormone Therapy ***Limited Benefits:*** • Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits.	$10 copayment per each generic prescription or refill $15 copayment per each brand named prescription or refill listed on our Preferred Drug List $25 copayment per each prescription or refill not listed on our Preferred Drug List

Prescription drug benefits – continued on next page

Covered medications and supplies *(continued)*	**You pay**
Here are some things to keep in mind about our prescription drug program: • We administer a 3 tier level prescription benefit. If your physician believes a generic or name brand product is necessary, your physician may prescribe a medication from our Preferred Drug List. This list of generic and name brand medications is a preferred listing of drugs that we have selected to meet your needs at a lower cost. To order a prescription drug brochure or a Preferred Drug List, call our Customer Service Department at 800/999-1147. • Some medications have a PA (Prior Authorization) requirement. Typically these medications will require your physician closely monitor your care while on these medications. Your physician must call our pharmacy manager to receive authorization for your medication before you go to the pharmacy. Medications with a PA are noted in our Preferred Drug List. To order a Preferred Drug List, call our Customer Service Department at 800/999-1147.	
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Smoking cessation drugs and medication including nicotine patches* • *Fertility drugs* • *Appetite suppressants* • *Prescriptions written by non-Plan providers except in emergency situations*	*All Charges*

Section 5 (g). Special Features

Feature	Description
Care 24	For any of your health concerns, 24 hours a day, 7 days a week, you may call a toll free number and talk with a registered nurse who will discuss treatment options and answer your health questions. Additionally, a full audio library of health care issues is available for you to access via the same 800 number. The Care24 number is listed on the back of your UnitedHealthcare ID card.
Healthy Pregnancy Program	Office visit copays may be refunded for the obstetrical services. This copayment may be refundable with successful completion of our Healthy Pregnancy Program. The Healthy Pregnancy Program requires that you enroll within your 1st trimester of pregnancy and that you participate in the program throughout your pregnancy. To register, you must call our Healthy Pregnancy Program at 800/411-7984 or you can call our Customer Service Department at 800/999-1147 to obtain more information about the program.
Seat Belt Safety	If you are in a motor vehicle accident and need emergency room services, you are eligible to receive a refund of your emergency room copayment, if your seat belt was fastened. Call our Customer Service Department at 800/999-1147 for details

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.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Treatment must take place and be completed within 6 months of date of injury. Maximum Plan payment is $1,500, per member per calendar year.	20% of eligible charges

Dental benefits

We have no other dental benefits.

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.

- Our Plan offers discounts at various fitness clubs throughout your service area. Please call our Customer Service Department at 800/999-1147 and we will be happy to send you a brochure of fitness clubs in your area. Each fitness club offers its own special discount to Plan members, which means you will need to call the facility to find out the discounted member amount.

- If you purchase a safety helmet for yourself or a covered dependent to wear while biking, skateboarding, etc. we will reimburse you $15 towards the helmet purchase. Call our Customer Service Department at 800/999-1147 for details.

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

The exclusions in this section apply to all benefits. 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 not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

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

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 claim questions and assistance, call us at 800/999-1147.

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

- Covered member's name and ID number;
- Name and address of physician or facility that provided the service or supply;
- 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: UnitedHealthcare of North Carolina, Inc.
P. O. Box 659741
San Antonio, TX 78265-9741

Prescription drugs

Make a copy of the prescription receipt you received from the pharmacy – receipt must have the prescription drug name, the quantity number dispensed, the prescription cost, and the prescribing physician's name;

Make a copy of your identification card and mail both the prescription receipt and ID card copy to UNITEDHealthcare of North Carolina to the below address:

Submit your claims to: UnitedHealthcare of North Carolina, Inc.
P. O. Box 659741
San Antonio, TX 78265-9741

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 pre-authorization:

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: UnitedHealthcare of North Carolina, Inc P. O. Box 26303, Greensboro, NC 27438-6303; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your medical 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 3, P.O. Box 436, Washington, D.C. 20044-0436.

The Disputed claims process (*continued)*

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 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 pre-authorization/prior approval, then call us at 800/999-1147 and we will expedite our review; or

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

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

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

•What is Medicare?

Medicare is a Health Insurance Program for:

•• People 65 years of age and older.

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

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

•The Original Medicare Plan

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

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care.

We will not waive any of our copayments or coinsurance.

(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		✓

If Medicare is primary you must still provide your Plan's Identification Card each time you see your Plan provider. Additionally, your Plan provider must submit to us your charges, along with your Medicare Explanation of Benefits (EOB), so we can coordinate with Medicare and process your claim. If you provider does not send us your EOB, then it becomes your responsibility to get the EOB to our Claims Department. We cannot process your claim until we receive the EOB from Medicare.

- **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, but we will not waive any of our copayments, coinsurance, or deductibles.

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

- **Enrollment in Medicare Part B**

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

TRICARE

TRICARE is the health care program for 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.

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 11.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 11.

Covered services

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

Custodial care

Custodial care is not a covered benefit.

Experimental or investigational services

A service is considered experimental, investigational if it is:

- Not generally accepted by informed health care professionals in the United States as safe and effective in treating any condition, illness, or diagnosis for which its use is proposed; or
- Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use; or
- Subject to federal law requiring Institutional Review Board review and approval for the proposed use; or
- The subject of ongoing FDA regulated Phase I, II, or Clinical Trials; or
- Not demonstrated, through suffficient peer-reviewed medical literature, to be safe and effective for the proposed use.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance as follows:

Your percentage coinsurance will be calculated on the lesser of the amount billed by the provider or the amount due by UnitedHealthcare of North Carolina's negotiated rate. Our preferred providers accept the plan allowance as payment in full.

Us/We

Us and we refer to UnitedHealthcare of North Carolina

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

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

Your medical and claims records are confidential

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

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

When you retire

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

When you lose benefits

•When FEHB coverage ends

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

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

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

• Spouse equity coverage

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

•TCC

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

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

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

•Converting to individual coverage

You may convert to an 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 800/999-1147 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 they try to obtain services for a person who is not an eligible family member, or are no longer enrolled in the Plan and try to obtain benefits. Your agency may also take administrative action against you.

Department of Defense/FEHB Demonstration Project

What is it?

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

Who is eligible

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

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

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

The demonstration areas

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

When you can join

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

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

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

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently

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

TCC eligibility

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

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

Other features

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

Index

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

NOTES:

Summary of Benefits for UnitedHealthcare of North Carolina, Inc. - 2001

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office.....	Office visit copay: $10 primary care; $10 specialist	13
Services provided by a hospital: • Inpatient..... • Outpatient.....	Nothing $100 copay per occurrence for free standing out patient facility	25 26
Emergency benefits: • In-area..... • Out-of-area	$50 per emergency room visit $50 per emergency room visit	28 28
Mental health and substance abuse treatment	Regular cost sharing	30
Prescription drugs	$10 generic; $15 brand listed on preferred drug list; $25 covered medications not listed on preferred drug list	33
Dental Care	No benefit except for tramatic injury.	37
Vision Care	Office visit copay for refraction exam: $10 No benefit for eyewear.	18
Special features: Care24, Healthy Pregnancy Program	Nothing.	36
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $2,500/Self Only or $5,000/Family enrollment per year Some costs do not count toward this protection	11

2001 Rate Information for:
UnitedHealthcare of North Carolina, Inc.

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and 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
High Option							
Self Only	**XM1**	**$86.59**	**$40.53**	**$187.61**	**$87.82**	**$102.22**	**$24.90**
Self and Family	**XM2**	**$195.82**	**$90.21**	**$424.28**	**$195.45**	**$231.17**	**$54.86**