PacifiCare®
of Colorado

PacifiCare of Colorado

http://www.pacificare.com/colorado

2002

A Health Maintenance Organization

Serving: The Front Range of Colorado

Enrollment in this Plan is limited. You must live in our geographic service area to enroll. See page 5 for requirements.

This plan has Commendable accreditation from the NCQA. See the 2002 Guide for more information on accreditation.

Enrollment codes for this Plan:

High Option

D61 Self Only
D62 Self and Family

Standard Option

D64 Self Only
D65 Self and Family

Authorized for distribution by the:

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

FEHB
Federal Employees
Health Benefits Program

RI 73-049

Table of Contents

Introduction

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

This brochure describes the benefits of PacifiCare of Colorado under our contract (CS 1761) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 6. Rates are shown at the end of this brochure.

Plain Language

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

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

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

Inspector General Advisory

Stop health care fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800/877-9777, or 303/714-5800 when calling from 303 or 720 area codes and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415.

Penalties for Fraud

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

Section 1. Facts about this HMO plan

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

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

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

How we pay providers

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

Your Rights

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

- Years in existence — PacifiCare of Colorado (and its predecessors) began offering health care coverage in Colorado in 1974.
- Profit status — For Profit.

If you want more information about us, call 800/877-9777, or 303/714-5800 when calling from 303 or 720 area codes, or write to 6455 South Yosemite Street, Greenwood Village, CO 80111. You may also contact us by fax at 303/714-3977 or visit our website at www.pacificare.com/colorado.

Service Area

To enroll in this Plan, you must live in our Service Area. This is where our providers practice. Our service area is: the Colorado counties of Adams, Arapahoe, Boulder, Clear Creek, Denver, Douglas, Elbert, El Paso, Gilpin, Jefferson, Larimer, Morgan, Park, Teller and Weld.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services received outside the service area unless the services have prior plan approval.

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

Section 2. How we change for 2001

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

Program-wide changes

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

Changes to this Plan

- Your share of the Standard Option non-postal premium will increase by 0.0% for Self Only coverage and 0.0% for Self and Family coverage.
- Your share of the High Option non-postal premium will increase by 27.0% for Self Only coverage and 68.9% for Self and Family coverage.
- We now cover certain intestinal transplants. (Section 5(b))
- Emergency room — the copayment will be $100 per visit inside or outside the service area under Standard Option and High Option.
- MRIs, CT and PET scans — a $75 copayment will apply per test under Standard and High Options.
- Dental benefits — the High Option dental benefit changes to a dental indemnity plan. A $50 deductible applies under Self-only coverage, and $150 per family (the deductible is waived for preventive services). Members pay up to 50% for covered services. The Standard Option dental benefits do not change.
- Orthodontic — the fixed fee for orthodontic treatment will increase from $1,950 to $2,150 for members under age 19, and from $2,200 to $2,500 for members 19 years or older.
- Mammography — we clarified the benefit to show mammograms are available once a year from ages 40 through 64.

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 800/877-9777, or 303/714-5800 when calling from 303 or 720 area codes.

Where you get covered care

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

• Plan providers

Plan providers are physicians and other health care professionals in our 15-county service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

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

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

• 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

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

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

• Primary care

Your primary care physician can be a family practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist. We contract with approximately 1,385 primary care physicians.

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

• Specialty care

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

- mental health and substance abuse benefits — refer to Section 5(e) for information on how to access these benefits.
- vision care — contact Vision Service Plan (VSP) at 888/426-4877.
- chiropractic care — go directly to a participating American Specialty Health Networks provider.
- obstetrical or gynecological care — access care through your primary care physician or go directly to a participating OB/GYN physician.

We contract with over 3,000 referral specialists.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, you may discuss whether or not it is appropriate to continue to see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  — terminate our contract with your specialist for other than cause; or

  — drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  — reduce our service area and you enroll in another FEHB Plan,

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

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

• Hospital care

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800/877-9777, or 303/714-5800 when calling from 303 or 720 area codes. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

Circumstances beyond our control

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

Services requiring our prior approval

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

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

- Septoplasty
- Hysterectomy
- MRIs and CTs and PET scans
- Angiography
- Upper GI endoscopy
- Colonoscopy
- Knee arthroscopy

PacifiCare of Colorado may determine medical necessity by using preauthorization programs and criteria. Our criteria are written guidelines established by us to determine medical necessity and/or coverage for certain procedures and treatments. Our criteria are based on research of scientific literature, collaboration with physician specialists and compliance with federal and national regulatory agency guidelines. Criteria are approved by the PacifiCare Health Care Standards and Education Committee and are reviewed and revised on a regular basis. Criteria are available for review by the member's participating physician, the member or the member's representative.

Section 4. Your costs for covered services

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

• Copayments

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

Example: When you see your primary care physician you pay a copayment of $10 (High Option) or $15 (Standard Option) per office visit.

• Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

- We do not have any deductibles under the High Option.
- Under the Standard Option, you must pay a $300 deductible per person, or a $500 maximum deductible per family for inpatient hospital services each calendar year. (See Section 5c)

• Coinsurance

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

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

Your catastrophic protection out-of-pocket maximum

After your copayments, coinsurance or deductibles total $3,600 per person or $10,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, your out-of-pocket expenses for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services:

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

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

Section 5. Benefits OVERVIEW

(See page 6 for how our benefits changed this year and page 58 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsection. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 800/877-9777, or 303/714-5800 when calling from 303 or 720 area codes, or at our website at www.pacificare.com/colorado.

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.
- 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	**You pay - Standard Option**	**You pay - High Option**
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion	$15 per office visit	$10 per office visit
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • At home when medically necessary	Nothing	Nothing
Not covered: • *Physical examinations that are not medically necessary, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel* • *Obesity treatment, except for surgical treatment of morbid obesity* • *Total Parenteral Nutrition (TPN)*	*All charges*	*All charges*

Lab, X-ray and other diagnostic tests	You pay — Standard Option	You pay — High Option
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Ultrasound • Electrocardiogram and EFG • MRIs, CT and PET scans	Nothing $75 copay per test	Nothing $75 copay per test
Preventive care, adult		
We cover periodic health appraisals for adults. These visits include coverage for routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including: — Fecal occult blood test — Sigmoidoscopy, screening • Prostate Specific Antigen (PSA test) • Routine pap test Note: The office visit is covered if pap test is received on the same day; *see Diagnostic and Treatment*, above.	$15 per office visit	$10 per office visit
Routine mammogram — covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every year • At age 65 and older, one every two years	Nothing	Nothing
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster — once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	Nothing	Nothing
Not covered: • *Physical examinations that are not medically necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel.*	*All charges*	*All charges*

Preventive care, children	You pay — Standard Option	You pay — High Option
• Childhood immunizations recommended by the American Academy of Pediatrics	$15 per office visit	$10 per office visit
• Well-child care charges for routine examinations, immunizations and care (up to age 22 years) • Examinations, such as: — Eye exams to determine the need for vision correction — Ear exams to determine the need for hearing correction — Examinations done on the day of immunizations (up to age 22 years)	$15 per office visit	$10 per office visit
Not covered: • *Physical examinations that are not medically necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel.*	*All charges*	*All charges*
Maternity care		
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 page 25 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$15 copay per office visit	$10 copay per office visit
Not covered: • *Any procedure intended solely for sex determination* • *Birthing classes* • *Normal delivery outside of our service area*	*All charges*	*All charges*

Family planning	You pay — Standard Option	You pay — High Option
A broad range of voluntary family planning services, such as: • Voluntary sterilization • Family planning counseling • Information on birth control • Injectable contraceptive drugs • Intrauterine devices (IUDs) and implantable contraceptive devices, including their insertion and removal • Diaphragms and cervical caps, including their fitting	$15 per office visit	$10 per office visit
Not covered: • *Reversal of voluntary, surgical sterilization* • *Genetic counseling* • *Pregnancy test kits and ovulation kits*	*All charges*	*All charges*
Infertility services		
• Diagnosis and treatment of infertility • Artificial insemination — intravaginal insemination (IVI) — intracervical insemination (ICI) — intrauterine insemination (IUI) This coverage is limited to members who have been diagnosed as biologically infertile in accordance with accepted medical practice.	50%	50%
Not covered: • *Fertility drugs* • *Assisted reproductive technology (ART) procedures* — *in vitro fertilization* — *embryo transfer, GIFT and ZIFT* • *Services and supplies related to excluded ART procedures* • *Cost related to donor sperm and donor ova* • *Infertility services for members who have undergone a voluntary sterilization procedure*	*All charges*	*All charges*
Allergy care		
Comprehensive diagnostic allergy evaluation including testing	$15 per office visit	$10 per office visit
Allergy injection	$5 per visit when not in conjunction with a physician s office visit	$5 per visit when not in conjunction with a physician s office visit
Allergy serum	Nothing	Nothing

Treatment therapies	You pay — Standard Option	You pay — High Option
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 23. • Respiratory and inhalation therapy • Dialysis — Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy — Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: — We will only cover GHT when we preauthorize the treatment. Your plan physician will handle this preauthorization process.	Nothing	Nothing
Physical and occupational therapy		
Physical therapy and occupational therapy: • Up to 20 visits or two months per condition, whichever is greater, if significant improvement can be expected within two months Physical/occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. Note: We provide physical and occupational up to 20 sessions for each type of therapy per year, for the care and treatment of congenital defects and birth abnormalities for children up to age five (5). This is without regard to whether the condition is acute or chronic or whether the purpose of the therapy is to maintain or to improve functional capacity.	$15 per office visit Nothing for inpatient	$10 per office visit Nothing for inpatient
Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided at an approved facility for up to 90 sessions for short-term follow-up care.	Nothing	Nothing
Not covered: • *Long-term rehabilitative therapy* • *Special evaluation and/or therapy for conditions such as behavior disorders and pulmonary rehabilitation*	*All charges*	*All charges*
Speech therapy		
Up to 20 visits or two months per condition, whichever is greater. Speech therapy is provided when medically necessary without regard to whether the purpose of the therapy is to maintain or to improve functional capacity.	$15 per office visit Nothing for inpatient	$10 per office visit. Nothing for inpatient

Hearing services (testing, treatment, and supplies)	You pay — Standard Option	You pay — High Option
Examinations to determine the need, if any, for hearing correction.	$15 per office visit	$10 per office visit.
Not covered: • *All other hearing testing* • *Hearing aids, and evaluation for them*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)		
• Diagnosis and treatment of diseases of the eye • Routine eye exams including refraction, once every 12 months, to determine the prescription for corrective lenses, eyeglasses or contact lenses. You may go directly to a participating Vision Service Plan (VSP) provider without a referral or authorization from VSP. For a list of participating providers call VSP at 888/426-4877. • Routine visual acuity exams as part of covered periodic health exams	$15 per office visit	$10 per office visit
We cover eyeglasses when prescribed following cataract surgery with an intra ocular lens implant. Eyeglasses must be obtained through participating providers, and are covered up to $125 per pair, with a limit of one pair per surgery and two pairs per lifetime.	All cost over $125	All cost over $125
Not covered: • *Fitting contact lenses* • *Vision therapy* • *Radial keratotomy, keratomileusis and excimer laser surgery* • *Eyeglasses or contact lenses, other than following cataract surgery as described above*	*All charges*	*All charges*
Foot care		
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$15 per office visit	$10 per office visit
Not covered: • *Cutting or trimming of the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Foot orthotics, except as covered under Durable Medical Equipment*	*All charges*	*All charges*

Orthopedic and prosthetic devices	You pay — Standard Option	You pay — High Option
• Orthopedic braces and podiatric shoe inserts meeting criteria are covered up to a combined maximum of $500 per member per calendar year. • Externally worn breast prostheses and surgical bras, including necessary replacements will be covered following a mastectomy up to $500 per member per calendar year. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, lenses following cataract removal, and surgically implanted breast implants following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See 5(b) for coverage of the surgery to insert the device. • External extremity prosthetics — please refer to the Durable Medical Equipment benefit for coverage information.	$15 per office visit	$10 per office visit
Not covered: • *Foot orthotics, except as covered under Durable Medical Equipment* • *Orthotic devices for podiatric use* • *Arch support* • *Prostheses for cosmetic purposes* • *Experimental/investigational or cosmetic implants*	*All charges*	*All charges*
Durable medical equipment (DME)		
The following durable medical equipment is covered based on criteria established by us, up to $1,500 per member per calendar year. The criteria may include that the equipment must eliminate the need for treatment in an acute care or rehabilitative facility. Please contact us for other criteria. Coverage is limited to: • Apnea monitors • Bilirubin lights or blankets • Bone stimulators • Continuous passive motion machines (CPM) • External extremity prosthetics (covered only if the prosthesis will restore function of the extremity) • Feeding pumps • Hospital beds	Nothing up to the annual $1,500 benefit limit; all charges thereafter	Nothing up to the annual $1,500 benefit limit; all charges thereafter

Durable medical equipment (DME) — *Continued on next page*

Durable medical equipment (DME) ***(continued)***	**You pay — Standard Option**	**You pay — High Option**
• Insulin pump supplies (including cartridges, extension tubing, batteries, infusion sets, and customary dressings provided by the pump supplier to secure infusion sets) • Lymphedema pumps • Nebulizers • Oxygen • Positive airway pressure devices (C-PAP) (Bi-PAP) • Prosthetic eyes • Suction machines • Traction equipment • Ventilators • Wheelchairs		
One peak flow meter per member per lifetime and one glucometer per member per lifetime.	Nothing	Nothing
Insulin pumps meeting criteria.	Nothing	Nothing
Not covered: medical supplies such as: • *Crutches* • *Colostomy supplies* • *Catheters*	*All charges*	*All charges*
Home health services		
• Home health services of nurses and therapists, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need. • Mothers with newborns released from the hospital in accordance with PacifiCare of Colorado guidelines are entitled to one visit at home by a nurse, as well as the services of a homemaker for four hours on two days within 30 days following delivery .	Nothing	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient s family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative*	*All charges*	*All charges*

Chiropractic	You pay — Standard Option	You pay — High Option
Chiropractic services — up to 20 outpatient visits with a participating chiropractor. Note: You may self refer to a participating chiropractor for the 1st visit per neuromusculoskeletal condition or injury; however the Plan must approve any additional treatment.	$15 per office visit	$10 per office visit
Not covered: • *Chiropractic services for maintenance care* • *Biofeedback*	*All charges*	*All charges*
Alternative treatments		
Not covered: • *Naturopathic services* • *Hypnotherapy* • *biofeedback*	*All charges*	*All charges*
Educational classes and programs		
Smoking Cessation — The StopSmoking℠ program is a one-year self-directed, self-paced smoking cessation program for our members. After enrollment in the program, a letter is sent to your PCP to inform him or her of your participation. The program includes: • Regularly scheduled motivational phone calls with a trained smoking cessation specialist. • A StopSmoking kit complete with video and audio tapes and brochures to guide smokers to quit. • One of two smoking cessation aid products; a transdermal patch for nicotine replacement therapy, or Zyban, a prescription drug. Coverage of these aids is available for up to 90 days per year, limited to 3 years per lifetime. To enroll in the StopSmoking program, or for more information, please call 800/877-777, or 303/714-5800 when calling from 303 or 720 area codes.	$20 enrollment fee for StopSmoking℠ program $20 copay per 30-day supply	$20 enrollment fee in the StopSmoking℠ program $20 copay per 30-day supply
Not covered: special service clinics, centers, or programs on an inpatient or outpatient basis, such as: • *Education clinics, such as premenstrual (PMS), lactation, headache, eating disorder, senior services and stress management*	*All charges*	*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.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- YOUR PHYSICIAN MUST GET SOME SURGICAL PROCEDURES PREAUTHORIZED. Please refer to the preauthorization information shown in Section 3 to be sure which services and surgeries require preauthorization.

IMPORTANT

Benefit Description	You pay	
Surgical procedures	**You pay — Standard Option**	**You pay — High Option**
A comprehensive range of services, such as: • Surgical services including normal pre- and post-operative care by the surgeon • Services of a surgical assistant and anesthesiologist when medically necessary • Correction of amblyopia and strabismis • Treatment of fractures, including casting • Removal of tumors and cysts • Endoscopy procedure • Biopsy procedure • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity based on criteria established by us • Insertion of internal prosthetic devices. Note: See Section 5 (a) for device coverage information. • Voluntary sterilization • Treatment of burns	$15 per office visit; nothing for outpatient or inpatient surgery	$10 per office visit; nothing for outpatient or inpatient surgery
Not covered: • *Reversal of voluntary, surgically-induced sterility* • *Surgery primarily for cosmetic purposes*	*All charges*	*All charges*

Reconstructive surgery	You pay — Standard Option	You pay — High Option
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or surgery 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. Some examples of congenital anomalies are cleft lip and cleft palate. • 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.	$15 per office visit; nothing for outpatient or inpatient surgery	$10 per office visit; nothing for outpatient or inpatient surgery
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*	*All charges*
Oral and maxillofacial surgery		
Oral surgical procedures, limited to: • Treatment of congenital conditions of the jaw that may be demonstrated to cause actual significant deterioration in the member's physical condition because of inadequate nutrition or respiration; • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • TMJ surgery and related non-dental treatment.	$15 per office visit; nothing for outpatient or inpatient surgery	$10 per office visit; nothing for outpatient or inpatient surgery

Oral and maxillofacial surgery — *Continued on next page*

Oral and maxillofacial surgery *(continued)*	You pay - Standard Option	You pay — High Option
Not covered: • *Orthodontic treatment, or other dental related services for treatment of TMJ.* • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*	*All charges*
Organ/tissue transplants		
Limited to: • Cornea • Heart • Heart/lung • Kidney • Liver • Allogeneic (donor) bone marrow and stem cell transplants • Autologous bone marrow and stem cell transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin s lymphoma; advanced non-Hodgkin s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We also cover donor screening charges for immediate family members to include spouses, parents, children, siblings, and, if appropriate, grandparents.	$15 per visit in a physician s office; nothing for outpatient or inpatient surgery	$10 per visit in a physician s office; nothing for outpatient or inpatient surgery
Not covered: • *Transplants not listed as covered* • *Implants of artificial organs*	*All charges*	*All charges*

Anesthesia	You pay - Standard Option	You pay — High Option
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	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.
- Unlike Sections (a) and (b), in this section the calendar year deductible applies to only a few benefits. In that case, we added "(calendar year deductible applies)". There is no deductible on the High Option. The Standard Option calendar year deductible for hospital admission is $300 per person ($500 per family).
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require preauthorization.

IMPORTANT

Benefit Description	You pay	
NOTE: The Standard Option calendar year deductible applies only when we say below: calendar year deductible applies .		
Inpatient hospital	**You pay - Standard Option**	**You pay - High Option**
Room and board, such as: • Semiprivate, or specialized care units, such as intensive care or cardiac care units; • 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.	$300 deductible per person per year; $500 maximum per family per year. (Calendar year deductible applies.)	Nothing

Inpatient hospital — *Continued on next page*

Inpatient hospital *(continued)*	You pay - Standard Option	You pay - High Option
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood, blood plasma, and blood products if not donated or replaced, including processing and administration • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia service when medically necessary	Nothing	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Special blood handling fees, wound healing products and storage of cord blood* • *Personal comfort items, such as telephone, television, articles for personal hygiene, guest meals and beds* • *Private duty nursing care* • *Take-home drugs and supplies* • *Hospitalization for any dental procedures, except for children under certain circumstances*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center		
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Blood, blood plasma, and blood products if not donated or replaced, including processing and administration • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service when medically necessary NOTE: — We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment and meeting criteria. We do not cover the dental procedures.	$100 copay for outpatient surgery or 23-hour observation	Nothing

Outpatient hospital or ambulatory surgical center — *Continued on next page*

Outpatient hospital or ambulatory surgical center *(continued)*	You pay — Standard Option	You pay — High Option
Not covered: • *Special blood handling fees, wound healing products and storage of cord blood* • *Hospitalization for any dental procedures, except for children under certain circumstances*	*All charges*	*All charges*
Extended care benefits/skilled nursing care facility benefits		
Subacute care facility services following hospitalization is covered up to 60 days per calendar year at an approved subacute care facility. This coverage includes: • Accommodations • Meals • General nursing care • Medical supplies and equipment ordinarily furnished by the facility • Prescribed drugs and biologicals	Nothing	Nothing
Skilled nursing facility (SNF): We cover up to 120 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by us. This coverage includes: • Accommodations • Meals • General nursing care • Medical supplies and equipment ordinarily furnished by the facility • Prescribed drugs and biologicals	Nothing	Nothing
Not covered: • *Custodial care* • *Care for chronic conditions* • *Private room, except when medically necessary* • *Personal comfort items, such as telephone, television, articles for personal hygiene, guest meals and beds* • *Private duty nursing care*	*All charges*	*All charges*

Hospice care	You pay - Standard Option	You pay - High Option
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility when approved by our Medical Director. Services include: • Inpatient and outpatient care • Family counseling These services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing	Nothing
Not covered: services such as independent nursing and homemaker services	*All charges*	*All charges*
Ambulance		
• Medically necessary air or ground ambulance service ordered or authorized by a Plan doctor	$25 per trip	$25 per trip

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:

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

Emergencies within our service area:

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

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

Emergencies outside our service area:

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

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

Emergency services/accidents benefits begin on the next page.

Benefit Description	You pay	
Emergency within our service area	**You pay - Standard Option**	**You pay - High Option**
• Emergency care at a doctor's office		
• During normal business hours	$15 per visit	$10 per visit
• After normal business hours	$25 per visit	$25 per visit
• Emergency care at an urgent care center	$25 per visit	$25 per visit
• Emergency room setting	$100 per visit	$100 per visit
Not covered: • *Follow-up care in the emergency facility* • *Emergency visits made in non-life or limb threatening situations without your PCP's authorization* • *Emergency room services obtained during normal physician office hours, except in the event of a life or limb threatening emergency or when preauthorized by your PCP*	*All charges*	*All charges*
Emergency outside our service area		
• Emergency care at a doctor's office	$25 per visit	$25 per visit
• Emergency care at an urgent care center	$25 per visit	$25 per visit
• Emergency room setting	$100 per visit	$100 per visit
We cover up to $400 per person per calendar year for follow-up care to emergency services received outside the service area. These services are covered when needed in order to prevent serious deterioration of your health that would result from an unforeseen illness or injury if you are temporarily absent from our service area and receipt of your health care cannot be delayed until your return to the service area.	You pay the appropriate emergency benefit copay listed in the box directly above	You pay the appropriate emergency benefit copay listed in the box directly above
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*	*All charges*
Ambulance		
Ground or air ambulance service approved by us	$25 per trip	$25 per trip

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

IMPORTANT

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.
- The calendar year deductible or, for facility care, the inpatient deductible apply to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- 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 After the calendar year deductible	
Mental health and substance abuse benefits	**You pay - Standard Option**	**You pay - High Option**
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.	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 office visit	$10 per office visit.
• Diagnostic tests	Nothing	Nothing
• Services provided by a hospital or other facility	$300 per person per year; $500 maximum per family per year	Nothing

Mental health and substance abuse benefits — *Continued on next page*

Mental health and substance abuse benefits *(continued)*	You pay — Standard Option	You pay — High Option
Not covered: • *Psychiatric evaluation or therapy, or substance abuse treatment, on court order or as a condition of parole or probation, unless determined by us to be necessary and appropriate* • *Services we have not approved* *Note: The same exclusions contained in this brochure that apply to other benefits apply to these mental health and substance abuse benefits, unless the services are included in a treatment plan that we approve. OPM's review of disputes about network treatment plans will be based on the treatment plan's clinical appropriateness. OPM will generally not order one clinically appropriate treatment plan in favor of another.*	*All charges*	*All charges*

Preauthorization

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

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

If your PCP is affiliated with the Primary Physician Partners (PPP)*, your mental health and substance abuse services are provided by Pro Behavioral Health. Pro Behavioral Health's toll-free number is 800/944-6527.

If your child's primary care physician is affiliated with Colorado Pediatic Partners*, you may access mental health services for your child by calling 1-877-700-5300.

* To determine your PCP's affiliation, please check your ID card, call your PCP or call PacifiCare Customer Service at 800/877-9777, or 303/714-5800 when calling from 303 or 720 area codes.

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

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 physician, an approved non-Plan physician, or a licensed dentist must write your prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy or through our mail-order program.
- **We use a formulary.** The PacifiCare Formulary is a list of over 1,600 prescription drugs that physicians use as a guide when prescribing medications for patients. The Formulary plays an important role in providing safe, effective and affordable prescription drugs to PacifiCare members. It also allows us to work together with physicians and pharmacies to ensure that our members are getting the drug therapy they need. A Pharmacy and Therapeutics Committee consisting of physicians and pharmacists evaluates prescription drugs based on safety, effectiveness, quality treatment and overall value. The committee considers first and foremost the safety and effectiveness of a medication before reviewing the cost. The Formulary is updated on a regular basis.

  You may obtain a copy of the Formulary by calling Customer Service, or by logging onto the PacifiCare website at www.pacificare.com/colorado. PacifiCare uses a generic based Formulary. Prescriptions will be filled with generics whenever possible. If you or your physician prefer a brand name product when a formulary generic equivalent is available you will pay the non-formulary copayment.
- **These are the dispensing limitations.** Drugs are dispensed in accordance with the Plan's drug formulary. Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. For medications that come in trade size packages, you will be responsible for one applicable copay per prepackaged unit. Non-formulary drugs will be covered when prescribed by a Plan doctor. Prior-authorization is not needed because there are different copayments for formulary and non-formulary medications. Clinical edits (limitations) can be used for safety reasons, quantity limitations and benefit plan exclusions.

  A 90-day supply of maintenance medications can be filled through our mail-order prescription drug program. You pay 2 applicable copays per 90-day supply of tablets and capsules, or up to 4 prepackaged units, for a covered medication. Contact PacifiCare of Colorado's Customer Service Department at 800/877-9777, or 303/714-5800 when calling from 303 or 720 area codes, for more information — and to receive a mail-order form.
- **Why use generic drugs?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you less money than a brand name drug.
- **When you have to file a claim.** Please refer to Section 7 for information on how to file a pharmacy claim, or contact our Customer Service Department at 800/877-9777, or 303/714-5800 when calling from 303 or 720 area codes.

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

Prescription drug benefits begin on the next page.

Benefit Description	You pay After the calendar year deductible	
Covered medications and supplies	**You pay - Standard Option**	**You pay - High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail-order program: • Drugs for which a prescription is required by law • Disposable needles and syringes for the administration of covered prescribed medications • Commercially prepared progesterone and estrogen products • Intravenous fluids and medication for home use are covered under "Home health services". See page 19. • Oral contraceptive drugs; contraceptive diaphragms; and cervical caps • Coverage for implantable and injectable contraceptives is listed under the "Family planning section" located in 5(a) The following benefit is covered, but limited: • Diabetic glucose and ketone test strips and lancets dispensed in the manufacturer's prepackaged unit, up to 100 test strips, or 200 lancets, per 30-day supply. For members who meet certain criteria, we provide coverage for up to 200 test strips per 30-day supply.	Per 30-day supply or prepackaged unit: Formulary Generic - $10 Formulary Brand - $20 Non-Formulary - $30	Per 30-day supply or prepackaged unit: Formulary Generic - $5 Formulary Brand - $10 Non-Formulary - $20
• Insulin	A copay is applied to every two vials of the same kind of insulin. You can receive up to six vials of the same kind of insulin through the mail-order program for two applicable copays.	A copay is applied to every two vials of the same kind of insulin. You can receive up to six vials of the same kind of insulin through the mail-order program for two applicable copays.
Injectable drugs (except insulin) when preauthorized	$10 copay per prescription unit or refill	$10 copay per prescription unit or refill
The following benefit is covered, but limited: • Drugs to treat sexual dysfunction are covered when plan criteria is met. Contact us for dose limits.	50% of the cost of the medication per prescription unit or refill up to the dosage limit; all charges above that	50% of the cost of the medication per prescription unit or refill up to the dosage limit; all charges above that

Covered medications and supplies — *Continued on next page*

Covered medications and supplies *(continued)*	You pay — Standard Option	You pay — High Option
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available* • *Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies* • *Vitamins and nutritional substances that can be purchased without a prescription* • *Medical supplies such as dressings and antiseptics* • *Smoking cessation drugs and medication, including nicotine patches, except through the StopSmoking program* • *Drugs for weight reduction* • *Lifestyle enhancement drugs, including but not limited to drugs to enhance hair growth, anti-aging and mental performance* • *Fertility drugs* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance* • *Convenience packaged medications, including but not limited to Insulin penfill*	*All charges*	*All charges*

Section 5 (g). Special features

Feature	Description
Services for deaf and hearing impaired	TDD phone line — 800/659-2656
Healthy Pregnancy℠ Program	A nurse health manager is available to pregnant women who have specific needs during their pregnancy. Moms can self-refer to this nurse, or the physician can refer expecting mothers. If you are interested in this program, contact Customer Service at 800/877-9777, or 303/714-5800 when calling from 303 or 720 area codes.
Diabetes Management Program	All PacifiCare members with diabetes are eligible for this program, which helps to improve their health status and ability to manage their diabetes. The following components are included: • Outreach program — available to all new enrollees to assure they understand and can access their full range of PacifiCare benefits. • Taking Charge of Diabetes® —An extensive self-education module for members with diabetes. • Individual case management — This feature is for specific diabetes concerns that require the involvement of a medical case manager from PacifiCare. • Reminder program — This is a pro-active support program reminding members about aspects of the clinical management of their diabetes. For example, a member may receive a phone call to remind them that they need to get a retinal eye exam.
Congestive Heart Failure Program	A telephone follow-up program for PacifiCare members with congestive heart failure which improves their health status and their ability to cope with their condition. This program has shown a decrease in the re-admission rate to the hospital, for those members who have received this intervention. Aspects of this program include: • Taking Charge of Your Heart Health® —An extensive self-education module for members with congestive heart failure. • Hospital follow-up program — A telemonitoring case management program for patients following hospitalization for congestive heart failure.

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 on the Standard Option, on the High Option you may go to any dentist you choose.
- On the Standard Option there is no deductible, on the High Option the calendar year deductible is $50 per person/$150 per family. The deductible is waived for preventive services.
- Plan orthodontists must provide or arrange your orthodontic 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.
- For more information call PacifiCare Dental Administrators at 1-800-591-5915

IMPORTANT

Dental Benefits —High Option

Service	We pay	You pay
Preventive and diagnostic services, such as: Periodic oral evaluation Intraoral X-rays — complete series (including bitewings) Panoramic X-ray Prophylaxis — (adult, every six months) Prophylaxis — (child, every six months) Child — fluoride with prophylaxis Adult — fluoride with prophylaxis	100% of the Plan's fee allowance.	All charges over the Plan's fee allowance up to the dentist's charge. The deductible is waived for preventive care.
Basic services, such as: Amalgam — one surface, permanent Amalgam — two surfaces, permanent Root canal — anterior (excluding final restoration) Root canal — bicuspid (excluding final restoration) Periodontal scaling and root planing, per quad Removal of impacted tooth — soft tissue	80% of the Plan's fee allowance, or the dentist's charge.	$50 deductible and all charges over the Plan payment up to the dentist's charge.
Major services, such as: Complete denture — maxillary Maxillary partial denture — resin base Pontic Crown — porcelain fused to high noble metal	50% of the Plan's fee allowance or the dentist's charge.	$50 deductible and all charges over the Plan payment up to the dentist's charge.

Please contact us for our full fee allowance and other details for High Option dental benefits.

Accidental injury benefit
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.

Orthodontics

• Please see the end of Section 5(h) for your orthodontic benefits.

Dental Benefits —Standard Option

With our plan you receive the following comprehensive program of dental coverage through participating Plan dentists. This listing represents a description of the benefits and exclusions. For more detailed information regarding covered services and claims related concerns, call PacifiCare Dental Customer Services at 800/228-3384.

Choosing your dentist

Please select a primary care dentist, from the list of Dental Providers available in your area, for each member of your family. Your dental benefits and services are available only through the participating dentist you selected, except for out-of-area emergencies. If you wish to change your primary care dentist, call PacifiCare Dental Customer Services.

Receiving care

Member fees are due at the time of service.

NOTE: Your dentist may prescribe certain procedures not covered under your Plan benefit. Non-member fees will be charged for such services. Where UCR is shown, the procedure is not a covered benefit, and you pay the dentist's usual, customary and reasonable fee for that service.

Specialty care

If you receive care from a specialist, you pay a 60% member payment (Standard Option) of the PacifiCare contracted specialists fee schedule.

PacifiCare Dental maintains a panel of qualified Dental Specialists to provide you with the treatment that is beyond the scope of the General Dentist. Once we have reviewed and approved the recommended specialty referral, we will coordinate the referral to the closest specialist in your area.

Service	You pay - Standard Option
Visits	
Office Visit, per visit charge in addition to procedure (may be referred to as a sterilization charge in some offices)	$5
After hours visit, in addition to service provided	$30
Missed appointment — without 24 hours notice (copay per each 30 minutes of appointment time)	$20
Preventive	
Emergency treatment, palliative	$10
Routine teeth cleaning, once every 6 months	$10
Topical application to age 14	$7
Oral Hygiene Instructions	$0
Diagnostic (film allowance includes exam and diagnosis)	
Single, film	$4
Additional, up to 12 films	$3
Full mouth series (including bite-wings, if necessary)	$17
Intra-oral, occlusal view	$4
Bite-wing films, 2 films	$5
Bite-wing films, 4 films	$9
Panographic-type film	$20

Service	You pay - Standard Option
Restorative Dentistry (fillings)	
Amalgam Restorations	
Primary teeth, 1 surface	$16
Primary teeth, 2 surfaces	$20
Primary teeth, 3 surfaces	$25
Primary teeth, 4 or more surfaces	$28
Permanent teeth, 1 surface	$18
Permanent teeth, 2 surfaces	$22
Permanent teeth, 3 surfaces	$26
Permanent teeth, 4 or more surfaces	$30
Composite Resins (tooth colored fillings, fee includes acid etching and/or bonding)	
1 Surface anterior	$20
2 Surfaces anterior	$28
3 Surface anterior	$36
4 Surfaces anterior	$42
Pin retention, per tooth (not including restoration)	UCR
Sealants per tooth	$10
Sedative base	$10
Oral Surgery	
Extractions (fees include local anesthesia and routine post-operative visits)	
Uncomplicated, single extraction	$18
Each additional uncomplicated extraction	$18
Surgical removal of an erupted tooth	$28
Removal of impacted tooth (soft tissue)	$60
Removal of impacted tooth (partially bony)	$85
Removal of impacted tooth (completely bony)	$110
Other Procedures	
Post-operative visit, complications (i.e. osteitis)	$0
Biopsy and microscopic examination	UCR
Alveoloplasty (edentulous), per quadrant	$85
Avleoloectomy per quadrant	$65
Intra-oral incision and drainage of abscess (soft tissue)	UCR
Frenectomy	$45
Removal of exostosis (tori)	UCR
Anesthesia	
Additional charges for general anesthetics, nitrous oxide, anesthetists or anesthesiologists are the responsibility of the patient	
Local anesthesia	$0
Periodontics	
Periodontal maintenance procedures (following active surgical and adjunctive periodontal therapies)	$50
Scaling and root planing per quadrant	$50
Full mouth debridement	$50
Correction of occlusion per quadrant, minor spot grinding (equilibration not a covered benefit)	$26
Gingivectomy per quadrant, includes post-surgical visits	$175
Osseous or muco-gingival surgery per quadrant (includes post-surgical visits)	$300
Gingivectomy treatment per tooth	$35
Gingival flap procedures (includes RP) Quad	UCR

Crown and bridge — *Continued on next page*

Service	You pay - Standard Option
Endodontics	
Direct pulp capping	$12
Therapeutic pulpotomy (in addition to restoration) per treatment	$20
Indirect pulp capping (recalcification), including temporary restoration	$15
Root Canal Therapy	
Anterior RCT	$110
Bicuspid RCT, 1-2 canals	$160
Molar RCT, 1 canal	$110
Molar RCT, 2 canals	$160
Molar RCT, 3 canals	$220
Molar RCT, 4 canals	$250
Apicoectomy and/or retrograde therapy-per tooth	$180
Apicoectomy, separate procedure, per tooth	$120
Hemisection, root amputation	UCR
Crown and Bridge	
Crowns*	
Plastic, permanent, processed	$120
Porcelain jacket	$260
Porcelain with metal	$260
Full cast metal	$240
3/4 metal	$240
Crown build up, extensive amalgam/composite, including pins	UCR
Stainless steel, primary	$50
Stainless steel, permanent	$50
Preformed post and build up	UCR
Cast post with core or coping	UCR
Crown recementation (or inlay)	$15
Bridge recementation	$20
Pontics* (artificial tooth on a fixed bridge)	
Cast, metal	$240
Porcelain with metal	$260
**Where precious metal is used, additional copayment will be required.*	
Prosthetics* (removable)	
Dentures*	
Dentures, partial dentures and reline allowances include adjustments for a 90-day period following installation. Fees for specialized techniques involving precision dentures, personalization or characterization are in addition to those listed.	
Complete upper or lower denture	$300
Immediate upper or lower denture	$320
Partial acrylic upper or lower base (teeth/clasps extra)	$100
Partial, upper or lower with chrome cobalt alloy palatal or lingual bar and acrylic saddles (teeth/clasps extra)	$350
Unilateral partial base	$100
Anterior stayplate base/temporary	$75
Teeth and clasps extra per unit (for partial, stayplates, etc.)	$15
Denture/partial adjustment	$15
Office reline, cold cure acrylic	$85
Denture reline, laboratory	$110
Tissue conditioning, per denture	UCR
Denture duplication (jump case), per denture	$110
Simple stress breakers	$30
**Additional fees will be required for laboratory services for removable prosthetics, not to exceed $80.*	

Service	You pay - Standard Option
Repairs*	
Denture/partial resin base (no teeth involved)	$40
Replace missing or broken teeth, each	$25
Replace missing or broken clasp, each	$35
**Where precious metal is used, additional copayment will be required.*	
Space Maintainers	
Removable, plastic	$50
Fixed, unilateral band type	$50
Fixed, stainless steel crown type	$50
Fixed, lingual, palatal bar type or bilateral	$50
What is not covered: • *Care by non-Plan dentists except for authorized referrals or emergencies* • *Cosmetic dental care* • *Hospital and medical charges of any kind, including dental services rendered in a hospital* • *General anesthesia, including intravenous or inhalation sedation, except when medically necessary for extractions only* • *Loss or theft of dentures, appliances or bridgework* • *Dental treatment started prior to the member's eligibility to receive benefits under this Plan or started after the member's termination* • *Other dental services not shown as covered*	*All charges*

In-Area emergency

In emergency situations, PacifiCare Dental primary care dentists shall furnish such care as needed immediately or, if appropriate, not more than 24 hours after the request. Dental emergencies are defined as conditions where hemorrhage, acute pain or infection of dental origin exists.

- **During Normal Business Hours:** Contact your primary care dental office. If you are unable to contact your primary care dental office, please call PacifiCare Dental at 800/228-3384 and a Dental Customer Services Representative will assist you.
- **After Normal Business Hours:** Contact your primary care dental office. If you are unable to contact your primary care dental office, you may seek emergency care only at any licensed dental office. PacifiCare Dental will reimburse you up to $50.

For emergency care requiring an after-hours appointment, you may be assessed a $30/visit charge in addition to any copayment.

Out-of-Area emergency

Coverage for emergency benefits outside the service area is limited to palliative treatment of infection and pain. Definitive treatment is not covered. The out-of-area coverage reimburses the usual and customary fee up to a maximum of $50 per occurrence. We must be notified within 30 days.

Out-of-area emergencies are covered as follows:
- if the member develops a condition or sustains an injury while temporarily outside of the Plan's service area;
- the need for such care was not reasonably foreseeable, and;
- it is not feasible for the member to call PacifiCare and present him/herself to a PacifiCare dentist.

Reimbursement for emergencies

Claims for emergency benefits should be filed with PacifiCare Dental Services, P.O. Box 483, Tustin, CA 92781 within 30 days after the emergency care, and must provide sufficient information to verify entitlement to payment. Include:

- covered member's name and ID number
- dentist's name
- nature of problem
- date of treatment
- treatment given
- itemized charges
- copy of receipt

Orthodontics

The orthodontic benefits described here are for both High Option and Standard Option plans.

Through a PacifiCare panel Orthodontist, plan members are eligible to receive up to a 2-year orthodontic treatment provided by a PacifiCare contracted provider. You pay orthodontic charges of $2,150 for members under 19 years of age, and $2,500 for members 19 years or older, plus $300 start-up fees, $250 retention fees and X-ray costs.

What is covered

- Comprehensive orthodontic care at a panel orthodontic office for a usual and customary 24 month treatment plan.
- The start-up services shall include initial examination, study models, diagnosis, consultation and placement of orthodontic appliances (braces).
- The retention services may include impressions for post-treatment retainers, placement of retainers, retainer adjustments, and post-treatment supervision as needed. The normal retention fee is $250 and shall not exceed this amount. This amount is limited to the customary 24 month retention phase.
- The orthodontist has agreed that any course of orthodontic treatment initiated under this plan shall be completed, at the election of the member, under the terms, conditions, and fees provided herein, should the member become ineligible as a Plan member prior to completion of orthodontic treatment.
- A qualified member with cleft lip/palate is not subject to the limits of this Plan and the benefit for the services of a specialist shall apply as stated at the beginning of the dental benefit description.
- Administrative Fee: If you do not keep an appointment and fail to notify the provider office of cancellation 24 hours in advance, you may be assessed a service charge.

Limitations

- Orthodontic treatment must be provided by a member of the PacifiCare orthodontic panel.
- Cases that are other than basic and usual may require additional charges.
- If a member does not require treatment or elects not to have treatment, after the doctor has completed a diagnosis and consultation, the patient may be charged a consultation fee of $85.

What is not covered

- *X-ray fees (orthodontic).*
- *Start-up and retention as described under Orthodontic Benefits.*
- *Lost, stolen or broken appliances.*
- *Procedures not listed or procedures required in addition to basic, usual and customary orthodontic services including palatal expansion devices, functional appliances and myofunctional therapy.*
- *Work in progress (i.e., cases banded prior to inception of eligibility).*
- *Orthodontic emergencies or changes in treatment necessitated by accidents of any kind, adverse growth patterns or poor patient cooperation.*
- *Orthodontic treatment and/or surgical procedures for skeletal abnormalities such as micrognathia, facial asymmetrical and facial deformities.*
- *Treatment related to temporomandibular joint disorders.*
- *Any procedures considered within the field of general dentistry and those not usually performed in the orthodontic office.*
- *Severe or mutilated malocclusions that are not amiable to ideal orthodontic therapy.*
- *Orthodontic treatment of impacted teeth requiring surgical exposure.*
- *Cosmetic braces (plastic, ceramic, sapphire, lingual, etc.).*

Section 5 (i). Non-FEHB benefits available to Plan members

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

PacifiCare Perks℠ Program

The PacifiCare Perks Program offers you discounts to alternative care, such as massage therapy and acupuncture, healthy mom and baby programs, and weight management programs. Call 800/531-3341 for a complete list of special discount services.

Supplemental Dental HMO

For a monthly premium, you can enroll in a buy-up HMO dental plan. Benefits will not be coordinated between this plan and the dental plans included with your medical plan. Call 800/591-5915 for more information.

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition and we agree, as discussed under services requiring our prior approval on page 9.**

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical, hospital and pharmacy 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 800/877-9777, or 303/714-5800 when calling from 303 or 720 area codes.

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

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

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

Prescription Drugs

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

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

Dental services

Please provide the same information detailed in the bullets above.

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

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
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: PacifiCare Attn: Member Appeals P.O. Box 4306 Englewood, CO 80155-4306 Or you can fax us your request at 303/714-2643; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial — go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us — if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street NW, Washington, D.C. 20415-3630.

Send OPM the following information:

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

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

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

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

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

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800/877-9777, or 303/714-5800 when calling from 303 or 720 area codes, 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 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

• What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

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

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

• The Original Medicare Plan (Part A or Part B)

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

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

(Primary payer chart begins on next page.)

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

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

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

•Claims process when you have the Original Medicare

When we are the primary payer, we process the claim first.
When Original Medicare is the primary payer, Medicare processes your claim first. When you receive your Medicare payment information, please call us at 800/877-9777, or 303/714-5800 when calling from 303 or 720 area codes, to find out if you need to do something about filing the claim with us.

Plan

We waive some costs when you have the Original Medicare Plan
When Original Medicare is the primary payer, we will waive some out-of-pocket costs, as follows:
- Physician office visit copayments are waived if you are enrolled in Medicare Part B.
- Standard option hospital copayments are waived if you are enrolled in Medicare Part A.

•Medicare managed care plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan-- 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 provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments, coinsurance, or deductibles for your FEHB coverage.

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

Suspended FEHB coverage 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's service area.

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

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

TRICARE

TRICARE is the health care program for 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 care. You must use our providers.

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 10.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 10.

Covered services

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

Custodial care

Any skilled or non-skilled health services, or personal comfort or convenience related services, which provide general maintenance, supportive, preventive and/or protective care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 10.

Experimental or investigational services

Our National and Regional Medical Committees determine whether or not treatments, procedures and drugs are no longer considered experimental or investigational. Our determinations are based on the safety and efficacy of new medical procedures, technologies, devices and drugs.

Medical necessity

Medical necessity refers to medical services or hospital services which are determined by us to be:

- Rendered for the treatment or diagnosis of an injury or illness; and
- Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and
- Not furnished primarily for the convenience of the Member, the attending physician, or other provider of service; and
- Furnished in the most economically efficient manner which may be provided safely and effectively to the Member.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance by our contracted rate with the participating provider.

Usual Customary and Reasonable (UCR)

Providers usual charge for furnishing treatment, service or supply; or the charge the company determines to be the general rate charged by others who render or furnish such treatment, services or supplies to persons who reside in the same geographical area.

Us/We

Us and we refer to PacifiCare of Colorado.

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 joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

Your medical and claims records are confidential

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

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

When you retire

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

When you lose benefits

• When FEHB coverage ends

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

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

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

• Spouse equity coverage

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

• Temporary Continuation of Coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

• Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

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

Long Term Care Insurance Is Coming Later in 2002!

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

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

What is long term care (LTC) insurance?

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

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

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

Is long term care expensive?

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

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

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

When will I get more information?

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

How can I find out more about the program NOW?

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

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

Summary of benefits for PacifiCare of Colorado - 2002

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

Benefits	You Pay — Standard Option	You Pay — High Option	Page
Medical services provided by physicians:			
• Diagnostic and treatment services provided in the office	Office visit copay: $15	Office visit copay: $10	12
Services provided by a hospital:			
• Inpatient	$300 deductible per person per year; $500 maximum per family per year	Nothing	25
• Outpatient	$100 copay for outpatient surgery or 23-hour observation	Nothing	25
Emergency benefits:			
• In-area	$100 per visit	$100 per visit	29
• Out-of-area	$100 per visit	$100 per visit	29
Mental health and substance abuse treatment	Same as any other illness or condition	Same as any other illness or condition	31
Prescription drugs	For a 30-day supply or trade-size package - $10 copay for generic formulary prescriptions; $20 copay for brand formulary prescriptions; $30 copay for non-formulary prescriptions	For a 30-day supply or trade-size package - $5 copay for generic formulary prescriptions; $10 copay for brand formulary prescriptions; $20 copay for non-formulary prescriptions	33
Dental Care	You pay copays for most services including preventive, restorative, orthodontic and other services.	You pay the applicable percentage of your dentist's charges, or the scheduled allowance, whichever is less.	37
Chiropractic Care	$15 copay per visit; based on medical necessity; maximum of 20 visits per year	$10 copay per visit; based on medical necessity; maximum of 20 visits per year	20
Vision Care	$15 copay per refraction; one refraction every 12 months.	$10 copay per refraction; one refraction every 12 months.	17
Special features: Health improvement programs			36
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $3,600/person or $10,000/family per year Some costs do not count toward this protection and you must continue to pay for some services.	Nothing after $3,600/person or $10,000/family per year Some costs do not count toward this protection and you must continue to pay for some services.	10

Premium page back cover

2002 Rate Information for
PacifiCare of Colorado, Inc.

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses , RI70-2B; and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

		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	D61	$97.55	$32.51	$211.35	$70.45	$115.43	$14.63
High Option Self and Family	D62	$223.41	$116.78	$484.06	$253.02	$263.75	$76.44
Standard Option Self Only	D64	$57.98	$19.32	$125.61	$41.87	$68.60	$8.70
Standard Option Self and Family	D65	$150.14	$50.05	$325.31	$108.44	$177.67	$22.52