PacifiCare Asia Pacific

http://www.pacificare.com

2002

A Health Maintenance Organization

Artwork:

For changes in benefits, see page xx.

Serving: *The Island of Guam , the Commonwealth of the Northern Mariana Island the Republic of Belau (Palau)*

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

Enrollment codes for this Plan:

High Option	**JK1 Self only** **JK2 Self and Family**
Standard Option	**JK4 Self Only** **JK5 Self and Family**

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United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

Federal Employees Health Benefits Program

RI 73-776

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Introduction

PacifiCare Health Insurance Company Micronesia
DBA PacifiCare Asia Pacific owned by PacifiCare Health Plans
P.O. Box 6578 Tamuning, Guam 96931

This brochure describes the benefits of PacifiCare Health Plans under our contract (CS 2825) 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 5. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plan's staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means PacifiCare Asia Pacific.
- 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 this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, 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 202/418-3300 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.

PacifiCare Health Insurance Company of Micronesia, Inc. is a Mixed Model Plan. This means the doctors provide care in contracted medical centers or in their own offices.

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.

- PHICM, dba PacifiCare Asia Pacific, has met all the licensing requirements needed on Guam, in the Commonwealth of the Northern Mariana Islands and the Republic of Belau (Palau) to conduct business as an insurance company
- PacifiCare has been operating on Guam for 28 years
- We are a for-profit organization

If you want more information about us, call 1/671-647-3526 or write to PacifiCare at P.O. Box 6578, Tamuning, Guam 96931. You may also contact us by fax at 1/671-646-6923 or visit our website at www.pacificare.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice.
Our service area is: The Island of Guam, the Commonwealth of the Northern Mariana Islands and the Republic of Belau (Palau).

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 health care services for members outside of our service area unless the services have prior plan approval. Medicare beneficiaries may only receive services at a plan participating Medicare contracted facility.

If you or a covered family member move outside of our service area, you should enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in the United States), 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 2002

Program-wide changes

- 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.
- 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 High Option non-Postal premium will increase by 34.8% for Self only or 43.5% for Self and Family.
- Your share of the Standard Option non-Postal premium will increase by 53.8% for Self only or 53.8% for Self and Family.
- We now cover certain intestinal transplants. (Section 5 (b))
- We no longer limit total blood cholesterol tests to certain age groups.
- **Out of area primary care –** We no longer cover out of area primary care. We do cover emergency care and off island referrals for specialty care.
- **Lab, X-ray and other diagnostic tests –** In addition to your office visit copayment, you now pay a $10 copayment for each radiological service under the High Option and a $15 copayment under the Standard Option. These services include X-rays, non-routine mammograms, CT Scans, MRIs, and ultrasound.
- **Maternity Care -** You now pay a $10 copayment under High Option and a $15 copayment under Standard Option for all maternity visits (pre and post natal)
- **Family Planning -** You now pay a $15 copayment for injectable contraceptives in addition to your office visit copayment under standard and high Option.
- **Physical and Occupational Therapies -** We now cover physical and occupational therapy for up to two (2) consecutive months per condition.
- **Orthopedic and prosthetic devices –** We now cover externally worn breast prostheses, surgical bras and necessary replacements following a mastectomy at 80% under the Standard Option and 100% under the High Option.
- **Orthopedic and prosthetic devices -** We no longer cover these devices under the Standard Option.
- **Orthopedic and prosthetic devices -** We no longer cover foot orthotics under the High Option.
- **Emergency Services (High Option) -** You now pay a $50 copayment and all charges over $500 for in area emergency care (outpatient hospital services)
- **Emergency Services (Standard Option) -** You now pay a $75 copayment and all charges over $500 for in area emergency care (outpatient hospital services)
- **Emergency Services (High Option) -** You now pay a $50 copayment and all charges over $500 for out of area emergency care (outpatient hospital services)

- **Emergency Services (Standard Option) -** You now pay 20% of the first $500 of charges and all charges over $500 for out of area emergency care (outpatient hospital services)

- **Out of pocket maximum -** The Standard Option out of pocket maximum is now $3000 per person and $6000 per family.

- **Dental Services –** We now limit dental coverage to $1500 per member per year for both options.

- **Vision Services -** We pay a maximum of $30 towards a basic vision exam and a maximum of $50 towards a comprehensive vision exam. You pay a $15 office visit copay under the standard Option and $10 copayment under the high Option

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 671-647-3526.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, and/or deductibles, and you will not have to file claims. Medicare beneficiaries may only receive services at a plan participating Medicare contracted facility.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards. We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. In selecting a primary care physician, call the PacifiCare Asia Pacific Customer Service Department at 1-671-647-3526. You may have a different primary care physician for each family member.

- **Primary care**

Your primary care physician can be a family practitioner, internist , or pediatrician for children under 18 years of age . Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one. You may change your primary care physician as often as once a month. Your change to the new primary care physician will be effective on the first of the following month

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow up care. Do not go to a specialist for return visits unless your primary care physician gives you a referral.

However, for well-woman care, you may see an OB/GYN within your provider group without a referral.

You may access mental health care and behavioral health care through your primary care physician for an initial consultation. You must return to your primary care physician after your consultation with the specialist. If your specialist recommends additional visits or services, your primary care physician will review the recommendation and authorize the visits or services as appropriate. You should not continue seeing the specialist after the initial consultation unless your primary care physician and the Plan's Medical Management Department has authorized the referral.

Here are other things you should know about specialty care:

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

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

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

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

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

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

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

  you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us at 1-671-647-3526 or, if we drop out of the Program, contact your new plan.

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at 1-671-647-3526. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

These provisions apply only to the hospital benefit 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 the following services such as, but not limited to:

- All surgical procedures
- Audiological exams
- Bone density studies
- CT scans
- Growth Hormone Therapy (GHT)
- Hospitalization
- MRIs
- Off-island referrals, consultations and procedures
- Out-of-area hospitalization
- Plastic/reconstructive consultation and procedures
- Podiatry consultations and procedures
- Sleep studies
- Specialty care
- Specialty care follow up (testing and procedures)
- Other procedures including colonoscopy and endoscopy

Emergency services do not require preauthorization. However, you or your family member must notify the Plan within 48 hours, or as soon as is reasonably possible, in order for the services to be covered.

Section 4. Your costs for covered services

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

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

  Example: When you see your primary care physician you pay a copayment of $10 per office visit for High Option and $15 per office visit for Standard Option and when you go in the hospital, you pay nothing per admission (High Option) or $150 per admission (Standard Option).

- **Deductible** — We do not have a deductible.

- **Coinsurance** — Coinsurance is the percentage of our allowance that you must pay for your care.

  Example: When you need emergency care outside our service area, under the Standard Option, you pay 20% of the first $500, then you are responsible for all charges thereafter.

Your out-of-pocket maximum

After your copayments total $3000 per person and $6000 per family enrollment (Standard Option) and $1,000 per person or $3,000 per family enrollment (High Option) in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services:

- *Prescription Drugs*
- *Contraceptive Devices*
- *Dental Services*
- *Vision Hardware*
- *Chiropractic Services*

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

Section 5. Benefits – OVERVIEW

(See page 5 for how our benefits changed this year and page 47 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. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1/671-647-3526 or at our website at www.pacificare.com/asia pacific.

(a) Medical services and supplies provided by physicians and other health care professionals.....14-24

- Diagnostic and treatment services
- Lab, X-ray, and other diagnostic tests
- Preventive care, adult
- Preventive care, children
- Maternity care
- Family planning
- Infertility services
- Allergy care
- Treatment therapies
- Physical and Occupational Therapies
- Speech Therapy
- Hearing services (testing and treatment)
- Vision services (testing, treatment and supplies)
- Foot care
- Orthopedic and prosthetic devices
- Durable medical equipment (DME)
- Home health services
- Chiropractic
- Alternative treatments
- Educational classes and programs

(b) Surgical and anesthesia services provided by physicians and other health care professionals 25-28

- Surgical procedures
- Reconstructive surgery
- Oral and maxillofacial surgery
- Organ/tissue transplants
- Anesthesia

(c) Services provided by a hospital or other facility, and ambulance services 29-32

- Inpatient hospital
- Outpatient hospital or ambulatory surgical center
- Extended care benefits/skilled nursing care facility benefits
- Hospice care
- Ambulance

(d) Emergency services/accidents.....33-34

- Medical emergency
- Ambulance

(e) Mental health and substance abuse benefits 35-37

(f) Prescription drug benefits 29-30

(g) Special features 41

- PacifiCare Health Centers(PHC) Urgent Care Center
- Health Improvement Programs

(h) Dental benefits 42

(i) Non-FEHB benefits available to Plan members 43

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Referrals to doctors or facilities not on Guam can only be made to those under contract to provide service off-island. A written referral must be made by a Plan provider and approved by the PacifiCare Medical Management Department.

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 • In an urgent care center • Office medical consultations • Second surgical opinion	$15 per office visit	$10 per office visit
Physicians' house calls or visits by nurses and health aides	Nothing	Nothing
Professional services of physicians • During a hospital stay • In a skilled nursing facility	Nothing	Nothing
Not covered: • *Off-island care without prior authorization, except in the case of emergency*	*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 • Electrocardiogram and EEG	Nothing	Nothing
• X-rays • Non routine mammograms • Ultrasound • CT scans/MRI (prior authorization required)	$15 per office visit in addition to regular office visit copay	$10 per office visit in addition to regular office visit copay
Preventive care, adult *(Continued)*	**You pay – Standard Option**	**You pay – High Option**
Routine screenings, such as, but not limited to: • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including: -Fecal occult blood test -Sigmoidoscopy, screening – every five years starting at age 50 Prostate Specific Antigen (PSA test) – one annually for men age 40 and older Routine pap test	Nothing	Nothing
Routine mammogram covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	$15 copayment in addition to your regular office visit copay	$10 copayment in addition to your regular office visit copay
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel and immunizations for them*	*All charges.*	*All charges.*

Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	Nothing	Nothing
Preventive care, children		
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing if included as part of office visit	Nothing if included as part of office visit
• Well-child care charges for routine examinations and care **up to** age 22 Examinations, such as: -Eye exams through age 17 to determine the need for vision correction. -Ear exams through age 17 to determine the need for hearing correction -Examinations done on the day of immunizations (up to age 22)	$15 per office visit	$10 per office visit
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel and immunizations for them.*	*All charges.*	*All charges.*

Maternity care	You pay – Standard Option	You pay - High Option
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 22 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. The newborn must be enrolled within 60 days of birth. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b) Note: **We will** cover labor and delivery at the Sagua Managu Birthing Center at 100% for both Standard Option and High Option. **See "Special Features", page 41.**	$15 per office visit; $150 copay per admission for inpatient services **Note:** Delivery is covered under inpatient services see section 5(c)	$10 per office visit; Nothing for inpatient services
Not covered: • *Routine sonograms (ultrasound) to determine sex*	*All charges*	*All charges.*
Family planning		
A broad range of voluntary family planning services, • Voluntary sterilization • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Surgically implanted contraceptives (such as Norplant NOTE: We cover oral contraceptives and diaphragms under the prescription drug benefit.	$15 per office visit Note: Injectable contraceptive drugs require an additional copay of $15.	$10 per office visit Note: Injectable contraceptive drugs require an additional copay of $15.

Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling,*	*All charges.*	*All charges.*
Infertility services	**You pay - Standard Option**	**You pay – High Option**
Diagnosis and treatment of infertility, such as: • Artificial insemination: *-intravaginal insemination (IVI)* *-intracervical insemination (ICI)* • Injectable Fertility drugs Note: We cover oral fertility drugs under the prescription drug benefit.	50% of charges	$10 per office visit
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* *-in vitro fertilization* *-embryo transfer, gamete GIFT, and zygote ZIFT* *-Zygote transfer* • *intrauterine insemination (IUI)* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges.*	*All charges.*
Allergy care		
Testing and treatment Allergy injection	$15 per office visit.	$10 per office visit
Allergy serum	Nothing	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*		

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 listed under Organ/Tissue Transplants on page 28. • Respiratory and inhalation therapy • Intravenous (IV)/ Infusion Therapy • Growth hormone therapy (GHT) Note: – We will only cover GHT when we preauthorize the treatment. Call 1/671-646-6956 for prior authorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3. Note: We cover GHT drugs under the Prescription Drug benefit	$15 per office visit; $150 copay per admission for inpatient services	$10 per office visit; Nothing for inpatient services
• Dialysis	Applies to hospital admission only	$10 per office visit , nothing for inpatient

Physical and Occupational Therapies	You pay – Standard Option	You pay – High Option
• Up to two (2) consecutive months per condition for the services of each of the following: -qualified physical therapists; -occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury	$15 per office visit, nothing for home visits, nothing per visit during covered inpatient admission.	$10 per office visit, nothing for home visits, nothing per visit during covered inpatient admission.
Not covered: • *long-term rehabilitative therapy* • *exercise programs, lifestyle modification programs* • *equipment, supplies or customized devices related to rehabilitative therapies, except those provided under Section 5(a) Durable Medical Equipment* • *services provided by schools or government programs*	*All charges.*	*All charges.*
Speech Therapy	**You Pay**	**You Pay**
Unlimited services for the services of: • Qualified Speech Therapists Note: All therapies are subject to medical necessity	$15 copayment per office visit; Nothing per visit during covered inpatient admission.	$10 copayment per office visit; Nothing per visit during covered inpatient admission.
Hearing services (testing and treatment)		
• Hearing testing and treatment for adults when medically indicated for other than hearing aids • Hearing testing for children through age 17 (see *Preventive care, children*)	$15 per office visit	$10 per office visit
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for them*	*All charges.*	*All charges.*

Vision services (testing, treatment, and supplies)	You pay - Standard Option	You pay – High Option
Medical and surgical benefits for the diagnosis and treatment of diseases of the eye	$15 per office visit	$10 per office visit
• Prescription Eyeglasses or prescription contact lenses	All charges after $100 at participating providers	All charges after $100 at participating providers

• Eye exam to determine the need for vision correction for children through age 17 (see preventive care)
• Annual eye refractions
  • Plan pays $30 maximum benefit towards basic vision exams
  • Plan pays $50 maximum benefit towards comprehensive exam
	$15 per office visit	$10 per office visit

Not covered: • *Eye exercises and orthoptics (vision therapy)* • *Radial keratotomy and other refractive surgery such as LASIK surgery*	*All charges.*	*All charges.*
Foot care		
Routine foot care when you are under active treatment for a metabolic disease or peripheral vascular disease such as diabetes.	$15 per office visit	$10 per office visit.
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery).*	*All charges.*	*All charges.*

Orthopedic and prosthetic devices	You pay - Standard Option	You pay – High Option
• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy (up to two surgical bras per benefit year)	$15 per office visit plus an additional 20% of the cost	$10 per office visit
• Internal prosthetic devices such as pacemakers, stents, leads, intraocular lens implants, cochlear implants and surgically implanted breast implant following mastectomy. **Note:** See Section 5 (b) for coverage of the surgery to insert the device. • Corrective appliances for treatment of non-dental TMJ.	$15 per office visit	$10 per office visit
• Orthopedic Devices, such as braces	Benefits are not available under Standard option	$10 copayment per visit
Not covered: • *Arch supports* • *Artificial eyes* • *Artificial joints and limbs* • *Braces and splints* • *Corsets, trusses, elastic stockings, support hose, stump hose and other supportive devices* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Orthopedic and corrective shoes* • *Over-the-counter (OTC) items* • *Prosthetic replacements provided less than 3 years after the last one we covered* • *Other internal prosthetics such as heart valves, automatic implantable cardioverter defibrillator (AICD) and other implantable devices not specified above*	*All charges.*	*All charges.*

Durable medical equipment (DME)	You pay - Standard Option	You pay – High Option
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician. Under this benefit, we cover: • Manual hospital beds; • Standard manual wheelchairs; • Crutches/walk aids; • Note: Call us at 1/671-647-3526 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	Benefits are not available under Standard option	Member is responsible for any deposit required.
Not covered: • *Motorized wheel chairs* • *Glucose monitors* • *Insulin pumps*	*All charges.*	*All charges.*

Home health services	You pay - Standard Option	You pay - High Option
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include-oxygen therapy, intravenous therapy and medications. Services ordered by a physician to homebound members: • Nursing • Physical therapy, speech therapy, occupational therapy, and respiratory therapy • Medical supplies included in the home health plan of care	Nothing.	Nothing.

Not covered: • Nursing care requested by, or for the convenience of, the patient or the patient's family; • Services primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative.	*All charges.*	*All charges.*
Chiropractic		
• Chiropractic services—You may self refer to a participating chiropractor for up to 10 visits per calendar year. • Manipulation of the spine and extremities	All charges above $25	All charges above $25
Alternative treatments		
• No benefits	All charges	All charges
Educational classes and programs	**You pay - Standard Option**	**You pay – High Option**
Coverage is limited to programs administered through the PacifiCare Health Center only: • Smoking Cessation • Diabetes management classes • Taking Charge of your Heart Health ***Note: Please call the PacifiCare Customer Service Department at 1-671-647-3526 to find out if your class or program has a nominal charge.***	Some programs may have a nominal charge. Note: Nicotine replacement prescription is available at a $20 copayment	Some programs may have a nominal charge. Note: Nicotine replacement prescription is available at a $20 copayment

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.
- YOUR PHYSICIAN MUST GET PREAUTHORIZATION OF ALL SURGICAL PROCEDURES. Please refer to the prior authorization information shown in Section 3 to be sure which services require prior authorization and identify which surgeries require preauthorization
- Referrals to doctors or facilities not on Guam can only be made to t hose under contract to provide service off-island. A written referral must be made by a Plan provider and approved by the PacifiCare Medical Management Department

IMPORTANT

Benefit Description	You pay	
Surgical procedures	**You pay – Standard Option**	**You pay - High Option**
A comprehensive range of services such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery • Surgical treatment of morbid obesity • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information. • Cardiac surgery for the implantation of stents, leads and pacemakers • Cardiac surgery for the implantation of valves • Voluntary sterilization	$15 per office visit; $150 copay per admission for inpatient services.	$10 per office visit; Nothing for inpatient services
• Treatment of burns Note: Plan pays for the cost of the insertion only. See Section 5(a) –Orthopedic and prosthetic devices for device coverage information.		

Surgical procedures - Continued on next page.	**You pay – Standard Option**	**You pay - High Option**
Not covered: • *Reversal of voluntary sterilization* *Routine treatment of conditions of the foot.*	*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 illness if: -the condition produced a major effect on the member's appearance and -the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toe • 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; $150 copay per admission for inpatient services	$10 per office visit; Nothing for inpatient services
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	You pay - Standard Option	You pay - High Option
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • TMJ surgery and other related non-dental treatment	$15 per office visit; $150 copay per admission for inpatient services	$10 per office visit; Nothing for inpatient services
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Other dental related services for treatment of TMJ*	*All charges.*	*All charges.*

Organ/tissue transplants	You pay - Standard Option	You pay – High Option
Limited to: • Cornea • Heart • Kidney • Liver • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • 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.	$15 per office visit; $150.00 copay per admission for inpatient services	$10 per office visit; Nothing for inpatient services
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of non-human or artificial organs* • *Transplants not listed as covered* • *Transportation, lodging and living expenses*	*All charges*	*All charges*
Anesthesia		
• Professional services provided in – • Hospital (inpatient) • Skilled nursing facility • Hospital outpatient department • 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.
- 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).
- Referrals to doctors or facilities not on Guam can only be made to those under contract to provide service off-island. A written referral must be made by a Plan provider and approved by the PacifiCare Medical Management Department.
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION OF HOSPITAL STAYS.**

IMPORTANT

Benefit Description	You pay	
Inpatient hospital	**You pay – Standard Option**	**You pay - High Option**
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$150 copay per admission	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, labor and delivery and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, x-rays and pathology tests • Administration of blood and blood products • Facility fees, including, but not limited to dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Rehabilitative therapies – See 5(a) for benefit limitations.	Nothing	Nothing
Not covered: • *Any inpatient dental procedure* • *Blood and blood products, whether synthetic or natural* • *Custodial care* • *Internal prosthetics except for those covered under Section 5(a) Prosthetic and Orthopedic Devices.* • *Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private duty nursing care* • *Take-home items*	*All charges.*	*All charges.*

Outpatient hospital or ambulatory surgical center	You pay - Standard Option	You pay - High Option
• Operating, recovery, and other treatment rooms • Diagnostic laboratory tests, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Anesthetics and anesthesia service • Facility fees, including but not limited to, dressings, splints, casts, sterile tray services NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the professional fees for dental procedures.	$15 per office visit if done as an inpatient $150 copay per admission	$10 per office visit. If done as an inpatient, nothing
• Diagnostic mammograms • Ultrasound • CT scans/MRI (prior authorization required) • X-rays	$15 per office visit in addition to regular office visit copay	$10 per office visit in addition to regular office visit copay
Not covered: • *blood and blood products, whether synthetic or natural*	*All charges*	*All charges*
Skilled nursing care facility benefits		
The Plan provides a comprehensive range of benefits when full-time skilled nursing care and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. Standard Option – 60 days per calendar year High Option - 100 days per calendar year All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	Nothing	Nothing

Not covered: • *blood and blood products, whether synthetic or natural* • *custodial care*	*All charges*	*All charges*
Hospice care		
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility when approved by the Plan's Medical Management Department. 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. Services include • inpatient and outpatient care • family counseling Note: This benefit is limited to a maximum of up to 180 days per lifetime.	Nothing	Nothing
Not covered: • *Independent nursing* • *Homemaker services*	*All charges*	*All charges*
Ambulance		
• Local ground ambulance service when medically appropriate.	Nothing	Nothing
Not covered: • *Transports that we determine are not medically necessary.* • *Air ambulance services*	All charges.	All charges.

Section 5 (d). Emergency services/accidents

IMPORTANT

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

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

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency?

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 is covered no matter where you are.

Emergencies within our service area: If you are in our service area and receive emergency care that results in your hospitalization, 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 are in our service area, call your primary care physician. 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. If your PCP's office is closed, you may access the PHC Urgent Care Center.

Emergencies outside the service area: If you receive emergency or urgent care outside our service area, you must contact the PacifiCare Customer Service Department on 1 671-647-3526 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; **otherwise, your care will not be covered** We may arrange for your transfer to a Plan facility as soon as it is medically appropriate to do so.

When you have to file a claim: Please refer to Section 7 for information on how to file a claim, or contact our Customer Service Department at 1-671-647-3526.

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

Benefit Description	You pay	
Emergency within our service area	**You pay - Standard Option**	**You pay - High Option**
Emergency care at a doctor's office Urgent care at the PacifiCare Health Center (PHC)	$15 per office visit	$10 per office visit
Emergency care in the hospital's emergency room	$75 copay per emergency room visit and all charges after $500 Note: We will waive the $75 copay if you are admitted in the hospital.	$50 copay per emergency room visit and all charges after $500 Note: We will waive the $50 copay if you are admitted in the hospital
Emergency outside our service area		
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	20% of the first $500 of charges and all charges after $500 Note: If emergency results in admission to the hospital, only the $150 copay applies.	$50 copay per visit and all charges after $500 Note: If emergency results in admission to the hospital, the $50 copay is waived.
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 ambulance service when medically necessary. See 5(c) for non-emergency service.	According to service area benefit	According to service area benefit
Not covered: • *air ambulance services* • *transport that we determine is not medically necessary*	*All charges.*	*All charges.*

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

Network Benefit	
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. Access to services must be through our behavioral health network managers. • Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare. • **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.	IMPORTANT

Description	You pay	
Mental health and substance abuse benefits	**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 • Diagnosis and treatment of psychiatric conditions, mental illness or disorders of children, adolescents, and adults: Outpatient services include: Diagnostic tests crisis intervention and stabilization for acute episodes • Psychological testing necessary to determine appropriate psychiatric treatment • Psychiatric treatment (including individual and group therapy visits) • Medication evaluation and management Diagnosis and treatment of alcoholism and drug abuse. Outpatient services include: • Detoxification (the withdrawal process from physically-addictive drugs and/or alcohol when withdrawal is likely to cause medical or life-threatening complications) • Treatment and counseling (including individual and group therapy visits)	$15 per office visit	$10 per office visit
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$150 copayment per admission	Nothing
• Day treatment programs for substance abuse		
Not covered: • *Services we have not approved* • *Evaluation or therapy on court order or as a condition of parole or probation, or otherwise required by the criminal justice system, unless determined by a Plan physician to be medically necessary and appropriate* *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*	*All charges*

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

Preauthorization

To be eligible to receive these enhanced mental health and substance abuse benefits you must follow your treatment plan and all of our network authorization processes. Please call 1/671-647-3526 for more information.

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2002, you will be eligible for continued coverage with your provider for up to 90 days under the following conditions:

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

If this condition applies to you, we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2002, the 90-day period ends before January 1 and this transitional benefit does not apply.

Network limitation

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

How to submit network claims

If you have out-of-pocket expenses for covered services, PacifiCare will reimburse you for those allowable charges, minus any applicable co-payments. You should contact the PacifiCare Customer Service Department at 1/671-647-3526 and provide PacifiCare with a copy of your bill, your proof of payment and a brief description of what happened.

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 licensed physician must write the prescription
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy or through the Plan's mail-order program
- **We use a formulary.** The PacifiCare Formulary is a list of over 1600 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 evaluate 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. PacifiCare physicians will request prior authorization for some non-formulary drugs. A participating physician may initiate the prior authorization request simply by phoning or faxing in the request. Requests are generally processed within ten minutes although a few require up to 2 working days when additional information is needed from the doctor.
- **These are the dispensing limitations.** Prescription drugs will be dispensed for up to a 30-day supply or one commercially prepared unit per copay (i.e., one inhaler, one vial of ophthalmic medication, one tube of ointment, one vial of insulin). For drugs that could be habit forming, the prescription unit is set at a smaller quantity for the protection and safety of our members.

  A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the non-formulary copay.

- Prescription drugs can also be obtained through the mail order program for up to a 90 day supply of oral medication; 6 vials of insulin; or 3 commercially prepared units (i.e., inhaler, vials ophthalmic medication or topical ointments or creams). Call 1(800) 531-3341 for mail order customer service.
- **Why use generic drugs?** To reduce your out-of-pocket expenses! A generic drug is the chemical equivalent of a corresponding brand name drug. Generic drugs are less expensive than brand name drugs; therefore, you may reduce your out-of-pocket costs by choosing to use a generic drug.
- **When you have to file a claim:** Please refer to Section 7 for information on how to file a pharmacy claim, or contact our Customer Service Department at 1-671-647-3526.

Prescription drug benefits begin on the next page.

Benefit Description	You pay	
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 and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as not covered. • Insulin, copay charged to each vial • Disposable needles and syringes for the administration of covered medications; lancets • Oral contraceptive drugs (Injectable and implantable contraceptive drugs are covered under Section 5(a) Family Planning)	$ 5 for each generic or brand formulary prescription unit or refill $20 for each non-formulary prescription unit or refill	$ 5 for each generic or brand formulary prescription unit or refill $20 for each non-formulary prescription unit or refill
• Contraceptive diaphragms • Growth hormone	$5 each	$5 each
• Drugs for sexual dysfunction are covered when Plan criteria is met. Contact Plan for dose limits.	50% per prescription unit or refill up to the dosage limits and all charges above that limit	50% per prescription unit or refill up to the dosage limits and all charges above that limit
• Fertility drugs	50% per prescription unit or refill up to the dosage limits and all charges above that limit	Nothing

Covered medications and supplies - Continued on next page

Covered medications and supplies *(continued)*	**You pay – Standard Option**	**You pay - High Option**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them unless listed in the Formulary* • *Non-prescription medicines* • *Drugs obtained at a non-Plan pharmacy* • *Drugs to enhance athletic performance* • *Medical supplies (such as dressing and antiseptics)* • *Hospital take-home drugs* • *Appetite suppressants*	*All charges.*	*All charges.*

Section 5 (g). Special Features

Feature	Description
PacifiCare Health Center - Urgent Care Center	Extended care hours are available to Plan members. If your Primary Care Doctor's clinic is closed, you may avail of the PHC's Urgent Care services.
Health Improvement Programs	The following programs are available to members at the PacifiCare Health Center only: **Taking Charge of Diabetes**: a self-directed intervention program that addresses both self-care and lifestyle areas. The major components are interactive member materials, telephonic support, and provider reporting. **Taking Charge of Your Heart Health**: a self directed lifestyle management program focusing on behavior modification with diet, exercise, stress, tobacco use and self-care. **Stop Smoking Program**: highly effective self-paced smoking cessation program designed to meet individual needs. The major components are counselor support and interactive member materials. This program requires a $20 copayment for materials and a$20 copayment for a nicotine replacement prescription. **Senior Member Health Questionnaire**: a program designed to identify patient health needs and positively affect their overall health.
Sagua Managu Birthing Center	Labor and delivery is covered at 100%.

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Dental services are limited to $1500 plan maximum per member per benefit year (High Option and Standard Option).

IMPORTANT

Emergency Care for Accidental Dental Injury	**You Pay (High Option and Standard Option)**
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. **You pay nothing**. If you are outside the service area and receive services from a non-plan dentist, we will reimburse you up to $100.00	

Dental Benefits

Service	You pay (Standard Option)	You pay (High Option)
OFFICE VISIT		
X-rays, including bitewings (once a year) and panoramic (once every three years) oral examination and treatment plan; vitality test; and oral cancer exam	Nothing	Nothing
PREVENTIVE SERVICES		
Prophylaxis (once every 6 month); sealants (up to age 12); annual topical application of fluoride (up to age 12);	Nothing	Nothing
RESTORATIVE DENTISTRY		
Amalgam -one, two or three surfaces; composite--one or two surfaces—anterior only	All changes	20% of covered charges
ORAL SURGERY		
Simple extraction for fully erupted teeth only	All charges	20% of covered charges
PROSTHETICS		
Full and partial dentures; crowns and bridges; repair; relining and/or reconstruction of dentures	All charges	75% of covered charges

Section 5 (j). 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.

Supplemental Dental Coverage

PacifiCare Asia Pacific offers a dental plan to supplement the dental coverage provided in the PacifiCare FEHBP plan option you have selected. Enrollment in the supplemental dental coverage will supersede your FEHB dental coverage. The supplemental dental plan covers services provided by participating dental providers and provides coverage as follows:

	YOU PAY
Diagnostic Services Routine x-rays, clinical examination and other diagnostic dental services.	Nothing
Preventive Services Routine teeth cleaning (prophylaxis), application of fluoride to the teeth, sealants (up to age 12)	Nothing
Restorative Services Routine fillings (silver amalgam and composite-anterior only)	Nothing
Oral Surgery Simple extractions, extractions of impacted teeth and other necessary oral surgery	Nothing
Endodontics Root canal fillings, pulpal therapy.	50% of covered charges
Periodontics Consultation, evaluation, and treatment of soft tissue and bones supporting teeth, supragingival and subgingival gross scaling, subgingival curettage, root planing and periodontal surgery.	50% of covered charges
Prosthodontics Full and partial dentures; repairs, relining and/or reconstruction of dentures.	50% of covered charges

Dental Plan Maximum
The supplemental dental plan will pay a maximum of $1500 per member per calendar year.

For more details on the coverage and cost of the supplemental dental plan and how to enroll, call 1/671-647-3526.

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 *What Services Require Our Prior Approval* on page 11.** We do not cover the following:

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

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 drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1/671-647-3526.

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

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

Submit your claims to: **P.O. Box 6578**
Tamuning, Guam 96931

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 prior authorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: P.O. Box 6578, Tamuning, Guam 96931; 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, DC 20415-3630.

The Disputed Claim Process *(Continued)*

Send OPM the following information:

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

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

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must 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 prior authorization/prior approval, then call us at 1/671-647-3526 and we will expedite our review; or

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

•What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. 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 health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

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

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

When you are in enrolled 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 authorized by your Plan PCP, or preauthorized as required.

We will not waive any of our copayments and coinsurance.

(Primary payer chart begins on next page.)

The following chart illustrates whether the 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,	✓	
a) Are a reemployed annuitant with the Federal government when b) The position is excluded from FEHB, or	✓	
c) The position is not excluded from FEHB (Ask your employing office which of these applies to you.)		✓
3) 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),	✓	
4) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
5) 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	✓	
d) Are a former spouse of an active employee		✓

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

Claims process – When you have the Original Medicare Plan

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 1/671-647-3526 or visit our web site at www.pacificare.com
- **We do not waive any out of pocket costs when you have the Original Medicare**

- **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 -- a Medicare Managed Care Plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to the 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 another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, but we will not waive any of our copayments, coinsurance, or deductibles. 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 to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare managed care plan eliminating your FEHB coverage 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+Choice service area.

- **If you do not enroll in Medicare Part A or Part 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 ~~members,~~ 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 illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

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

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 12

Copayment

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

Covered services

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

Custodial Care

Day to day care that can be provided by a non-medical individual.

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 xx.

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. If the charges exceed our contracted rate, you will be responsible for the excess over the allowance in addition to your coinsurance

Us/We

Us and we refer to PacifiCare Asia Pacific

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 premuim start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage and premiums begin 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

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; or
- You are not eligible for coverage under TCC or the spouse equity law.

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

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

Getting a Certificate of Group Health Plan Coverage

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

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 question. These 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.

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.

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?
- You should 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 nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. It 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?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half 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 everyone should have a plan just in case. Many people now consider long term care insurance to be vital to their financial and retirement planing.

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8- hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

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

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet the state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

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

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NOTES:

Summary of benefits for the *PacifiCare Asia Pacific* – 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	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copayment: $10 primary care; $10 specialist for High Option Office visit copayment: $15 primary care; $15 specialist for Standard Option	14
Services provided by a hospital: • Inpatient	Nothing per admission for high Option $150 copayment per admission for Standard Option	29
• Outpatient	Outpatient services are covered at your office visit copayment	31
Emergency benefits: • In-area	$50 copayment for High Option $75 copayment for Standard Option per emergency visit and all charges over $500	32
• Out-of-area	$50 copayment per emergency room visit High Option and 20% of 1st $500 for Standard Option and all charges after $500	32
Mental health and substance abuse treatment	Regular cost sharing	35
Prescription drugs	*$5 copayment for formulary prescriptions $20 for non-formulary prescriptions*	38
Dental Care	*Nothing for preventive services*	42
Vision Care	Office visit copayment: $10 for High Option; $15 for Standard Option	21

Special features:		43
Protection against catastrophic costs (your out-of-pocket maximum).....	Nothing after $1,000/Self Only or $3,000/Family enrollment per year for High Option Nothing after $3,000/Self Only or $6,000/Family enrollment per year for Standard Option Some costs do not count toward this protection	12