Prudential HealthCare HMO® – Austin

Prudential Health Care Plan, Inc.

A Health Maintenance Organization

For changes in benefits see page 22

Serving: Austin, Texas Area

Enrollment in this Plan is limited; see page 9 for requirements.

Enrollment code:
UN1 Self only
UN2 Self and family

This plan has full accreditation from the NCQA. See the FEHB Guide for more information on NCQA.

Visit the OPM website at http://www.opm.gov/insure

http://www.prudential.com/healthcare

Authorized for distribution by the:

United States Office of Personnel Management

Federal Em
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Prudential HealthCare HMO-Austin

Prudential Health Care Plan, Inc., 7700 Chevy Chase Drive, Chevy Chase I, Suite 500, Austin, Texas, 78752 has entered int
contract (CS 1914) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benef
(FEHB) law, to provide a comprehensive medical plan herein called Prudential HealthCare HMO-Austin or the Plan.

This brochure is the official statement of benefits on which you can rely. A person enrolled in the Plan is entitled to the bene
stated in this brochure. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1999, and are shown on page 22
brochure.

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Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in o to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that provider, such as a doctor, hospital or pharmacy, charged your plan for services you did not receive, billed for the same serv twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 800/621-2645 and explain the si
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adver administrative action by your agency.

General Information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confid will be used only: 1) by the Plan and its subcontractors for internal administration of the coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or crimina 3) by OPM to review a disputed claim or perform its contract administration functions; OPM and the General Accounting Office when conducting audits as required by the FE or 5) for bona fide medical research or education. Medical data that does not identify in members may be disclosed as a result of the bona fide medical research or education.

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay b receive your identification card and member information from the Plan. Until you receiv card, you may show your copy of the SF 2809 enrollment form or your annuitant confir letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you receive your ID card within 60 days after the effective date of your enrollment, you shou contact the Plan.

If you made your open season change by using Employee Express and have not received new ID card by the effective date of your enrollment, call the Employee Express HELP to request a confirmation letter. Use that letter to confirm your new coverage with Plan

If you are a new member of this Plan, benefits and rates begin on the effective date of y enrollment, as set by your employing office or retirement system. **As a member of this once your enrollment is effective, you will be covered only for services provided or by a Plan doctor except in the case of emergency as described on pages 15 and 16.** confined in a hospital on the effective date, you must notify the Plan so that it may arran the transfer of your care to Plan providers. See “If you are hospitalized” on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered famil member may have solely on the basis that it was a condition that existed before you enr plan under the FEHB Program .

General Information *continued*

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effe date of your enrollment in your new plan or option, unless you or a covered family mem confined in a hospital or other covered facility or are receiving medical care in an alterna care setting on the last day of your enrollment under the prior plan or option. In that cas confined person will continue to receive benefits under the former plan or option until th of (1) the day the person is discharged from the hospital or other covered facility (a mov alternative care setting does not constitute a discharge under this provision), or (2) the da the day all inpatient benefits have been exhausted under the prior plan or option, or (3) t day after the last day of coverage under the prior plan or option. However, benefits for o family members under the new plan will begin on the effective date. If your plan termina participation in the FEHB Program in whole or in part, or if the Associate Director for R and Insurance orders an enrollment change, this continuation of coverage provision does apply; in such case, the hospitalized family member's benefits under the new plan begin effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing o retirement system can provide information about: when you may change your enrollmen family members are; what happens when you transfer, go on leave without pay, enter mi service, or retire; when your enrollment terminates; and the next open season for enrolln Your employing office or retirement system will also make available to you an FEHB G brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in t if you changed plans or plan options, see "If you are a new member" above. In both c however, the Plan's new rates are effective the first day of the enrollee's first full pay that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five y before you retire to continue your enrollment for you and any eligible family membe you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Fa coverage for the enrollee, his or her spouse, and unmarried dependent children under Under certain circumstances, coverage will also be provided under a family enrollme disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a chi change to a Self and Family enrollment up to 60 days after the birth or addition. The date of the enrollment change is the first day of the pay period in which the child was became an eligible family member. The enrollee is responsible for his or her share of and Family premium for that time period; both parent and child are covered only for received from Plan providers.
- You will not be informed by your employing office (or your retirement system) or yo when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a depen 22 or older is eligible for coverage, to your employing office or retirement system. Th does not determine eligibility and cannot change an enrollment status without the nec information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also cover Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepai when one is available in your area. If you later change your mind and want to reenrol FEHB, you may do so at the next open season, or whenever you involuntarily lose co the Medicare prepaid plan or move out of the area it serves.

Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, y enroll in a Medicare prepaid plan, but you will probably have to pay for hospital cove addition to the Part B premium. **Before** you join the plan, ask whether they will provi hospital benefits and, if so, what you will have to pay.

You may also remain enrolled in this Plan when you join a Medicare prepaid plan.Co your local Social Security Administration (SSA) office for information on local Medi prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request SSA at 1-800/638- 6833. Contact your retirement system for information on dropping FEHB enrollment and changing to a Medicare prepaid plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order t covered under the FEHB Program nor are their FEHB benefits reduced if they do not Medicare Part B.

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service c family member is no longer eligible for coverage under an employee or annuitant enroll the person is not otherwise eligible for FEHB coverage, he or she generally will be eligi free 31-day extension of coverage. The employee or family member may also be eligible of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to el coverage under the spouse equity law. If you are recently divorced or anticipate divorcin the employee's employing office (personnel office) or retiree's retirement system to get facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from servi may be eligible to temporarily continue your health benefits coverage under the FEHB P in any plan for which you are eligible. Ask your employing office for RI 79-27, which d TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are se for gross misconduct, TCC is available to you if you are not otherwise eligible for continu coverage under the Program. For example, you are eligible for TCC when you retire if you unable to meet the five-year enrollment requirement for continuation of enrollment after re

Your TCC begins after the initial free 31-day extension of coverage ends and continues f 18 months after your separation from service (that is, if you use TCC until it expires 18 following separation, you will only pay for 17 months of coverage). Generally, you mus total premium (both the Government and employee shares) plus a 2 percent administrati charge. If you use your TCC until it expires, you are entitled to another free 31-day exte coverage when you may convert to nongroup coverage. If you cancel your TCC or stop premiums, the free 31-day extension of coverage and conversion option are not available

Children or former spouses who lose eligibility for coverage because they no longer qua family members (and who are not eligible for benefits under the FEHB Program as empl under the spouse equity law) also may qualify for TCC. They also must pay the total pre plus the 2 percent administrative charge. TCC for former family members continues for months after the qualifying event occurs, for example, the child reaches age 22 or the da divorce. This includes the free 31- day extension of coverage. When their TCC ends (ex cancellation or nonpayment of premium), they are entitled to another free 31-day extens coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the en is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for pre payments retroactive to the effective date and coverage may not exceed the 18 or 36 mo period noted above.

Notification and election requirements

Separating employees – Within 61 days after an employee's enrollment terminates beca separation from service, his or her employing office must notify the employee of the opp to elect TCC. The employee has 60 days after separation (or after receiving the notice fr employing office, if later) to elect TCC.

General Information *continued*

Children – You must notify your employing office or retirement system when a child be eligible for TCC within 60 days after the qualifying event occurs, for example, the child age 22 or marries.

Former spouses – You or your former spouse must notify the employing office or retire system of the former spouse's eligibility for TCC within 60 days after the termination of marriage. A former spouse may also qualify for TCC if, during the 36-month period of T eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 o the qualifying court order. This applies even if he or she did not elect TCC while waiting spouse equity coverage to begin. The former spouse must contact the employing office v days of losing spouse equity eligibility to apply for the remaining months of TCC to whi she is entitled.

The employing office or retirement system has 14 days after receiving notice from you o former spouse to notify the child or the former spouse of his or her rights under TCC. If wants TCC, he or she must elect it within 60 days after the date of the qualifying event (receiving the notice, if later). If a former spouse wants TCC, he or she must elect it with days after any of the following events: the date of the qualifying event or the date he or receives the notice, whichever is later; or the date he or she loses coverage under the spo equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or fo spouse's eligibility for TCC within the 60-day time limit. If the employing office or retir system is not notified, the opportunity to elect TCC ends 60 days after the qualifying ev case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices are available or chosen when coverage as an employee member ends, or when TCC coverage ends (except by cancellation or nonpayment of pr you may be eligible to convert to an individual, nongroup contract. You will not be requ provide evidence of good health and the plan is not permitted to impose a waiting perio coverage for preexisting conditions. If you wish to convert to an individual contract, you apply in writing to the carrier of the plan in which you are enrolled within 31 days after notice of the conversion right from your employing agency. A family member must appl convert within the 31-day free extension of coverage that follows the event that terminat coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contra differ from those under the FEHB Program.

Certificate of creditable coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automati receive a Certificate of Group Health Plan Coverage from the last FEHB Plan to cover y certificate, along with any certificates you receive from other FEHB Plan you may have enrolled in, may reduce or eliminate the length of time a pre-existing condition clause ca applied to you by a new non-FEHB insurer. If you do not receive a certificate automatic must be given one on request.

Facts about Prudential HealthCare HMO-Austin

This Plan is a comprehensive medical plan, sometimes called a health maintenance organization (HMO). When you enroll i HMO, you are joining an organized system of health care that arranges in advance with specific doctors, hospitals and other providers to give care to members and pays them directly for their services. **There are no claim forms when plan doctors**

Your decision to join an HMO should be based on your preference for the plan's benefits and delivery system, not be particular provider is in the plan's network. You cannot change plans because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providi comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as visits, physical exams, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of ill

Facts about this Plan *continued*

Information you have a right to know

All carriers in the FEHB Program must provide certain information to you. If you did nc information about this Plan, you can obtain it by calling the Carrier at 800-621-2645 or write the Carrier at 7700 Chevy Chase Drive, Chevy Chase I, Suite 500, Austin, Texas, at its website at http://Prudential.com/healthcare.

Information that must be made available to you includes:

- Disenrollment rates for 1998.
- Compliance with State and Federal licensing or certification requirements and the dat noncompliant, the reason for noncompliance.
- Accreditations by recognized accrediting agencies and the dates received.
- Carrier's type of corporate form and years in existence.
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solv confidentiality and transfer of medical records.

Who provides care to Plan members?

Prudential HealthCare HMO - Austin s first health maintenance organization (HMO), is model HMO, with services provided through Prudential HealthCare HMO-Austin medic facilities and by participating primary care doctors operating out of their independent of When you enroll in Prudential HealthCare HMO-Austin, you choose your own personal care doctor from the carefully screened list of Plan doctors. Your personal doctor provid of your care and coordinates specialized care from other doctors. Network physicians ar conveniently located throughout Austin and the surrounding area and offer easy appointr scheduling and flexible hours. Prudential healthCare HMO-Austin member have access pharmacies located throughout the service area. The hospital network consists of 15 area hospitals. Please refer to the provider directory for specific doctor, hospital or pharmacy

Role of a primary care doctor

The first and most important decision each member must make is the selection of a prim doctor. The decision is important since this doctor coordinates all health services; includ specialty care. Your primary care doctor not only refers you to specialists, if necessary, b arrangements for hospitalization. Services of other providers are covered only when ther been a referral by the member's primary care doctor with the following exceptions: serv participating OB/GYN, Mental Health Provider, and Optometrist. A woman may see her obstetrician/gynecologist for a routine annual gynecological exam and for specific femal medical conditions, without a referral from her primary care doctor. Also, members may annual routine eye exam from a Plan optometrist without a referral.

Choosing your doctor

The Plan's provider directory lists primary care doctors (General Family Practitioners, Pediatricians, Obstetricians / Gynecologist, and Internist), with their locations and phone and notes whether or not the doctor is accepting new patients. Directories are updated or regular basis and are available at the time of enrollment or upon request by calling the M Services Department at **800-621-2645**. You can also find out if your doctor participates Plan by calling this number.

If you are interested in receiving care from a specific provider who is listed in the direct the provider to verify that he or she still participates with the Plan and is accepting new Important note: **When you enroll in this plan, services (except for emergency benefit provided through the Plan's delivery system; the continued availability and/or part of any one doctor, hospital, or other provider, cannot be guaranteed.**

In the event that a member is receiving services from a doctor who terminates a participat agreement, the Plan will provide payment for covered services until the Plan can make re and medically appropriate provisions for the assumption of such services by a participatir

Referrals for specialty care

Except in a medical emergency, or when a primary care doctor has designated another d see patients when he or she is unavailable, you must contact your primary care doctor fo referral before seeing any other doctor or obtaining specialty services. Referral to a parti specialist is given at the primary care doctor's discretion; if specialists or consultants are beyond those participating in the Plan, the primary care doctor will make arrangements f appropriate referrals.

Facts about this Plan *continued*

When you receive a referral from your primary care doctor, you must return to the prima doctor after the consultation. All follow-up care must be provided or authorized by the p care doctor. On referrals, the primary care doctor will give specific instructions to the co as to what services are authorized. If additional services or visits are suggested by the cc you must first check with your primary care doctor. Do not go to the specialist unless yo primary care doctor has arranged for and the Plan has issued an authorization for the ref advance.

If you have a chronic, complex, or serious medical condition that causes you to see a Pla specialist frequently, your primary care doctor will develop a treatment plan with you an health plan that allows an adequate number of direct access visits with that specialist. Th treatment plan will permit you to visit your specialist without the need to obtain further

Authorizations

The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition. Your Plan doctor must Plan s determination of medical necessity before you may be hospitalized, referred for s care or obtain follow-up care from a specialist.

For new members

If you are already under the care of a specialist who is a Plan participant, you must still referral from your Plan primary care doctor for the care to be covered by the Plan. If the who originally referred you prior to your joining this Plan is now your Plan primary care you need only call to explain that you now belong to this Plan and ask that a "referral fo sent to the specialist for your next appointment.

If you are selecting a new primary care doctor and want to continue with this specialist, schedule an appointment so that the primary care doctor can decide whether to treat the directly or refer you back to the specialist.

Hospital care

If you require hospitalization, your primary care doctor or authorized specialist will mak necessary arrangements and continue to supervise your care. **Outpatient surgeries are performed at participating hospitals.**

Out-of-pocket maximum

Copayments are required for a few benefits. However, copayments will not be required f remainder of the calendar year after your out-of-pocket expenses for services provided or by the Plan reach $3,363 per Self Only enrollment or $9,083 per Self and Family enrollm

You should maintain accurate records of the copayments made, as it is your responsibilit determine when the copayment maximum is reached. You are assured a predictable max out-of-pocket costs for covered health and medical needs. Copayments are due when ser rendered, except for emergency care.

Deductible carryover

If you changed to this Plan during open season from a plan with a deductible and the eff date of the change was after January 1, any expenses that would have applied to that pla deductible will be covered by your old plan if they are for care you got in January befor effective date of your coverage in this Plan. If you have already met the deductible in fu old plan will reimburse these covered expenses. If you have not met it in full, your old p first apply your covered expenses to satisfy the rest of the deductible and then reimburse any additional covered expenses. The old plan will pay these covered expenses accordin year's benefits; benefit changes are effective January 1.

Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your promptly. The Plan will not pay benefits for claims submitted later than December 31 of calendar year following the year in which the expense was incurred unless timely filing prevented by administrative operations of Government or legal incapacity, provided the submitted as soon as reasonably possible.

Experimental/ investigational determinations

Services and supplies are not covered to the extent that they are experimental or investig In making a determination as to whether a supply or service is experimental or investiga Prudential will initiate the evaluation described below. This description is a summary. Fo complete description, please contact Member Services at 800-621-2645.

Facts about this Plan *continued*

- Determine if the service or supply is under study or in a clinical trial to evaluate its effectiveness for a particular diagnosis or set of indications.
- Assess whether the prevailing opinion within the appropriate specialty of the United S medical profession is that the service or supply needs further evaluation for the partic diagnosis. In making this determination, Prudential relies on published reports in auth medical literature, and on regulations, reports, publications, and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the N Institutes of Health, and the FDA.
- Determine if the provider s institutional review board acknowledges that the use of th or supply is experimental or investigational and requires that the patient, parent, or gu give an informed consent stating that the service or supply is experimental or investig or part of a research project or study.
- Determine if research protocols indicate that the service or supply is experimental or investigational, or is part of a research project or study.

Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course treatment. Before you enroll in this Plan, you should determine whether you will be able accept treatment or procedures that may be recommended by Plan providers.

The Plan's service area

The service area for this Plan, where Plan providers and facilities are located, is fully de below. You must live in the service area to enroll in this plan. Benefits for care outside th area are limited to emergency services, as described on pages 15 and 16.

The service area includes the Austin, Texas area and Bastrop, Caldwell, Hays, Trav Williamson counties inclusive of the following zip codes and communities:

76574 (Taylor), 76577 (Thorndale), 76578 (Thrall), 78602 (Bastrop), 78610 (Buda), (Cedar Creek), 78613 (Cedar Park), 78615 (Coupland), 78616 (Dale), 78617 (Del Va 78619 (Driftwood), 78620 (Dripping Springs), 78621 (Elgin), 78622 (Fentress), 7862 (Georgetown), 78630 (Cedar Park), 78634 (Hutto), 78640 (Kyle), 78641 (Leander), (Liberty Hill), 78644 (Lockhart), 78645- 78646 (Leander), 78650 (Mc Dade), 78651 78652 (Manchaca), 78653 (Manor), 78655 (Martindale), 78656 (Maxwell), 78659 (Pa 78660 (Pflugerville), 78662 (Red Rock), 78664 (Round Rock), 78666-78667 (San Ma 78669 (Spicewood), 78676 (Wimberley), 78680-78681 (Round Rock), 78691 (Pfluger 78700-78799 (Austin), 78953 (Rosanky), 78957 (Smithville)

If you or a covered family member move outside the service area, you may enroll in anc approved plan. It is not necessary to wait until you move or for the open season to make change; contact your employing office or retirement system for information if you are anticipating a move.

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or of your illness or condition. **No oral statement of any person shall modify or otherwi the benefits, limitations and exclusions of this brochure, convey or void any coverag increase or reduce any benefits under this Plan or be used in the prosecution or def claim under this Plan.** This brochure is the official statement of benefits on which you

Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a signi number of Plan providers, complete or partial destruction of facilities, or other circumsta beyond the Plan's control, the Plan will make a good faith effort to provide or arrange fo services. However, the Plan will not be responsible for any delay or failure in providing due to lack of available facilities or personnel.

General Limitations *continued*

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a so other than this Plan. You must disclose information about other sources of benefits to the and complete all necessary documents and authorizations requested by the Plan.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, and/or Part B, the coordinate the benefits according to Medicare s determination of which coverage is prim However, this Plan will not cover services, except those for emergencies, unless you use providers. You must tell you Plan that you or your family member is eligible for Medica Generally, that is all you will need to do, unless your Plan tells you that you need to file Medicare claim.

Group health insurance and automobile insurance

This coordination of benefits (double coverage) provision applies when a person covered Plan also has, or is entitled to benefits from, any other group health coverage, or is entitl payment of medical and hospital costs under no-fault or other automobile insurance that benefits without regard to fault. Information about the other coverage must be disclosed Plan.

When there is double coverage for covered benefits, other than emergency services from Plan providers, this Plan will continue to provide its benefits in full, but is entitled to rec payment for the services and supplies provided, to the extent that they are covered by th coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays benefit as the secondary payer. When this Plan is the secondary payer, it will pay the les its benefits in full, or (2) a reduced amount which, when added to the benefits payable b other coverage, will not exceed reasonable charges. The determination of which health c is primary (pays its benefits first) is made according to guidelines provided by the Natio Association of Insurance Commissioners. When benefits are payable under automobile i including no-fault, the automobile insurer is primary (pays its benefits first) if it is legall obligated to provide benefits for health care expenses without regard to other health ben coverage the enrollee may have. This provision applies whether or not a claim is filed u other coverage. When applicable, authorization must be given this Plan to obtain inform about benefits or services available from the other coverage, or to recover overpayments other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a pr plan, special limitations on your CHAMPUS coverage apply; your primary provider mus authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions a CHAMPUS coverage.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for services required as the result of occupational disease or injury which any medical benefits are determined by the Office of Workers Compensation Prog (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S. a similar agency under another Federal or State law. This provision also applies when a t party injury settlement or other similar proceeding provides medical benefits in regard to under workers' compensation or similar laws. If medical benefits provided under such la exhausted, this Plan will be financially responsible for services or supplies that are other covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the agency) f services it provided that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Ind Health Service are entitled to seek reimbursement from the Plan for certain services and provided to you or a family member to the extent that reimbursement is required under t Federal statutes governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly other local, State, or Federal Government agency.

General Limitations *continued*

Liability insurance and third party actions

If a covered person is sick or injured as a result of the act or omission of another person the Plan requires that it be reimbursed for the benefits provided in an amount not to exce amount of the recovery, or that it be subrogated to the person's rights to the extent of the received under this Plan, including the right to bring suit in the person's name. If you ne information about subrogation, the plan will provide you with its subrogation procedures

General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. **Although a specific service may be listed as a b will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat illness or condition, and the Plan agrees, as discussed under Authorizations on page 8.** The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (**Emergency Benefits);**
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB Program;
- Services not required according to accepted standards of medical, dental, or psychiatr practice;
- Procedures, treatments, drugs or devices that are experimental or investigational;
- Procedures, services, drugs and supplies related to sex transformations; and
- Procedures, services, drugs and supplies related to abortions except when the life of t would be endangered if the fetus were carried to term or when the pregnancy is the re act of rape or incest.

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by I doctors and other Plan providers. This includes all necessary office visits; **you pay** a $1(visit copay, but no additional copay for laboratory tests and X-rays. Within the Service A house calls will be provided if in the judgement of the Plan doctor such care is necessary appropriate; you pay a $10 copay for the doctor s house call and $10 for home visits by and health aides.

The following services are included and are subject to the office visit copayment unless noted:

- Preventive care, including well-baby care and periodic check-ups
- Mammograms are covered as follows: for women age 35 through age 39, one mamm during these five years; for women age 40 through 49, one mammogram every one o years; for women age 50 through 64, one mammogram every year; and for women ag above, one mammogram every two years. In addition to routine screening, mammogr covered when prescribed by the doctor as medically necessary to diagnose or treat yo
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Medical and Surgical Benefits *continued*

- Complete obstetrical (maternity) care for all covered females, including prenatal, deli postnatal care by a Plan doctor. The $10 office visit copay applies to the first pernatal only. **The mother at her option, may remain in the hospital up to 48 hours after a delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended medically necessary.** If enrollment in the Plan is terminated during pregnancy, benef not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for m will be covered under either a Self Only or Self and Family enrollment; other care of who requires definitive treatment will be covered only if the infant is covered under a Family enrollment.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Vision and hearing screenings up to the age of 18
- Allergy testing and treatment, including test and treatment materials (such as allergy s **you pay** 50% of charges.
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints. **Y** nothing.
- Cornea, heart, heart-lung, kidney, liver, lung(single/double), pancreas and pancreas-ki transplants; **nonexperimental** allogeneic (donor) bone marrow transplants; autologou marrow transplants (autologous stem cell and peripheral stem cell support) for the fol conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lyr advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multipl myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ov germ cell tumors. Transplants are covered when approved by the Medical Director. R medical and hospital expenses of the donor are covered when the recipient is covered Plan. **You pay** nothing.
- Women who undergo mastectomies may, at their option, have this procedure perform inpatient basis and remain in the hospital up to 48 hours after the procedure. **You pay**
- Dialysis; **you pay** nothing
- Chemotherapy, radiation therapy, and inhalation therapy; **you pay** nothing
- Surgical treatment of morbid obesity; **you pay** nothing
- Home health services of nurses and health aides, including intravenous fluids and me when prescribed by your Plan doctor, who will periodically review the program for c appropriateness and need; **you pay** nothing
- Durable medical equipment, such as wheelchairs and hospital beds or iron lung; **you** of covered charges.
- Oxygen and rental of equipment for its administration. **You pay** 25% of charges.
- Chiropractic services
- Diabetic supplies including insulin syringes and needles, glucose tablets and tape, Be solution or equivalent, acetone test tablets, lancets and test strips.
- Disposable needles to inject covered prescribed medication.
- Orthopedic devices, such as braces; foot orthotics; **you pay** 25% of charges
- Prosthetics, including artificial limbs and initial lenses or eyeglasses following catara surgery. **You pay** 25% of charges.
- All necessary covered medical or surgical care in a hospital or extended care facility doctors and other Plan providers

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Medical and Surgical Benefits *continued*

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or su procedures occurring within or adjacent to the oral cavity or sinuses including, but not li treatment of fractures and excision of tumors and cysts. Treatment of temporomandibula disease is covered when determined to be of a medical rather than dental nature. **You pa** nothing. All other procedures involving the teeth or intra-oral areas surrounding the teetl covered, including any dental care or orthodontia involved in treatment of temporomand joint (TMJ) pain dysfunction syndrome.

Reconstructive surgery will be provided to correct a condition resulting from a functio or from an injury or surgery that has produced a major effect on the member's appearanc the condition can reasonably be expected to be corrected by such surgery. **You pay** nothi

Short-term rehabilitative therapy (physical, speech and occupational) is provided on a inpatient or outpatient basis. **You pay** a $10 copay per outpatient session. Speech therap limited to treatment of certain speech impairments of organic origin. Occupational thera limited to services that assist the member to achieve and maintain self-care and improve functioning in other activities of daily living.

Diagnosis and treatment of infertility, including artificial insemination, is covered. Yo **50%** of charges. The covered artificial insemination procedures are: intra vaginal insemi (IVI); intra cervical insemination (ICI) and intrauterine insemination (IUI). The cost of c sperm is not covered. Fertility drugs are covered; you pay 50%. Assisted reproductive te (ART) procedures (i.e., in vitro fertilization, embryo freezing or transfer, gamete or zygo fallopian transfer, etc.) are **not** covered.

Serious Mental Illness treatment is covered up to 45 days of inpatient care and 60 outp visits per calendar year. Serious Mental Illness means the following psychiatric illnesses defined in the most recent edition of the American Psychiatric Association s Diagnostic Statistical Manual of Mental Disorders : schizophrenia; paranoid and other psychotic dis bipolar disorders (hypomanic, manic and mixed), major depressive disorders (bipolar an depressive); schizoaffective disorders (bipolar or depressive); pervasive developmental d obsessive-compulsive disorders, and depression in childhood and adolescence. **You pay** for inpatient treatment up to 45 days and a $10 copay for each covered outpatient visit u visits, all charges thereafter. Mental illnesses that do not meet the definition of serious m illness are covered under Mental Conditions/Substance Abuse Benefits.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infa provided at a Plan facility. **You pay** $10 copay.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those requi obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Transplants not listed as covered
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, suc nearsightedness (myopia), farsightedness (hyperopia), and astigmatism.
- Hearing aids and examinations to fit them; the cost of cochlear implant devices
- Homemaker services
- Blood or blood plasma replaced by or for the patient

Hospital/Extended Care Benefits *continued*

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when y hospitalized under the care of a Plan doctor. **You pay** nothing. A**ll necessary services ar covered, including:**

- Semiprivate room accommodations; when a Plan doctor determines it is medically ne the doctor may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units

Extended care

The Plan provides a comprehensive range of benefits for up to 100 days per condition fo confinements which are due to the same or related causes and which are separated by les three months. Coverage is provided when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Pla and approved by the Plan. **You pay** nothing. **All necessary services are covered, includ**

- Bed, board and general nursing care
- Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the sk nursing facility when prescribed by a Plan doctor.

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hosp facility. Services include inpatient and outpatient care, and family counseling; these serv provided under the direction of a Plan doctor who certifies that the patient is in the termi stages of illness, with a life expectancy of approximately six months or less. Benefits are to $7,400 per period of care. Family counseling is limited to $200.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doct **pay** a $25 copay per occurrence.

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines t need for hospitalization for reasons totally unrelated to the dental procedure; the Plan wi the hospitalization, but not the cost of the professional dental services. Conditions for wh hospitalization would be covered include hemophilia and heart disease; the need for anes by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, d treatment of medical conditions, and medical management of withdrawal symptoms (acu detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 17 for nonmedical substance abuse benefits.

Serious Mental Illness

The Plan provides a comprehensive range of benefits for inpatient care for up to 45 days you are hospitalized for serious mental illness under the care of a Plan doctor. You pay n Each full day of treatment in a Psychiatric Day Treatment Facility, Residential Treatmen for Children and Adolescents or Crisis Stabilization Unit will be considered a half of one treatment during a Hospital Inpatient stay.

Serious Mental Illness means the following psychiatric illnesses as defined in the most r edition of the American Psychiatric Association s Diagnostic and Statistical Manual of M Disorders : schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hyp manic and mixed), major depressive disorders (bipolar and depressive); schizoaffective d (bipolar or depressive); pervasive developmental disorders; obsessive-compulsive disord depression in childhood and adolescence. Mental illnesses that do not meet the definitio serious mental illness are covered under Mental Conditions/Substance Abuse Benefits.

Hospital/Extended Care Benefits *continued*

What is not covered

- Personal comfort items, such as telephone and television
- Custodial care, rest cures, domiciliary or convalescent care
- Blood or blood plasma replaced by or for the patient

Emergency Benefits

What is a medical emergency?

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

Emergencies within the service area

If you are in an emergency situation, please call your primary care doctor. In extreme emı if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 system) or go to the nearest hospital emergency room. Be sure to tell the emergency room that you are a Plan member so they can notify the Plan. You or a family member should nc Plan within 48 hours. It is your responsibility to ensure that the Plan has been timely notifi

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first v day following your admission, unless it was not reasonably possible to notify the Plan w time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be b provided in a Plan hospital, you will be transferred when medically feasible with any am charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if c reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this Plan, any follow-up care recommended by non-Plan provider be approved by the Plan or provided by Plan providers.

Plan pays... Reasonable charges for emergency services to the extent the services would have been c received from Plan providers.

You pay... $75 per hospital emergency room visit or $10 per urgent care center visit for emergency that are covered benefits of this Plan. If the emergency results in admission to a hospital emergency care copay is waived.

Emergencies outside the service area

Benefits are available for any medically necessary health service that is immediately req because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first v day following your admission, unless it was not reasonably possible to notify the Plan w time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan provider be approved by the Plan or provided by Plan providers.

Plan pays... Reasonable charges for emergency care services to the extent the services would have be covered if received from Plan providers.

Emergency Benefits *continued*

You pay...

$75 per hospital emergency room visit or $10 per urgent care center visit for emergency which are covered benefits of this Plan. Urgent care center services rendered outside the area must be coordinated through the National Service Hotline for the $10 copay to appl **If emergency results in an admission to a hospital, the emergency care copay is wai**

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service determined by the Plan to be medically necessary

What is not covered

- Elective care or nonemergency care
- Emergency care provided outside the service area if the need for care could have beer foreseen before leaving the service area
- Charges incurred after your condition would permit you to travel to the nearest Plan c office or Plan hospital

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emer care upon receipt of their claims. Physician claims should be submitted on the HCFA 15 form. If you are required to pay for the services, submit itemized bills and your receipts Plan along with an explanation of the services and the identification information from yc card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim denied. If it is denied, you will receive notice of the decision, including the reasons for t and the provisions of the contract on which denial was based. If you disagree with the P decision, you may request reconsideration in accordance with the disputed claims proced described on page 21.

Portability (Reciprocity)

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

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

- Contact the Prudential National Service Hotline (1-800-526-2963) to obtain a referra local participating physician. This toll free number is also located on the back of your ID card and is answered 24 hours a day.
- In life-threatening emergencies, we recommend that you seek appropriate treatment immedicately. However, you or a member of your family must notify your primary ca within 48 hours concerning the emergency care you received.

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

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

To the extent shown below, the Plan provides the following services necessary for the di and treatment of acute psychiatric conditions, including the treatment of mental illness o disorders:

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Mental Conditions/Substance Abuse Benefits *continued*

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Serious Mental Illness is covered under the Medical/Surgical and Hospital/Extended Car Benefits. Serious Mental Illness means the following psychiatric illnesses, as defined in recent edition of the American Psychiatric Association s Diagnostic and Statistical Manu Mental Disorders : schizophrenia; paranoid and other psychotic disorders; bipolar disord (hypomanic, manic and mixed), major depressive disorders (bipolar and depressive); schizoaffective disorders (bipolar or depressive); pervasive developmental disorders; obs compulsive disorders, and depression in childhood and adolescence.

Outpatient care

Up to 20 outpatient visits to Plan doctors, consultants or other psychiatric personnel eacl year, **you pay** a $35 copay for each covered visit - all charges thereafter.

Inpatient care

Up to 30 days of hospitalization each calendar year; **you pay** nothing for the first 30 day charges thereafter.

Each full day of treatment in a Psychiatric Day Treatment Facility, Residential Treatmen for Children and Adolescents or Crisis Stabilization Unit will be considered a half of on treatment during a Hospital Inpatient Stay.

What is not covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are r subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probati determined by a Plan doctor to be necessary and appropriate
- Psychological testing when not medically necessary to determine the appropriate trea a short-term psychiatric condition

Substance abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services f medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addi same as for any other illness or condition.

Outpatient care

All necessary outpatient visits to Plan providers for treatment; **you pay** a $10 copay for covered visit.

Inpatient care

Hospitalization necessary for the diagnosis and treatment of Substance Abuse; **you pay** r

What is not covered

- Treatment that is not authorized by a Plan doctor.

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharma dispensed for up to a 30-day supply or 100 unit supply, whichever is less; or one comme prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin). **You pay a $5 per prescription unit or refill for generic drugs. You pay a $10 copay for prescriptio refill for name brand drugs.** A mail order prescription drug benefit is also available. M may obtain a 90-day supply of maintenance drugs per refill for $5 (generic drugs) or $1(copayment (name brand drugs).

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Prescription Drug Benefits *continued*

Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan s drug f
Non- formulary drugs will be covered when prescribed by a Plan doctor.

Formulary Development

The Prudential HealthCare Drug Formulary was developed and is maintained by the Pru
HealthCare National Pharmacy and Therapeutics committee (P&T) with the understandi
well constructed formulary enhances quality of care. The P&T committee evaluates the cl
of drugs and develops policies and procedures for developing new drug therapies and ma
the formulary. The P&T is also responsible for conducting therapeutic class reviews and a
new drugs as they enter the market. The formulary reflects our medical and pharmaceutic
experience in formulary management and rigorous reviews of individual clinical studies.

Non-Formulary Drug Requests

In order to request coverage for a non-formulary drug, the patient's physician may call o
toll-free unit or fax a request form to the plan s Drug Request Unit.

After obtaining all of the required information, the request will be evaluated. The Unit h
hours (one business day) to make a decision. The physician will be notified within one b
day after the Drug Request Unit has made the decision. A copy of the decision will be fa
mailed to your physician.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Oral contraceptive drugs; contraceptive diaphragm
- Implantable drugs, such as Norplant; **you pay** a $10 copay
- Insulin with a copay charge applied to each 10ml vial
- Disposable needles and syringes needed to inject covered prescribed medication; cov
  100% (except insulin syringes and needles)
- Intravenous fluids and medication for home use
- Prescription drugs prescribed for the treatment of infertility (including injectable ferti
  drugs) are covered; **you pay** 50% of charges.

Limited Benefits

Sexual dysfunction drugs have dispensing limitations. For complete details, please call P
HealthCare customer services at 800-621-2645.

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance

Other Benefits

Dental care

Accidental injury benefit

Restorative services and supplies necessary to promptly repair or replace sound natural t
Replacement of sound natural teeth does not include dental implants. The need for these
must result from an accidental injury. **You pay** a $10 copay per visit.

What is not covered

- Any dental services not shown as covered

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Other Benefits *continued*

Vision Care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of d of eye, this Plan provides annual eye refractions (which include a written lens prescriptio glasses, glaucoma testing, dilation from Plan providers; **you pay** a $10 copay per visit.

What is not covered

- Eye exercises
- Eyeglasses and frames, contact lenses or the fitting of lenses

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB program, but ar made available to all enrollees and family members who are members of the Plan. The cost of the benefits described on page is not included in the FEHB premium; any charges for these services do not count toward any FEHB deductibles, c out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedures.

Along with the medical benefits described elsewhere, Prudential HealthCare HMO gives you access to additional progra that can enhance your quality of life.

Prudential offers a discount dental program, with more than 10,000 participating dentists across the country. These denti have agreed to provide services to program participants at reduced rates including periodic exams, cleanings...even orthodontia care.

For as little as $5.00 a month ($6.00 for families), you will have access to dental services at a discount. You may enroll submitting a completed application and a full year s premium, $60.00 for an individual and $72.00 for a family. (Please this is not a payroll deduction plan.) Applications and more details about the Dental Program are included in your Prude Healthcare open enrollment packet.

As a Prudential HealthCare HMO member, you can obtain discounts on eyeglasses and frames at designated locations.

Prudential HealthCare plan members receive HealthSmart®, our member magazine. From health updates to safety advice diet and exercise tips, it's information that can contribute to a healthy life.

As a Prudential HealthCare HMO member, you can enjoy programs designed to improve or enhance your health and the health of your family. Health & Fitness Advantage® offers wellness, fitness and home health products at a discount to pl members. With FlexClub Advantage®, it's easy to maintain a regular exercise program by enrolling in a participating hea club even when you're traveling. And the Prudential HealthCare Bike Helmet Program makes quality bicycle helmets available to people of all ages even non-plan members for as little as $10. Call 1-800 MY HEALTH.

Benefits on this page are not part of the FEHB contract

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the P Membership Services at 800-621-2645 or you may write to the Plan at 7700 Chevy Cha Suite 500, Chevy Chase I, Austin, Texas 78752 or through the website at http://www.Prudential.com/healthcare.

Disputed claims review

Plan reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writin within six months of the date of the denial, to reconsider its denial before you request a OPM. (This time limit may be extended if you show you were prevented by circumstanc beyond your control from making your request within the time limit.) OPM will not revi request unless you demonstrate that you gave the Plan an opportunity to reconsider your Your written request to the Plan must state why, based on specific benefit provisions in t brochure, you believe the denied claim for payment or service should have been paid or

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the writing to you, pay the claim, provide the service, or request additional information reas necessary to make a determination. If the Plan asks a provider for information it will sen copy of this request at the same time. The Plan has 30 days after receiving the informati its decision. If this information is not supplied within 60 days, the Plan will base its deci the information it has on hand.

OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determin whether the Plan's actions are in accordance with the terms of its contract. You must req review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your request for reconsideration or 30 days after you have supplied additional information to In this case, OPM must receive a request for review within 120 days of your request to t for reconsideration or of the date you were notified that the Plan needed additional infor either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Provic counsel, and other interested parties may act as your representative only with your speci written consent to pursue payment of the disputed claim. OPM must receive a copy of y written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provis this brochure, you believe the denied claim for payment or service should have been pai provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide i (a) the date of your request to the Plan or (b) the dates the Plan requested and you pr additional information to the Plan);
- Copies of documents that support your claim, such as doctors' letters, operative repor medical records, and explanation of benefit (EOB) forms; and
- Your daytime phone number.

Medical documentation received from you or the Plan during the review process becom permanent part of the disputed claim file, subject to the provisions of the Freedom of Inf Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance P Contracts Division 3, P.O. Box 436, Washington, DC 20044.

How to Obtain Benefits *continued*

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a treatment, services, supplies or drugs covered by this Plan until you have exhausted the review procedure, established at section 890.105, title 5, Code of Federal Regulations (C OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based denial, the lawsuit must be brought no later than December 31 of the third year after the which the services or supplies upon which the claim is predicated were provided. Pursua section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Perso Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan' or coverage or payments with respect to those benefits. Judicial action on such claims is to the record that was before OPM when it rendered its decision affirming the Plan's der benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement - If you ask OPM to review a denial of a claim for payment or ser OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from the Plan to determine if the Plan has acted properly in denying you the payment or servi the information so collected may be disclosed to you and/or the Plan in support of OPM decision on the disputed claim.

How Prudential HealthCare HMO – Austin Changes January 19

Do not rely on this page; it is not an official statement of benefits.

Program-wide benefits changes

- Several changes have been made to comply with the President s mandate to implemer recommendations of the Patient Bill of Rights.
- If you have a chronic, complex or serious medical condition that causes you to freque a Plan specialist, your primary care physician will develop a treatment plan with you health plan that allows an adequate number of direct access visits with that specialist, the need to obtain further referrals. (See page 8)
- A medical emergency is defined as the sudden and unexpected onset of a condition or injury that you believe endangers your life or could result in serious injury or disabili requires immediate medical or surgical care (See page 15)
- The medical management of mental conditions will be covered under the Plan's Medi Surgical Benefits provisions. Related drug costs will be covered under the Plan's Pres Drug Benefits, and any costs for psychological testing or psychotherapy will be cover this Plan s Medical Conditions Benefits. Office visits for the medical aspects of treatr not count toward the outpatient Mental Conditions visit limit. (See page 13).
- Coverage for drugs to treat sexual dysfunction is shown under the Prescription Drug (See page 18).

Changes to this Plan

- The office visit copay will increase from $5.00 to $10.00. See page 11.
- Day and visit limits have been eliminated for outpatient rehabilitative therapy. The nu visits will be based on the medical necessity of care. Members pay a $10.00 copay pe outpatient session. See page 13.
- The hospital emergency room copay under the Emergency Benefits will increase fron to $75.00. The urgent care center copay will increase from $5.00 to $10.00. See page
- Members will now pay 50% for the diagnosis and treatment of infertility, including ir drugs. The Plan will continue to exclude benefits for Assisted Reproductive Technolo procedures. See page 13.

Summary of Benefits for Prudential HealthCare HMO–Austin –

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exc set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enro change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear cover of this brochure). ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.

	Benefits	Plan pays/provides
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limi Includes in-hospital doctor care, room and board, general nursing care, semi-priv room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity c **You pay** nothing.....
	Extended care	All necessary services for up to 100 days per period of care. **You pay** nothing ....
	Serious Mental Illnesses	Diagnosis and treatment of Serious Mental Illnesses is covered up to 45 days of inpatient care per year. **You pay** nothing.....
	Other Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. **You pay** nothing.....
	Substance abuse	Hospitalization necessary for diagnosis and treatment. **You pay** nothing .....
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or in including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete mat care. **You pay** a $10 copy per office visit. .....
	Home health care	All necessary visits by nurses and health aides. **You pay** nothing.....
	Serious Mental Illnesses	Up to 60 outpatient visits for the diagnosis and treatment of Serious Mental Illne per calendar year. **You pay** $10 per covered visit. .....
	Other Mental conditions	Up to 20 outpatient visits per year. **You pay** a $35 copay per visit .....
	Substance abuse	All necessary outpatient visits are covered. **You pay** a $10 copay per visit.....
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $75 copay to the hospital for each emergency room visit a any charges for services that are not covered by this Plan.....
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $5 copay per prescription unit or refill for generic drugs; a $10 copay for name b drugs. Mail order prescriptions are covered for one copayment for a 90-day supp
Dental care		Accidental injury benefit. **You pay** $10.....
Vision Care		One refraction annually. **You pay** a $10 copay per visit.....
Out-of-pocket maximum		Copayments are required for a few benefits; however, after your out-of-pocket ex reach a maximum of $3,363 per Self Only or $9,083 per Self and Family enrollm calendar year, covered benefits will be provided at 100%. This copay maximum include prescription drugs or dental services.....

1999 Rate Information for Prudential HealthCare HMO℠ – Austin

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

Postal rates apply to most career U.S. Postal Service employees, but do not apply to non-career Postal employees, Postal re certain special Postal employment categories or associate members of any Postal employee organization. If you are in a spec employment category, refer to the FEHB Guide for that category.

		Non-Postal Premium				Postal Prem	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Y S
Self Only	UN1	$50.29	$16.76	$108.96	$36.32	$59.51	$
Self and Family	UN2	$135.68	$45.22	$293.96	$97.99	$160.55	$