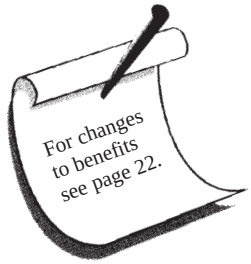
PacifiCare®
of Ohio

PacifiCare® 1999

A Health Maintenance Organization



Serving: Greater Cincinnati, Ohio and Northern Kentucky area.

Enrollment code:
R81 Self Only
R82 Self and Family

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

Visit the OPM website at http://www.opm.gov/insure
and
this Plan's website at http://www.phs.com

Authorized for distribution by the

United States Office of Personnel Management

Federal Employees Health Benefits Program

RI 73-254

PacifiCare® of Ohio, Inc.

PacifiCare of Ohio, Inc. dba as PacifiCare 11260 Chester Rd.,Suite 800, Cincinnati, Ohio 45246 has entered into a contract (CS 2067) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law to provide a comprehensive medical plan herein called PacifiCare, PACIFICARE Health Plan, 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 benefits 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** of this brochure.

Table of Contents

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 order 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 a provider, such as a doctor, hospital or pharmacy, charged your plan for services you did not receive, billed for the same service 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 800/824-0428 and explain the situation
- 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 member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General Information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, 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 criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual 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 before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

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

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on page 14. If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for 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 family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, 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 this Plan; if you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period 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 years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a 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 child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers except for emergency benefits.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

Things to keep in mind *continued*

Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide 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.

Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your 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 to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

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

Former spouse coverage

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

Temporary continuation of coverage (TCC)

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

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying 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 qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

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

Notification and election requirements

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

General Information *continued*

Notification and election requirements *continued*

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

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

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse 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 former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the 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 or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Certificate of Creditable Coverage

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

Facts about this plan

This Plan is a comprehensive medical plan, sometimes called a health maintenance organization (HMO). When you enroll in an 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. Benefits are available only from Plan providers except during a medical emergency. **Members are required to select a personal doctor from among participating Plan primary care doctors.** Services of a specialty care doctor can only be received by referral from the selected primary care doctor. There are no claim forms when Plan doctors are used.

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

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

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 not receive information about this Plan,you can obtain it by calling the carrier at 1-800/824-0428 or you may write the carrier at 11260 Chester Rd.,Suite 800, Cincinnati, OH 45246.

Information that must be available to you includes:

- Disenrollment rates for 1997.
- Compliance with State and Federal licensing or certification requirements and the dates met. If 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 solvency, confidentiality and transfer of medical records.

Who provides or arranges care to Plan members

PacifiCare Health Plan is a Health Maintenance Organization (HMO) serving the greater Cincinnati, and Northern Kentucky areas. PacifiCare Health Plan offers an extensive range of health services.

As a mixed model plan, PacifiCare Health Plan contracts with over 963 primary care physicians who see PacifiCare Health Plan members throughout the service area in their private offices and in group practice facilities.

Each new PacifiCare Health Plan member is asked to select a family practice, internal medicine or pediatric physician as their primary care doctor. Once the doctor is selected, all of your health care will be coordinated by him/her. PacifiCare Health Plan utilizes area Plan-designated hospitals and specialists with the authorization or referral of your primary care doctor. Mental health and substance abuse care must also be received from Plan-designated providers. The plan has designated certain hospitals for organ transplants to be performed. These hospitals have been selected for their experience in performing transplants. In some instances, the designated hospital may not be located in the Plan's service area and you will be responsible for your travel expenses to that facility. Contact the Plan for a list of designated organ transplant facilities.

Role of a primary care physician

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other Plan providers are covered only when there has been a referral by the member's primary care doctor, with the following exceptions: no referral is necessary for one visit per year for routine gynecological care from a participating gynecologist and one mammogram per year at a participating center. Other benefits which may be obtained without a referral are vision care, and mental health and substance abuse care through participating providers.

Choosing your doctor

The Plan's provider directory lists primary care doctors (generally family practitioners, pediatricians, and internists), with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Member Services Department at 800/824-0428; you can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: When you enroll in this plan, services (except for emergency benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider, cannot be guaranteed.

Should you decide to enroll, you will be asked to complete a primary care doctor selection form and send it directly to the Plan, indicating the name of the primary care doctor(s)you select for you and each member of your family. Members who have not selected a Primary Care Physician within 31 days of enrollment may be assigned one by the Plan. Members may change their doctor selection by notifying the plan 30 days in advance.

In the event a member is receiving services from a doctor who terminates a participation agreement, the Plan will provide payment for covered services until the Plan can make reasonable and medically appropriate provisions for the assumption of such services by a participating doctor, by the Plan. Members may change their doctor selection by notifying the plan 30 days in advance.

Facts about this Plan *continued*

Referrals for specialty care

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

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

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

Authorizations

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

For new members

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

If you are selecting a new primary care doctor, you must schedule an appointment so the primary care doctor can decide whether to treat the condition directly or refer you to a specialist.

Hospital Care

If you require hospitalization, your primary care doctor or authorized specialist will make the necessary arrangements and continue to supervise your care.

Out-of-pocket maximum

Copayments are required for a few benefits. However, copayments will not be required for the remainder of the calendar year after your out-of- pocket expenses for services provided or arranged by the Plan reach **$1,500** per Self only enrollment or **$3,000** per Self and Family enrollment.

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

Deductible carryover

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

Facts about this Plan *continued*

Submit claims promptly

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

Experimental/investigational determinations

PacifiCare accepts the determination of recognized National and Regional Medical Committees as to whether treatments, procedures and drugs are accepted as no longer experimental or investigational. The determinations are based on the safety and efficacy of new medical procedures, technologies, devices and drugs.

Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to 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 described below. You must live or work in the service area to enroll in this Plan.

Service Area: Services from Plan providers are available only in the following area:
The Cincinnati, Ohio area which includes Brown, Butler, Clermont, Hamilton, and Warren counties. The Northern Kentucky area includes Boone, Campbell, Carroll, Gallatin, Grant, Kenton, Owen, and Pendleton counties.

This Plan accepts enrollments from this additional geographic area:
Adams, Clinton, Highland and counties in Ohio; Bracken, Harrison, Robertson and Scott counties in Kentucky; Dearborn, Franklin, Ohio, Switzerland and Union counties in Indiana.

Benefits for care outside the service area are limited to emergency services, as described on page 14.

If you or a covered family member move outside the service area, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a 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, in the judgement of your Plan doctor, it is medically necessary for the prevention, diagnosis and treatment of your illness or condition. No oral statement of any person shall modify or otherwise affect the benefits , limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this Plan. This brochure is the official statement of benefits on which you can rely.

Circumstances beyond Plan control

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

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan 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 Medicare Part A and/or Part B, the Plan will coordinate benefits according to Medicare's determination of which coverage is primary. However, this Plan will not cover services, except those for emergencies, unless you use Plan providers. You must tell your Plan that you or your family member is eligible for Medicare. Generally, that is all you will need to do, unless your Plan tells you that you need to file a Medicare claim.

Group health insurance and automobile insurance

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

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

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits or services available from the other coverage, or to recover overpayments from 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 prepaid plan, special limitations on your CHAMPUS coverage apply; your primary care provider must authorize all care. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

Medicaid

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

Worker's Compensation

The Plan will not pay for services required as a result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar preceding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for 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 Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other government agencies

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

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 or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more 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 benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness or condition as discuss under Authorizations on page 8. The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see 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 psychiatric 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 the mother would be endangered if the fetus were carried to term.

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** a $5 office visit copay, but no additional copay for laboratory tests and X-rays in the doctor's office; **you pay** a $5 copay per visit to other outpatient providers for laboratory tests and X-rays. A single office visit copay of $5 applies to the 1st pre-natal visit; all subsequent pre-natal visit copayments are waived for the remainder of the pregnancy. Within the service area, house calls will be provided if in the judgement of the Plan doctor such care is necessary and appropriate; **you pay** a $5 copay for a doctor's house call or for home visits by nurses and health aides; **you pay** a $50 copay per outpatient surgery performed in an ambulatory surgical facility.

The following services are included:

- Preventive care, including well-baby care and periodic check-up
- Mammograms are covered for women age 35 and over, one mammogram every year. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will 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 maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services, including Norplant (an internally implanted time-release contraceptive) and Depo-Provera (an injectable contraceptive)
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.

What is covered *continued*

- Cornea, heart, heart-lung, kidney, liver, lung (single and double), and pancreas transplants; 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. Treatment for multiple myeloma and epithelial ovarian cancer may be provided in an NCI or NIH approved non-randomized 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. Related medical and hospital expenses of the donor are covered.
- Organ (transplant) procurement expenses are covered if the organ is harvested from a cadaver or donated by a living person. **You pay** a $100 per admission copay for organ procurement.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you, except where noted.

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 surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures ad excisions of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including shortening of the mandible or maxilla for cosmetic purposes, correction of malocclusion, and any dental treatment of TMJ.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two months per condition if significant improvement can be expected within two months; **you pay** a $5 copay per outpatient session and a $100 copay per inpatient admission. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Chiropractic services are provided up to a maximum benefit of $500 per member per calendar year. You pay a $5 copay per outpatient visit; all charges thereafter.

Diagnosis and treatment of infertility is covered; artificial insemination is covered; the following types of artificial insemination are covered: intravaginal insemination (IVI), intracervical insemination (ICI), and intrauterine insemination (IUI); **you pay** a 30% copay per visit. Cost of donor sperm is not covered. Orally administered medications to treat infertility, or the underlying cause of infertility are covered under Prescription Drug Benefits. Injectable medications prescribed for the treatment of infertility are not covered. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization and embryo transfer are not covered.

Services and supplies for dialysis for acute renal failure and end stage renal disease when medically necessary is provided; **you pay** 20% copay per visit or month supply.

Pain and headache clinic services are provided up to a maximum lifetime benefit of $7,500; **you pay** a $5 copay per outpatient visit, $100 copay per inpatient admission.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to two months; **you pay** a $5 copayment per outpatient visit.

Medical and Surgical Benefits *continued*

Limited benefits *continued*

Orthopedic and prosthetic devices and durable medical equipment such as braces, artificial limbs, wheelchairs and hospital beds, and oxygen and the rental of equipment for the administration of oxygen are provided up to a maximum benefit of $500 per member per calendar year. **You pay** 20% of the charges up to a maximum benefit of $500 per member per calendar year for covered devices and equipment-all charges thereafter.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or traveling outside the United States
- Blood and blood derivatives not replaced by member
- Outpatient injectable substances and supplies related to infertility
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Hearing aids
- Homemaker services
- Long-term rehabilitative therapy
- Transplants not listed as covered
- Organ donor expenses for registry, testing for donor compatibility, and transportation
- Foot orthotics
- Lenses following cataract removal
- Dietary teaching and or counseling in the absence of a physiologic disease condition

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay** $100 copay per admission or observation service; All necessary services are covered, including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, 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 60 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate in lieu of hospitalization as determined by a Plan doctor and approved by the Plan. **You pay** a $5 copay per outpatient visit or $100 copay per inpatient admission. 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

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. **You pay** $5 per outpatient visit; nothing per inpatient admission.

Ambulance care

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor or pre-authorized by PacifiCare Health Plan. **You pay** a $25 copay per trip.

Limited benefits

Inpatient dental procedures

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

Hospital/Extended Care Benefits *continued*

Acute inpatient detoxification

Acute inpatient detoxification Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 15 for nonmedical Substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Custodial care, rest cures, domiciliary or convalescent care
- Dietary teaching and/or counseling in the absence of a physiologic disease or condition
- Blood and Blood derivatives not replaced by member

Emergency Benefits

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 the Plan may determine are medical emergencies - what they all have in common is the need for quick action.

Emergencies within the service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours(unless it is not reasonably possible to do so). It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full. Benefits are available for care from non-Plan providers in a medical emergency only if delay in 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 providers must be approved by the Plan or provided by Plan providers. To be covered by this Plan, any follow-up care recommended by non-Plan providers must 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 covered if received from Plan providers.

You pay...

$50 copayment per visit at a hospital; you pay $5 per visit at a participating urgent care center or doctor's office. If the emergency results in admission to a hospital, the emergency care copay is waived.

Emergencies outside the service area

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness. If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that 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 providers must 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 been covered if received from Plan providers.

You pay...

$50 per emergency room visit; $5 per urgent care center visit; $5 per physician's office visit for emergency care services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copay is waived.

Emergency Benefits *continued*

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 approved by the Plan; you pay $25 per trip
- Short-term supply of prescription drugs directly related to the out-of-area medical emergency, less the $5 prescription drug copayment

What is not covered

- Elective care or nonemergency 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.

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 19.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

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

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

Outpatient care

Up to 20 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; **you pay** a $10 copay for each covered visit-all charges thereafter.

Inpatient care

Up to 30 days of hospitalization each calendar year; **you pay** 20% of charges for first 30 days-all charges thereafter.

What is not covered

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

Substance abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition and, to the extent shown below, the services necessary for diagnosis and treatment.

Mental Conditions/Substance Abuse Benefits *continued*

Outpatient care

Up to 20 outpatient visits to Plan providers for treatment each calendar year; you pay a $10 copay for each covered visit-all charges thereafter.

The substance abuse benefit may be combined with the outpatient mental conditions benefit shown above, provided such treatment is necessary as a mental health care service and is approved by the Plan, to permit an additional 20 outpatient visits per calendar year with the applicable mental conditions copayment.

Inpatient care

Lifetime maximum of two 30-day substance abuse rehabilitation (intermediate care) programs in an alcohol detoxification or rehabilitation center approved by the Plan; **you pay** 20% of charges during the benefit period-all charges thereafter.

What is not covered

- Treatment that is not authorized by a Plan doctor.
- All charges if the member does not complete the treatment program

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 34 day supply (or 100 unit supply, whichever is less; 240 milliliters of liquid (8 oz.); 60 grams of ointment, creams or topical preparation; or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin). Prescription drugs prescribed by a Plan or referral doctor and obtained through the Plan mail order pharmacy service will be dispensed for up to a 90 day supply. **You pay** a $5 copay per prescription unit or refill for generic drugs or for name brand drugs when generic substitution is not permissible. When generic substitution is permissible (i.e., a generic drug is available and the prescribing doctor does not require the use of a name brand drug), but you request the name brand drug, **you pay** the price difference between the generic and name brand drug as well as the $5 copay per prescription unit or refill. Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Non-formulary drugs will be covered when prescribed by a Plan doctor.

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's physicians may receive pre-authorization for non-formulary drugs. A participating physician may initiate the pre-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.

Non-Formulary drugs will be covered in the following instances:

- No Formulary alternative is appropriate
- You have tried the Formulary drugs and they have not been effective or you have been experiencing side effects or interactions with other drugs. The physicians is asked to provide a copy of the medical chart notes specifically stating treatment failure with the Formulary alternatives.
- You have been under treatment and remain stable on a non-Formulary prescription drug and conversion to a Formulary drug would be medically inappropriate.
- Your physician provides evidence to PacifiCare in the form of documents, records, or clinical trials which establishes that use of the requested non-Formulary drug over the Formulary drug is medically necessary, as determined by PacifiCare.

Covered medications and accessories include:

- Drugs for which a prescription is required by Federal law
- Oral contraceptive drugs and contraceptive diaphragms. (Injectable contraceptives are covered under Medical and Surgical Benefits - see page 11)

Prescription Drug Benefits *continued*

What is covered *continued*

- Implanted time-release medications, such as Norplant (covered under Medical and Surgical Benefits - see page 11)
- Insulin, with a copay charge applied to each vial
- Lancets and blood glucose test strips
- Disposable needles and syringes needed to inject covered prescribed medication
- Intravenous fluids and medications for home use (covered under Medical and Surgical Benefits as a Home Health Service - see page 11)
- Prenatal and B-12 vitamins
- Injectable medications for home use and self-administration by patient when approved by the Plan
- Orally administered medications prescribed to treat infertility, or the underlying cause of infertility including Clomiphene Citrate, Bromocriptine Mesylate and Dexamethasone

Limited benefits

Drugs to treat sexual dysfunction are limited. Contact the plan for dose limits; **you pay** a 50% copayment up to the dosage limits and all charges above that.

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription (except prenatal and B-12 vitamins)
- Medical supplies such as dressings and antiseptics
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Smoking cessation drugs and medication, including nicotine patches
- Diabetic supplies, except needles and syringes, including glucose test tablets and test tape, Benedict's solution or equivalent and acetone test tablets
- Injectable medications prescribed for the treatment of infertility

Other Benefits

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (to provide a written lens prescription for eyeglasses) may be obtained from Plan providers. **You pay** a $7.50 copay per visit.

What is not covered

- Corrective eyeglasses and frames or contact lenses (including the fitting of the lenses)
- Eye exercises

Non-FEHB Benefits Available to Plan Members

Vision care

PacifiCare Health Plan member receive up to a 20% discount on services provided by participating LensCrafters locations. Simply show your PacifiCare ID card to receive this discount. For additional information, contact the nearest LensCrafters location.

Medicare Prepaid Enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare.` As indicated on page 4, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid Plan when one is available in their area. They may then later re-enroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the Plan, ask whether the Plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 1-800/543-8737 for information on the prepaid plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 1-800/543-8737 information on the benefits available under the Medicare HMO.

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 arange for care, contact the Plan's Member Services Office at 880/824-0428 or you may write to the Plan at 11260 Chester Rd., Suite 800, Cincinnati, OH 45246.

Disputed claims review

Plan reconsideration

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

Within 30 days after receipt of you request for reconsideration , the Plan must affirm the denial in writing to you, pay the claim provide the service or request additional information reasonable necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If the information is not supplied within 60 days, the Plan will base its decision on 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 determine whether the Plan's actions are in accordance with the terms of its contract. You must request the 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 written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

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

Your written request for and OPM review must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify 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 instead (a) the date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim, such as doctors' letters, operative reports, bills, medical records, and explanation of benefit (EOB) forms; and
- Your daytime phone number.

OPM Review
continued

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

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

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

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

Privacy Act statement - If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 80 of title 5, U.S.C., to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan support of OPM's decision on the disputed claim.

How PacifiCare® Health Plan Changes 1999

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

Program-wide Changes

Several changes have been made to comply with the President's mandate to implement the recommendations of the Patient Bill of Rights.

- If you have a chronic, complex, or serious medical condition that causes you to frequently see a Plan specialist, your primary care doctor will develop a treatment plan with you and your health plan that allows an adequate number of direct access visits with that specialist, without the need to obtain further referrals (See page 8 for details).
- A medical emergency is defined as 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 (See page 14).
- The medical management of mental conditions will be covered under this Plan's Medical and Surgical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits. Office visits for the medical aspects of treatment do not count toward the 20 outpatient Mental Conditions visit limit.

Changes to this Plan

The out-of-pocket maximum has decreased to $1,500 per Self only and $3,000 per Self and Family enrollment.

Under the "Medical and Surgical Benefits" provision, the pre-natal care copay applies only to the 1st visit. Previously, a copay was required for each visit.

Under the "Emergency Benefits" provision, the emergency services copay is now $50 at any hospital, $5 per urgent care center or physician's office visit for in-area or out-of-area emergency care.

Under the "Limited Benefits" provision, chiropractic services are now limited to a $500 benefit maximum per calendar year. Previously, no limitations applied.

TMJ services are now covered with a $5 copay per visit. Previously, there was a 20% copay to a $500 copay maximum per course of treatment.

Under the "Medical and Surgical Benefits" provision, the copayment for outpatient surgery performed at an ambulatory surgical facility or hospital is now $50. Previously, the copayment was $5.

Under the "Limited Benefits" provision, the copay for dialysis is now 20% per visit or month supply.

Under the "Limited Benefits" provision, "Pain and Headache Clinics or Services" are limited to a maximum lifetime benefit of $7,500. Previously no limitation applied.

Under the "Limited Benefits" provision, infertility services copay has increased to 30% per visit Previously, the copay was 20% of billed charges up to a maximum $500 per course of treatment.

Under the "Hospital/Extended Care Benefit" provision, the per visit copay for outpatient "Hospice Care" is $5. Previously, there was no copayment.

Under the "Hospital/Extended Care" provision, extended care is covered for up to 60 consecutive days; you pay $5 per outpatient visit or $100 per inpatient admission. Previously, extended care was covered for up to 62 days at no cost.

Under the "Hospital/Extended Care" provision, the copay for observation services has increased to $100.

Under the "Hospital/Extended Care" provision, the copay for inpatient hospital care has increased to $100. Previously, there was no copayment.

Changes to this Plan *continued*

Under the "Medical and Surgical" limited benefits provision, short-term rehabilitative therapy now has a $100 copay per admission. Previously, the inpatient copay was $200.

Under the "Medical and Surgical Benefits" provision transplants are no longer subject to a 5% copayment. Transplants are now covered in full after a $100 per admission copayment.

The "Prescription Drug Benefit" section regarding the Plan drug formulary policy has been clarified. See page 16 for this Plan's policy.

The following counties are no longer part of the Plan's Service Area: Clark, Greene, Miami, Montgomery and Preble.

The Plan no longer accepts enrollments from the counties of Champaign or Shelby in Ohio.

Coverage of drugs for sexual dysfunction is shown under the Prescription Drug Benefit.

Summary of Benefits for PacifiCare® of Ohio 1999

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

	Benefits	Plan pay/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of the operating room, intensive care and complete maternity care. **You pay** $100 per admission except infertility services, and dialysis are subject to different copays	13
	Extended care	All necessary services, up to 60 days per calendar year. **You pay** $100 per admission	13
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. **You pay** 20% of charges	15
	Substance Abuse	Each member is entitled to a lifetime maximum of two 30-day substance abuse programs. **You pay** 20% of charges.	15, 16
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care;prevenetive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** $5 per office visit; $5 per house call by a doctor	11
	Extended care	All necessary visits up to 60 consecutive days per calendar year. **You pay** $5 per visit	13
	Home Health care	All necessary visits by nurses and health aides. **You pay** $5 copay per visit	11, 12
	Mental conditions	Up to 20 outpatient visits per year. **You pay** $10 copay per visit	15
	Substance Abuse	Up to 20 outpatient visits per year. **You pay** $10 copay per visit	16
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $50 copay to any hospital; $5 copay per urgent care center or physician's office and any charges for services that are not covered by this Plan	14
Prescription drugs		Drugs prescribed by a Plan physician and obtained at a plan pharmacy. **You pay** a $5 copay per prescription unit or refill for generic drugs	16
Dental care		No current benefit	
Vision care		Eye refraction; one per year. **You pay** $7.50 per visit	17
Out-of-pocket		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $1,500 per Self Only or $3,000 per Self and Family enrollment per calendar year, benefits will be provided at 100%	8

1999 Rate Information for PacifiCare®

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to an FEHB Guide 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 retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	R81	$66.64	$22.21	$144.38	$48.13	$78.85	$10.00
Self and Family	R82	$156.61	$52.20	$339.32	$113.10	$183.29	$25.52