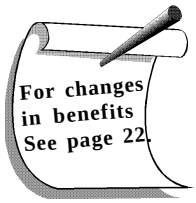
Omni Healthcare 1999

A Health Maintenance Organization



Serving: Central Valley and Sacramento area

Enrollment code:

HN1 Self Only

HN2 Self and Family

Enrollment in Omni is limited, see page 8 for instructions.

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

Authorized for distribution by the:

United States
Office of
Personnel
Management

FEHB
Federal Employees
Health Benefits Program

RI73-406

OMNI HEALTHCARE, INC.

Omni Healthcare, Inc., 2450 Venture Oaks Way, Suite 300, Sacramento, CA 95833-3292 contract (CS 2385) 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 Omni Healthcare, Omni or the Plan.

This brochure is the official statement of benefits on which you can rely. A person enrolled in Omni 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 the inside back cover of this 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 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 209-474-6664 or 800-342-8462 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 Omni, 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 Omni, including claim files, is kept confidential and will be used only: 1) by Omni and its subcontractors for internal administration of Omni, 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 Omni. 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 Omni. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact Omni.

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 Omni, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. As a member of Omni, 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 Omni 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.

General Information *continued*

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 Omni; if you changed plans or plan options, see "If you are a new member" above. In both cases, however, Omni'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 Omni 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. Omni 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 Omni 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.

- 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 Omni 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 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 of coverage

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*

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 Credible 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 Omni Healthcare

Omni Healthcare 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 Omni 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 HMO.

Because Omni 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, Omni 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 Omni Healthcare - *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 Omni at 209-474-6664 or 800-342-8462 or you may write Omni at 1776 W. March Lane, Suite 240, Stockton, CA 95207-6425.

Information that must be made 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 care to plan members?

Omni Healthcare is a mixed model comprehensive medical plan (HMO) with doctors who practice both as individuals and in group practice. Omni contracts with primary care doctors, specialists and with certain area hospitals.

Choosing your doctor

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 Omni before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when there has been a referral by the members primary care doctor.

Omni's provider directory lists primary care doctors (family practitioners, internists, obstetricians, gynecologists and pediatricians), 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 Customer Service Department at 209-474-6664 or 800-342-8462; you can also find out if your doctor participates with Omni 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 Omni and is accepting new patients. Important note: **When you enroll in this plan, services (except for emergency benefits) are provided through the Omni'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 Omni, indicating the name of the primary care doctor(s) selected for you and each covered member of your family. Members may change their doctor selection by calling an Omni Customer Service Representative. Changes will become effective on the first day of the month following the month in which the change was requested.

If you are receiving services from a doctor who leaves the Plan, Omni will pay for covered services until Omni can arrange with you for you to be seen by another participating doctor.

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 doctors discretion; your doctor will generally refer exclusively to specialists affiliated with his/her Medical Group or IPA. If specialists or consultants are required beyond those participating in Omni, the primary doctor will request appropriate referrals. A prior authorization must be obtained from Omni by the primary care doctor. Members may self refer once in a twelve (12) month period to a participating gynecologists for a gynecological exam only; or to a participating ophthalmologist for a refractive eye exam. Members who have selected a primary doctor affiliated with a medical group or IPA must self-refer to specialists affiliated with their primary care doctors medical group or IPA.

Facts about Omni Healthcare - *continued*

If you have a chronic, complex, or serious medical condition that causes you to see a Plan specialist frequently, your primary care doctor will develop a treatment plan with you and Omni 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

Omni 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 obtain authorization from Omni before you may be hospitalized, referred for specialty 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 obtain a referral from an Omni primary care doctor for the care to be covered by Omni. If the doctor who originally referred you prior to your joining Omni is now your Plan primary care doctor, you need only to call to explain that you now belong to Omni and ask that a "referral form" be sent to the specialist for your next appointment.

Hospital care

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 back to the specialist.

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 Omni reach $750 per Self Only enrollment or $1,500 per Self and Family enrollment. This copayment maximum does not include the cost of prescription drugs and durable medical equipment.

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 Omni 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 Omni. 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.

Submit claims promptly

When you are required to submit a claim to Omni for covered expenses, submit your claim promptly. Omni 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

Omni provides an external, independent review to evaluate it's decisions concerning experimental or investigational therapies. This review is based on criteria from recognized medical organizations such as, but not limited to, the FDA, The National Institutes of Health, and the American Medical Association.

Other considerations

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

Omni's Service area

The service area for Omni, where Plan providers and facilities are located, is described below. You must live or work inside the service area to enroll in Omni.

The service area for Omni includes the following areas: Amador, Calaveras, Colusa, El Dorado, Glenn, Lake, Merced, Nevada, Placer, Sacramento, San Joaquin Stanislaus, Sutter, Tuolumne, Yolo and Yuba Counties; and the California cities of Rio Vista and Dixon in Solano County. Omni's service area is limited to specific zip codes in Nevada and Placer Counties. If you live in one of these two counties, you must reside within the following zip codes to enroll in Omni:

Facts about Omni Healthcare - *continued*

Nevada County: 95712, 95924, 95945, 95946, 95949, 95959, 95975, 95977 (partial), 95986

Placer County: 95602, 95603, 95604, 95626 (partial), 95631, 95648, 95650, 95658, 95661, 95663, 95677, 95678, 95747, 95681, 95701, 95703, 95704, 95713, 95714, 95715, 95717, 95722, 95736, 95746, 95765

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, or you no longer work there, 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.

Services from Plan providers are available only in the Central Valley and Sacramento area of California.

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or 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 Omni or be used in the prosecution or defense of a claim under Omni.** This brochure is the official statement of benefits on which you can rely.

Circumstances beyond Omni's 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 Omni's control, Omni will make a good faith effort to provide or arrange for covered services. However, Omni will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Arbitration of claims

Any claim for damages of personal injury, mental distrubance or wrongful death arising out of the rendition of or failiure to render services under this contract must be submitted to binding arbitration.

Other sources of benefits

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

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 Omni 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 Omni.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, Omni 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 primary 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 Omni 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 Omni to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

General Limitations - *continued*

CHAMPUS

If you are covered by both Omni and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Omni will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; your primary 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 Omni and Medicaid, Omni will pay benefits first.

Worker's Compensation

Omni will not pay for services required as the 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 proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, Omni will be financially responsible for services or supplies that are otherwise covered by Omni. Omni 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 Services

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from Omni 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

Omni will not provide benefits for services 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, Omni 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 Omni, including the right to bring suit in the person's name. If you need more information about subrogation, Omni 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 discussed 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 Omni
- 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
- Abortion, unless the continuation of the pregnancy or birth would threaten the life of the mother.

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 $4 copay per office visit during office hours, a $10 copay for office visits between 6 p.m. and 7 a.m. weekdays and on holidays and weekends, and a $20 copay for annual physicals for members 6 years of age and older. There is no additional copay for laboratory tests and X-rays. Within the service area, house calls will be provided if in the judgment of the Plan doctor such care is necessary and appropriate. You pay a $4 copay for a doctor's house call and nothing for home visits by nurses and health aides.

The following services are included:

- Preventive care, including well-baby care and periodic check-ups
- Mammograms are covered as follows: One base line mammogram for women 35 to 40 years of age; a mammogram every two years for women 40 to 49 years of age, or more frequently based on the woman's medical history; a mammogram every year for women 50 years of age and above. 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 (office visit copays are waived for obstetrical care). The mother, at her option, may remain in the hospital for up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if necessary. If enrollment in Omni is terminated during pregnancy, benefits will not be provided after coverage under Omni 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 IUD's and diaphragms
- Diagnosis and treatment of diseases of the eye
- Vision and hearing examinations
- 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
- Cornea, heart, heart/lung, lung (single or double) kidney liver 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. Related medical and hospital expenses of the donor are covered when the recipient is covered by Omni.
- 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.
- Dialysis
- 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.

Medical and Surgical Benefits - *continued*

- Injectable medications other than insulin, and intravenous fluids and medications for home use, including injectable contraceptive medication
- Cardiac and pulmonary rehabilitation
- Implantable time-release medications, such as Norplant

Limited benefits

Oral and maxillofacial surgery is provided for non-dental 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 and excision of tumors and cysts. All other procedures involving the teeth or inter-oral areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

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, occupational and biofeedback) 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 $4 copay per outpatient session. 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.

Diagnosis and treatment of infertility is covered; you pay 50% of charges. The following types of artificial insemination are covered: intracervical insemination (ICI) and intrauterine insemination (IUI), limited to one treatment period of up to 3 cycles per Lifetime; gamete intrafallopian transfers (GIFT) limited to one treatment per lifetime (prior authorization is required); and drug therapy, limited to 6 menstrual cycles per lifetime, is covered. Cost of donor sperm is not covered. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization and embryo transfer, are not covered.

Orthopedic (e.g., braces and special footwear for persons suffering from foot disfigurement)) and prosthetic (e.g., artificial limb) devices, including external lenses following cataract removal, are covered. Foot disfigurement includes, but is not limited to cerebral palsy, arthritis, polio, spina bifida, diabetes and foot disfigurement as a result of accident or developmental disability. You pay 20% of charges.

Durable medical equipment, wheelchairs and hospital beds and medical supplies, such as ostomy supplies, chem strips, disposable needles and syringes needed for injecting covered prescribed medication (except for insulin), intravenous fluids and medications for home use oxygen and oxygen supplies, are covered; you pay 50% of charges. Replacement parts for, or repairs of, durable medical equipment due to misuse or abuse are not covered.

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 travel
- Blood and blood derivatives
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Hearing aids
- Long-term rehabilitative therapy
- Chiropractic services
- Homemaker services
- Infant formulas
- Supportive devices for the feet, including foot orthotics not listed as covered
- Weight loss programs, aids, or prescriptions
- Educational programs
- Radial keratotomy
- Acupuncture or accupressure treatments
- Transplants not listed as covered

Hospital/Extended Care Benefits

What is covered

Hospital care

Omni 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 nothing. 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

Omni provides a comprehensive range of benefits for up to 100 days in a calendar year with no dollar limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by Omni. You pay nothing. 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

Subject to prior authorization, the following services and supplies of a plan hospice facility or agency will be covered when medically necessary and appropriate, including:

- Dietary and nutritional guidance
- 24-hour home care for periods of crisis
- Bereavement counseling for family members
- Respite care
- Services of registered nurses, home health aides and medical social workers. Each service must be requested by Plan doctor and have prior authorization.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor.

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; Omni 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.

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 16 for non-medical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Blood and blood derivatives
- Custodial care, rest cures, domiciliary or convalescent care

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 Omni 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 an Omni member so they can notify Omni. You or a family member should notify Omni within 48 hours. It is your responsibility to ensure that Omni has been timely notified.

If you need to be hospitalized, Omni must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify Omni 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 Omni, any follow-up care recommended by non-Plan providers must be approved by Omni or provided by Plan doctors.

Plan pays...

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

You pay...

$30 per hospital emergency room visit or $30 per urgent care center visit for emergency services that are covered benefits of Omni. If the emergency results in immediate admission as an inpatient directly from the emergency room, the $30 copay will be 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, including urgently needed services to prevent serious deterioration of your health resulting from unforeseen illness or injury for which treatment cannot be delayed until you return to the service area.

If you need to be hospitalized, Omni must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify Omni 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.

To be covered by Omni, any follow-up care recommended by non-Plan providers must be approved by Omni or provided by Plan doctors.

Plan pays...

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

You pay...

$30 per hospital emergency room visit or $30 per urgent care center visit for emergency services that are covered benefits of Omni. If the emergency results in immediate admission as an inpatient directly from the emergency room, the $30 copay will be waived.

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 Omni

What is not covered

- Elective care or non-emergency care
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area

Emergency Benefits *- continued*

Filing claims for non-Plan providers

With your authorization, Omni 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 Omni 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 Omni's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 18.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

To the extent shown below, Omni 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 40 outpatient visits to Plan doctors or other psychiatric personnel each calendar year; for visits 1-3 you pay a $4 copay per visit, for visits 4-40 you pay a $20 copay per visit - all charges thereafter.

Inpatient care

Up to 30 days of hospitalization each calendar year; you pay nothing for the 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

Substance abuse

What is covered

Omni 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. Services for the psychiatric aspects are provided in conjunction with the mental conditions benefits shown above. Outpatient visits to Plan providers for treatment are covered. as well as inpatient services necessary for diagnosis and treatment. The mental conditions benefits visit/day limitations and copays apply to any covered substance abuse care. In addition, Omni provides:

Rehabilitative care

One 30-consecutive-day rehabilitative program per lifetime; you pay a $200 admission copay and a $50 copay per day.

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 pharmacy will be dispensed for up to a 30-day supply or 120-unit supply, whichever is less, with a single copayment. If a 30-day supply is more than 120 units, an additional copayment will apply. Prescriptions for controlled substances and other drugs not intended for continuous chronic use may be limited to a smaller quantity per copayment; you pay a $6 copay per generic prescription or an $12 copay per brand name prescription.

The pharmacist will automatically substitute an equivalent generic drug (when available) for the prescribed brand name drug unless otherwise specified by the prescribing physician as medically necessary. Unless there is no generic drug available, or documentation of an allergic reaction to a generic drug can be provided by the prescribing physician, a generic drug will be dispensed. You are responsible for the brand name copay when a brand name medication is dispensed. If you elect to receive a brand name drug only, without such medical documentation from the prescribing physician, you will be responsible for the difference between the cost of the generic drug and the cost of the brand name drug, in addition to the $12 copay per prescription.

You and your family dependents may also obtain prescription drugs through Omni's mail-order program. This program has been designed for individuals using maintenance medications such as oral contraceptives and insulin, and for treatment of long-term conditions such as diabetes, arthritis, heart conditions and high blood pressure. Prescriptions for maintenance medications will be dispensed for up to a 90-day or 360-unit supply, whichever is less, for a single copayment; you pay $12 for generic and $24 for brand name prescriptions. If a 90-day supply exceeds 360-units, an additional copay will apply.

You will receive more information about the mail-order program in your new member packet, or you may call Omni's Customer Service Department at 209/474-6664 or 1-800/342-8462 for informtion.

Drugs are prescribed by Plan doctors and dispensed in accordance with Omni's drug formulary. If a prescription is written for a drug not included in Omni's formulary, the prescription will be covered if approved by Omni in advance, with the appropriate generic or brand name copayment. It is the prescribing doctor's responsibility to obtain the authorization from Omni. Non-formulary drugs not authorized by Omni and not already excluded will be covered when prescribed by Plan doctors; you pay a $25 copayment per prescription for a 30-day supply, or $50 copayment per prescription for a 90-day supply, up to no more than 50% of the cost of the medication.

The Plan's formulary is made up of all antibiotics, antineoplastics and antiretroviral drugs as soon as they become available, as well as drugs that have been evaluated by an internal review committee and/or requests by Plan providers. The committee looks at 5 criteria when determining whether a drug is to be added to the formulary; effectiveness and safety in general practice, misuse potential, essential need and cost.

Covered medications and accessories include:

- Drugs for which a prescription is required by Federal law
- Oral contraceptive drugs
- Diabetic supplies limited to insulin, needles and syringes
- Prescription prenatal vitamins and vitamins in conjunction with fluoride
- Inhalers (limited to two per prescription)
- Implantable drugs, such as Norplant, are covered under the Medical and Surgical Benefit provision. See Page 12.

Related benefits

- Disposable needles and syringes for administration of prescribed injectable medication other than insulin and intravenous fluids and medication for home use, are covered under durable medical equipment. See page 12.

Limited benefits

- Fertility drugs are covered as part of infertility treatment, you pay 50% of charges. See page 12.
- Drugs to treat sexual dysfunction are limited. Contact the plan for dose limits. You pay the name brand copayment up to the dosage limits per prescription unit or refill and all charges above that.

Prescription Drug Benefits -*continued*

What is not covered

- Drugs available without a prescription or for which there is a non-prescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for a maximum 10-day supply for out-of-area emergencies
- Prescriptions written by a non-Plan provider
- Vitamins and nutritional substances that can be purchased without a prescription except for prenatal vitamins
- Medical supplies such as dressings and antiseptics
- Contraceptive devices, except for IUD's and diaphragms, which are covered under the Medical and Surgical Benefit provision.
- Dietary supplements, including appetite suppressants and nutritional aids
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Drugs required for foreign travel

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, Omni provides annual eye refractions, including lens prescriptions from Plan providers. You pay a $4 copay per visit.

What is not covered

- Corrective lenses or frames
- Eye exercises

Non-FEHB Benefits Available to Omni Members

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

Omni Healthcare Enhanced Dental Benefits

Omni offers a Value Added Dental program which is available to plan members and their eligible enrolled dependents at no additional premium.

The following services are provided by participating Plan dentists as follows:

- Oral examination ..... **No charge**
- Prophylaxis (cleaning) **$20**
- X-rays (bitewings) ..... **No charge**
- Pulp vitality tests ..... **No charge**
- Fluoride application (children and adults) **$5**
- Sealant - per tooth **$20**

Orthodontic Care

- Consultation **$40**
- Full upper and lower banded case ..... **$1,950** for a child and **$2,300** for an adult
- Retention, upper & lower ..... **$250** for a child and **$300** for an adult

In addition to the preventive benefits, a comprehensive list of dental procedures is available at reduced fixed copayments, as defined in the supplemental dental information. Please call Omni at 209/ 474-6664 or 1-800/ 342-8462 if you did not receive a complete packet of information.

Smoking Cessation

If you have a sincere desire and real commitment to quit smoking, Omni offers you a special wellness program. Here's how it works:

- Discuss your desire to quit smoking with your primary care doctor, and have him/her write a prescription for a transdermal nicotine system.
- Fill this prescription at a participating Omni pharmacy, and follow the course of treatment per your doctor's instructions. You will be required to pay the complete out-of-pocket cost to the pharmacy at the time you purchase your prescription.
- After you have been smoke-free for 120 days, obtain a written confirmation of this from your primary care doctor and mail this along with your pharmacy receipts to the Omni office nearest you, attention "Smoking Cessation." (See our address on page 20.)
- If you purchase a transdermal nicotine system over the counter, without a prescription from your primary physician, Omni will only reimburse you for the cost of the product when you submit the receipt along with certification that you also completed a smoking cessation class or program.
- Omni will send you a full reimbursement within 4-6 weeks, provided you have submitted your receipts and physician's note.

Omni will cover one 10-week course of a nicotine transdermal treatment per lifetime.

For further information on our Smoking Cessation Program, call Omni's Customer Service Department: 1/800/342-8462 or 209/474-6664.

BENEFITS ON THIS PAGE ARE NOT PART OF THE FEHB CONTRACT

How to Obtain Benefits

Questions

If you have a question concerning Omni benefits or how to arrange for care, contact Omni's Customer Service Department at 209-474-6664 or 800-342-8462 or you may write to Omni at 1776 W. March Lane, Suite 240, Stockton, California 95207-6425.

Disputed claims review

Plan reconsideration

If a claim for payment or services is denied by Omni, you must ask Omni, in writing and within six months 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 your request within the time limit.) OPM will not review your request unless you demonstrate that you gave Omni an opportunity to reconsider your claim. Your written request to Omni 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 your request for reconsideration, Omni must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If Omni asks a provider for information it will send you a copy of this request at the same time. Omni has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, Omni will base its decision on the information it has on hand.

OPM review

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

You may also ask OPM for a review if Omni fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to Omni. In this case, OPM must receive a request for review within 120 days of your request to Omni for reconsideration or of the date you were notified that Omni needed additional information, 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. Providers, 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 an 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 Omni 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 Omni requesting reconsideration;
- A copy of Omni's reconsideration decision (if Omni failed to respond, provide instead (a) the date of your request to Omni or (b) the dates Omni requested and you provided additional information to Omni);
- 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.

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

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division IV, 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 Omni until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds Omni's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of 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 Omni'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 Omni's denial of the 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 service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and Omni to determine if Omni has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or Omni in support of OPM's decision on the disputed claim.

How Omni Healthcare changes - January 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 referrals (See page 7 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 40 outpatient Mental Conditions visit limit.

Changes to this Plan

- The copayment for a 90-day supply of maintenance medications obtained through Omni's mail order program has been increased from $6 to $12 for generic drugs, and from $12 to $24 for brand name drugs.
- Non-formulary drugs that are authorized by Omni will be covered with the appropriate generic or brand name copayment.
- Other non-formulary drugs that are not already excluded will be covered when prescribed by a Plan doctor with a $25 copayment for a 30-day supply and a $50 copayment for a 90-day supply, up to no more than 50% of the cost of the medication.
- Coverage of drugs to treat sexual dysfunction is shown under the Prescription Drug Benefit.
- The following counties are no longer part of the Plan's Service area:

  Butte, Del Norte, Humboldt, Marin, San Francisco, San Mateo, Santa Clara, and Sonoma

Summary of Benefits for Omni Healthcare - 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 Omni. If you wish to enroll or change your enrollment in Omni, 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 pays/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 operating room, intensive care and complete maternity care. You pay nothing.	11
Extended care	All necessary services, up to 100 days per calendar year. You pay nothing.	13
Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. You pay nothing	16
Substance Abuse	Covered under Mental conditions benefit. In addition, one 30-consecutive-day inpatient rehabilitation program per lifetime is covered. You pay nothing for Mental conditions benefits and $200 admission copay plus $50 per day for rehabilitation program.	16
Outpatient care	Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. You pay a $4 copay per office visit; $4 per house call by a doctor; a $10 copay per office visit on weekends and holidays and on weekdays between 6 p.m. and 7 a.m.	11, 12
Home health care	All necessary visits by nurses and health aides. You pay nothing	11
Mental conditions	Up to 40 outpatient visits per year. You pay $4 each for visits 1-3 and $20 each for visits 4 - 40	16
Substance abuse	Covered under Mental conditions benefit	16
Emergency care	Reasonable charges for services and supplies required because of a medical emergency. You pay a $30 copay to the hospital for each emergency room visit and any charges for services that are not covered by Omni. Copay is waived if hospitalized as inpatient directly from emergency room	14, 15
Prescription drugs	Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. You pay a $6 copay per generic prescription or $12 per brand name prescription unit or refill. A brand name drug will be dispensed only when a generic drug is not available or when specified by the Plan doctor. Up to a 90 day supply of maintenance medication may be purchased through the mail order program. You pay $12 copay for generic drugs and a $24 copay for brand name drugs.	17, 18
Dental care	No current benefit	
Vision care	Annually, one refraction. You pay $4 copay	18
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 Omni reach $750 per Self Only enrollment and $1,500 per Self and Family enrollment. This copay maximum does not include the cost of prescription drugs and durable medical equipment	8

1999 Rate Information for
Omni Healthcare

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

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

		Non-Postal Premuim				Postal Premuim	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your share
Self Only	HN1	$66.83	$22.28	$144.80	$48.27	$79.09	$10.02
Self and Family	HN2	$160.39	$63.77	$347.51	$138.17	$183.29	$40.87