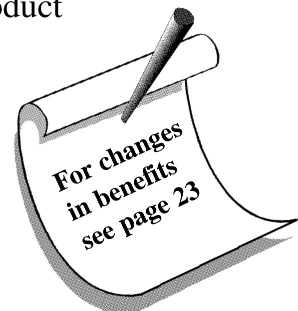
1999
Prudential HealthCare HMO® – Mid-Atlantic
Prudential Health Care Plan, Inc.

A Health Maintenance Organization With a Point of Service Product



Serving: Most of Maryland, Northern Virginia, and Washington, D.C.

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

Enrollment code:
JB1 Self only
JB2 Self and family

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

and

this Plan's website at http://www.prudential.com/healthcare

Authorized for distribution by the:

United States Office of Personnel Management

RI 73-413

Prudential HealthCare HMO Mid-Atlantic

Prudential Health Care Plan, Inc., dba Prudential HealthCare HMO Mid-Atlantic, 2800 North Charles Street, Baltimore, Maryland 21218, has entered into a contract (CS 2379) 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 the Prudential HealthCare HMO Mid-Atlantic, Prudential HealthCare, 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 25 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 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 1-800/888-5447 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 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 pages 15-17, or when you self-refer for point of service, or POS, benefits as described on pages 19-20. 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 conditions 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 he 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 are setting on the last day of your enrollment under the prior plan or option. In that case, the covered 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 and 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 you 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 he 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 he 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 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 or POS 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.

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 non-group 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 linger 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 continued 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 non-group 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.

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 if, within 60 days after 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, non-group contract. You will not be required to provide evidence of good health and the plan is not permitted in 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) that offers a point of service, or POS, product. Whenever you need services, you may choose to obtain them from your personal doctor within the Plan's provider network or go outside the network for treatment. Within the Plan's network **you are required to select a personal doctor who will provide or arrange for your care** and you will pay minimal amounts for comprehensive benefits. There are no claim forms when Plan doctors are used. When you choose a non-Plan doctor or other non-Plan providers under the POS option, you will pay a substantial portion of the charges and the benefits available may be less comprehensive. See page 19 for more information.

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 the Plan provides or arranges your care and pays 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.

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 1-800-888-5447 or you may write the Carrier at 2800 North Charles Street, Baltimore, MD 21218. You may also contact the Carrier at its website at http://www.prudential.com/healthcare.

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 non compliant, the reason for noncompliance.
- Accreditation's 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?

The Prudential HealthCare HMO Mid-Atlantic is a Mixed Model Plan that offers a complete program of medical care through a network which includes medical groups and individual doctors in 144 cities, more than 3,200 specialists, and over 60 affiliated hospitals throughout the service area. All of the participating doctors are credentialed through the Prudential HealthCare HMO Mid-Atlantic. If hospitalization is necessary, you will be confined in local hospitals in most instances. Each member chooses his or her own personal doctor; family members need not select the same site or the same doctor.

The Plan has a point-of-service benefit which allows a member to receive non-emergency benefits outside of the standard HMO network on a fee-for-service basis. Read this brochure carefully to get a clear understanding of the benefits available through the POS benefit. For more information regarding this option, see page 19.

Role of a primary care 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 the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when you have been referred by your primary care doctor or when you use POS benefits, with the following exception: a woman may see her Plan obstetrician/gynecologist for all medically necessary gynecological care without a referral, and members may seek mental health and substance abuse services without a referral from the primary care doctor.

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 1-800-888-5447. 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 or POS 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.

If you enroll, you will be asked to let the Plan know which primary care doctor(s) you've selected for you and each member of your family, by sending a selection form to the Plan. If you need help choosing a doctor, call the Plan. Members may change their doctor selection by notifying the Plan 30 days in advance.

Certain medical groups, as indicated in the Plan provider directory, are contracted to render, provide and/or arrange for covered health care service through their medical group providers. Therefore, referrals to specialists are limited to those directly associated with that medical group.

If you are receiving services from a doctor who leaves the Plan, the Plan will pay for covered services until the Plan 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 his or her patients, or when you choose to use the Plan's POS benefits, 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 non-Plan specialists or consultants are required, the primary care doctor will arrange appropriate referrals. Members who wish to self-refer to a doctor of their choice can use the POS benefits described on page 19.

When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation unless your doctor authorizes additional visits. All follow-up care must be provided or authorized by the primary care doctor. Do not go to the specialist for a second visit unless your primary care doctor has arranged for, and the Plan has issued an authorization for, the 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 doctor 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 the 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 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 a Plan primary care doctor for the care to be covered by the Plan. If the doctor who originally referred you to this specialist is now your Plan primary care doctor, you need only call to explain that you are now a Plan member and ask that you be referred for your next appointment.

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

Outpatient surgical services will be performed at a participating ambulatory surgical center, outpatient center or, if medically necessary, at a participating hospital. (Contracted outpatient surgical centers will be utilized whenever possible).

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 $2,400 per Self Only enrollment or $ 4,800 per Self and Family enrollment. This copayment maximum does not include charges for prescription drugs. If you elect to use the POS Benefits, the out-of-pocket maximum for copays and deductibles is $ 1,650 per member per calendar year or $3,300 per family per calendar year.

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.

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. Claims for POS benefits may be submitted by the member or the provider. You may submit claims to Prudential HealthCare HMO Mid-Atlantic, Claims Department, P.O. Box 44221, Jacksonville, FL 32232.

Experimental/ investigational determinations

In making a determination as to whether a supply or service is experimental or investigational, Prudential will initiate the evaluation described below. This description is a summary. For a more complete description, please contact Member Services at 800-888-5447.

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

Other considerations

Plan Providers will follow generally accepted medical practice in prescribing any course 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 may enroll in this Plan if you live or work inside the service area or live in the geographic area described below.

The service area for this Plan includes the following areas: **The District of Columbia.** In **Maryland**: Baltimore City, Anne Arundel, Baltimore, Calvert, Carroll, Cecil, Frederick, Harford, Howard, Kent, Montgomery, Prince George's, Queen Anne's and Washington Counties. In **Virginia**: the counties of Arlington, Fairfax, Loudoun and Prince William, as well as the **Virginia Cities** of Alexandria, Fairfax, and Falls Church.

The Plan accepts enrollments from this additional geographic area: In **Maryland**: Allegany, Caroline, Charles, Dorchester, Somerset, St. Mary's, Talbot, Wicomico and Worcester Counties. In **Pennsylvania**: Adams, Chester, Franklin, and York Counties; in **Virginia**: Spotsylvania and Stafford Counties; and in **West Virginia**: Berkeley, Jefferson and Morgan Counties

Benefits for care outside the service area are limited to emergency services, as described on pages 16-17, and to services covered under Point of Service Benefits, as described on page 19.

If you or a covered family member move outside the service area or the geographic 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 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 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 to 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 or services are covered under this Plan's POS benefits. 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 you 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 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 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.

General Limitations *continued*

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.

Workers' 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 proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for General Exclusions continued 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 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, 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 surrogated 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, and the Plan agrees, as discussed under Authorizations on page 8. The following are excluded:**

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see Emergency Benefits) or eligible self-referred services obtained under Point of Service Benefits (see page 19);
- Expense 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 or when the pregnancy is the result of an act of rape or incest.

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 primary care office visit copay; a $10 copay for specialty care office visits. 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 $10 copay for a doctor's house call, nothing for home visits by nurses and health aids.

The following services are included:

- Preventive care, including vision and hearing screenings for children through age 17, well-baby care and periodic check-ups
- Routine immunizations and boosters
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Visit to a network obstetrician/gynecologist (OB/GYN) for medically necessary gynecological care, including, but not limited to care that is routine care, without authorization from a primary care physician.
- 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 cesarean delivery. Inpatient stay 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
- Diagnosis and treatment, including testing and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints including the cost of the device.
- Cornea, heart, lung (single and double), heart/lung, intestinal, pancreas, kidney and liver 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. Transplants are covered when approved by the Medical Director. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.
- Patients 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 (or longer if medically necessary).
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Medical supplies, such as dressings and splints, that are not available over-the-counter
- Oxygen and its administration

- 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
- Implanted time-release medications, such as Norplant
- Diabetes nutritional counseling upon referral
- Medical food and low protein modified food products for the treatment of inherited metabolic disease will be covered if the medical food and low protein modified food products are: (a) prescribed and pre-authorized as medically necessary for the therapeutic treatment of inherited metabolic diseases; and (b) administered under the direction of a physician.

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 intra-oral areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Cleft lip and Cleft palate: Coverage shall include benefits for inpatient or outpatient expenses arising from orthodontics, oral surgery, and otologic, audiological, and speech/language treatment for the management of the birth defect cleft lip or cleft palate or both.

General Anesthesia for Dental Care: General anesthesia and associated hospital or ambulatory charges in conjunction with dental care for members age 7 or younger or is developmentally disabled; or is extremely uncooperative, fearful, or uncommunicative child age 17 or younger with dental needs that treatment should not be delayed or deferred. Coverage does not apply to care for temporal mandibular joint disorders.

Qualified Medical Clinical Trials: Clinical trials that provide treatment for life threatening conditions; or is for prevention, early detection, and treatment studies on cancer. If the treatment or studies are being conducted in a Phase 1, II, III, or IV clinical trial for cancer; or Phase II, III, or IV clinical trial for any other life threatening condition. Coverage may be provided for a Phase I clinical trial for these conditions on a case by case basis.

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 $10 copay per outpatient visit. 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.

Prosthetic devices: Internal and external breast prostheses following a mastectomy are covered. Internal breast prostheses are limited to the initial provision only and the services necessary for implantation; external breast prostheses are limited to the device and to no more than one each calendar year; related garments and other supplies are not covered. You pay 20% of charges. Lenses following cataract removal are limited to the initial pair only. After cataract surgery, an allowance of $50 shall be provided towards the lens purchase.

Durable medical equipment, such as wheelchairs and hospital beds, and orthopedic devices, such as braces will be provided up to a maximum of $7,500 per calendar year. **You pay** 20% of charges to Plan maximum payment all charges thereafter. The plan does not cover repair and maintenance of durable medical equipment, including normal wear and tear.

Diagnosis and treatment of infertility, including artificial insemination and fertility drugs are covered; **you pay** 50% of charges. The following types of artificial insemination are covered: intravaginal insemination (IVI), intracervical insemination (ICI) and intrauterine insemination (IUI); **you pay** 50% of the charges; cost of donor sperm is not covered. Fertility drugs are covered. Other **assisted reproductive technology (ART) procedures,** such as in vitro fertilization and embryo transfer, are not covered.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 60 consecutive days; **you pay** a $10 copay per visit.

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
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Transplants not listed as covered
- Hearing aids, hearing related implants, exams to determine the need for hearing aids, or the need to adjust them
- Chiropractic services
- Homemaker services
- Prosthetic devices, except breast prostheses
- Refractions, including lens prescriptions
- Blood and blood derivatives donated or replaced by another program
- Corrective eyeglasses and frames or contact lenses (including the fitting of the lenses) except for the initial lenses following cataract surgery. See prosthetic devices above.
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia) and astigmatism (blurring)
- Long-term rehabilitative therapy
- Foot orthotics

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** 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

The Plan provides a comprehensive range of benefits for up to 90 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. **You pay** nothing for the first 60 days. **You pay** 50% of charges per day for days 61 through 90 all charges thereafter. **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.

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; 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.

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 non-medical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Custodial care, rest cures, domiciliary or convalescent care
- Blood and blood derivatives donated or replaced by another program.

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 must notify the Plan within 48 hours, unless it was 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 provides in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition (except as shown below).

To be covered by this Plan, any follow-up care recommended by a non-Plan provider must be approved by the 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 hospital emergency room visit or urgent care center for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency room copay is waived.

Emergencies outside the Service Area

Benefits are available for any medically necessary health service that is immediately required because of the 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.

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 hospital emergency room visit or $10 per urgent care center visit for emergency services that are covered benefits of this Plan. (Urgent care services rendered outside the service area must be coordinated through the Prudential National Service Hotline in order for the $10 copay to apply). If the emergency results in admission to a hospital, the emergency room ($50) copay is 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 the Plan

What is not covered

- Elective care or non-emergency care except as covered under POS Benefits
- Emergency care provided outside of 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 deliver of a baby outside the service area except as covered under POS Benefits

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 22.

Portability (Reciprocity)

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

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

- Contact your primary care doctor at home to obtain permission for out-of-area care. In life-threatening emergencies, we recommend that you seek appropriate treatment immediately. However, you or a family member must notify the Plan or your primary care doctor within 48 hours concerning the emergency care your received.
- Contact the Prudential HealthCare office in the city you are visiting or the Prudential National Hotline (1-800-526-2963) to obtain a referral to a local participating doctor. This toll free number is also located on the back of your member ID card and is answered 24 hours a day.
- Your home plan is responsible for reimbursing the providers in the out-of-area Prudential HealthCare HMO plan. You should not be asked to make payments, except applicable copays, or file a claim form unless you receive authorized treatment from a non-Prudential HealthCare provider.

Mental Conditions/Substance Abuse Benefits

You must call ValueOptions at 1-800-750-6979 prior to services being rendered. ValueOptions will determine and authorize the appropriate number of visits. A referral from your primary care doctor is not required.

Mental conditions

What is covered

To the extent shown below, the Plan provides the following services:

Outpatient care

All medically necessary outpatient treatment for mental illnesses, emotional disorders, drug abuse and alcohol abuse (substance abuse) upon referral by a Plan provider are covered. You pay 20% of charges for visits 1-5; 35% of charges for visits 6-30; and 50% of charges for each visit over 30.

Partial hospitalization is limited to 60 days per calendar year. These visits are intensive or intermediate short term treatment for periods of less than twenty-four (24) hours in a day in duration. **You pay** $5 per visit.

Inpatient care

All medically necessary inpatient treatment of mental illnesses, emotional disorders, drug abuse and alcohol abuse (including professional services rendered in an inpatient facility) will be provided upon referral by a Plan provider on the same basis as other hospital care benefits. **You pay** nothing.

What is not covered

Outpatient, inpatient, or partial hospitalization services for mental illnesses, emotional disorders, drug abuse and alcohol abuse which in the professional judgment of the Plan Medical Director are not medically necessary or treatable are not covered.

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. Services for the psychiatric aspects are provided as described under the mental conditions benefit shown above. The mental conditions visit/day limits and copays apply.

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; **you pay** a $5 copay per prescription unit or refill for generic, or a $10 copay per prescription or refill for brand name drugs.

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

Formulary development:

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

Non-Formulary Drug Requests:

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

After obtaining all of the required information, the request will be evaluated. The physician will be notified within one business day after the Drug Request Unit has made the decision. A copy of the decision will be faxed and mailed to your doctor.

Covered Medications and accessories include:

- Drugs for which a prescription is required by Federal law
- Oral contraceptive drugs, or maintenance medications up to a 3 month supply per order may be obtained. Copay applies to each 34-day supply
- Contraceptive devices, including diaphragms
- Insulin, copay applies to each vial
- Disposable needles and syringes needed to inject covered prescribed medication
- Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape, Benedict's solution or equivalent, glucose monitors (DME copay applies) and acetone test tablets.
- Fertility drugs; **you pay** 50%
- Certain smoking cessation drugs and medications

Intravenous fluids and medication for home use, implantable drugs such as Norplant®, and some injectable drugs such as Depo Provera® are covered under Medical and Surgical Benefits.

Limited benefits

Sexual dysfunction drugs have dispensing limitations. For complete details, please call the Prudential HealthCare customer service phone number shown on your ID card.

What is not covered

- Drugs available without prescription or for which there is a nonprescription equivalent available
- Over the counter smoking cessation drugs and medications
- Drugs obtained at a non-Plan pharmacy except out-of-area emergencies
- Vitamins and nutritional substances which can be obtained without a prescription
- Over the counter medical supplies such as dressing and antiseptics
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance

Other Benefits

Dental care

The following dental services are covered when provided by participating Plan dentists; **you pay** nothing.

What is covered

- Annual oral exam
- Prophylaxis, or cleaning
- Annual topical application of fluoride (up to age 14)
- Preventive dental instructions
- X-rays, including bite wings and panoramic
- Vitality test
- Oral cancer exam
- Study mode

Members are subject to a $15 charge for failure to give at least 24 hours notice of cancellation for an appointment

Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth are covered. The need for these services must result from an accidental injury. **You pay** nothing.

What is not covered

- Other dental services not shown as covered

Point of Service Benefits

Facts about Prudential's Point of Service Benefits (HMO Opt-Out)

At your option, you may receive some services from providers who do not participate in the HMO or from HMO providers without a referral from your primary care physician. Only services covered under the HMO are covered under HMO Opt-Out. However, some HMO services are only covered under the HMO and not under HMO Opt-Out. Under HMO Opt-Out, you are responsible for more of the costs than under the HMO. Benefits under the Opt-Out are subject to the definitions, limitations, and exclusions shown elsewhere in this brochure. Although a specific service may be listed as a benefit, it will not be covered for you unless the Plan determines it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition.

Benefits and Services

The following benefits and services are covered under HMO Opt-Out:

- Physician Office Visits
- Preventive care
- Rehabilitative therapy
- Specialty Physician Care
- One routine GYN Exam for well woman care per calendar year
- Obstetrical Care
- Diagnosis and treatment of diseases of the eye
- Diagnostic procedures including laboratory tests and X-rays
- Outpatient Surgery, with pre-certification
- Hospital Inpatient Care, with pre-certification
- Voluntary Sterilization
- Family Planning
- Newborn Care
- Allergy Testing & Treatment
- Mental Health Services and Alcohol or Substance Abuse Treatment (Note: Medical necessity for MH/SA benefits must be verified by calling Plan representatives at 1-800-750-6979 before receiving care. They will determine the appropriate number of visits based on your condition) You pay 20% of the reasonable and customary (R&C) charges for visits 1-5; 35% of the R&C for visits 6-30; and 50% of the R&C for each visit over 30.
- Prescription drugs prescribed and obtained at a Plan pharmacy will be dispensed for up to a 34-day supply; you pay a $5 copay per prescription unit or refill for generic, or a $10 copay per prescription or refill for brand name drugs. Drugs are prescribed and dispensed in accordance with the Plan's drug formulary.

Deductibles and Copayments

When you self-refer to a non-HMO provider or to an HMO provider without a referral from your primary care physician, you must meet a $150 deductible per member per calendar year or $300 per family per calendar year (but no more than $150 per person). After you satisfy the deductible, you are responsible for a 20% copayment of the reasonable and customary charges for all covered services. The Plan will be responsible for the balance of the reasonable and customary charges provided the care: (1) is a covered service; (2) is medically necessary; and (3) has been rendered according to generally accepted utilization review and quality assurance criteria.

The copayments under HMO Opt-Out do not apply to the out-of-pocket maximum under the HMO. The maximum costs for total copayments and deductibles for which you will be responsible under HMO Opt-Out are $1,650 per member per calendar year or $3,300 per family per calendar year.

Pre-certification

Prior to receiving inpatient or outpatient hospital care, you must receive pre-certification from the Plan by calling the Care Management Department at 1-800-582-2748, or 1-800-888-5447. If you do not pre-certify, you must pay a penalty. The penalty for failure to pre-certify out-patient hospital care is 20% of the cost of our medical bill up to a maximum of $300. The penalty for failure to pre-certify inpatient care is $300. That penalty will not apply toward any deductible or other copayment.

Medical necessity for mental health and substance abuse services must be approved by Plan representatives before receiving care. **You must call 1-800-750-6979 prior to accessing services.**

Claims

Once you satisfy the deductible and copayment, the Plan will pay the balance of the reasonable and customary charges. If the provider charges more than the reasonable and customary charges, you will be responsible for the difference between the provider's charge and the reasonable and customary charge (in addition to any deductible and copayment).

A claim for payment under HMO Opt-Out should be submitted within ninety (90) days of obtaining the service. If you file a claim for a covered benefit or service, payment will be made to you. If the provider files the claim, payment will be made to the provider. Payment will be made within sixty (60) days of receipt of an undisputed claim.

HMO-Only Benefits

The following benefits and services are covered only through the HMO and are not part of HMO Opt-Out:

- Durable Medical Equipment
- Hospice Care
- Home HealthCare
- Emergency Benefits
- Emergency Out-of-Area Coverage
- Reconstructive Surgery
- Dialysis
- Transplants
- Orthopedic Devices
- Prosthetic Devices
- Infertility testing and treatment
- Chemotherapy, Radiation Therapy, and Inhalation Therapy
- Skilled Nursing Care
- Dental Care
- Oral and Maxillofacial Surgery

If you have any questions regarding HMO Opt-Out, please do not hesitate to call the Prudential Healthcare HMO Mid-Atlantic toll-free number at 1-800-888-5447.

Non-FEHB Benefits Available to Plan Members

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

Prudential HealthCare HMO gives you access to additional programs that can enhance your quality of life:

Fun & Fitness Discount Program

This unique program offers discounts on a wide variety of health-related products and services, available through local retailers. To take advantage of the discounts, simply present your Prudential HealthCare I.D. card at the time of purchase at any participating location. If you have questions or would like a program brochure, please call 1(800)888-5447 or 1(800)668-1886 ext. 7197.

Health News

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

Women's and family health programs

Prudential HealthCare HMO includes a number of programs and features designed specifically for women and families. Prudential HealthCares Starting Right provides valuable information and resources for plan members who are planning, expecting or raising a family..

Health, Safety and fitness programs

As a Prudential HealthCare HMO member, you can enjoy programs designed to improve or enhance your health and the health of your family. And the Prudential HealthCare Bike Helmet Program makes quality bicycle helmets available to people of all ages even non-plan members- for as little as $10. Call 1-800-MY HEALTH.

HealthCare Committed Quitters

A stop smoking plan that combines nicotine replacement therapy (NRT) and a personalized smoking cessation plan.

Expanded dental benefits

In addition to Diagnostic and Preventive Care, the Plan offers the following dental services when provided by Plan participating general dentists. The following is a summary; complete schedules and copayment amounts of benefits are available on request.

Dental benefits	You Pay
Extractions	Copayment applies
Root Canals	Copayment applies
Standard Fully-Banded Braces	Copayment applies
Upper or Lower Dentures	Copayment applies
Fillings	Copayment applies
Crowns (non-gold)	Copayment applies

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Membership Services Office at 1-800-888-5447 or you may write to the Plan at 2800 North Charles Street, Baltimore, MD 21218.

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 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 the Plan an opportunity to reconsider your claim. Your written request 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 your request for reconsideration, the Plan 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 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 this 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 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 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 the 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 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 the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, 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, 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 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 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 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 in support of OPM's decision on the disputed claim.

How Prudential HealthCare HMO Mid-Atlantic 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 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 15)
- 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
- Coverage of drugs for sexual dysfunction are shown under the Prescription Drug benefit. See page 18.

Changes to this Plan

- Point of Service (Opt-Out) copayment has decreased to members paying 20% of the reasonable and customary charges. See page 19.
- Hearing-related implants, including but not limited to cochlear implants, are now excluded. See page 14.
- Cleft lip and cleft palate benefits have increased. See page 13.
- Coverage is now provided for medical foods. See page 13.
- Coverage is now provided for qualified medical clinical trials for phases of cancer and other life threatening conditions. See page 13.
- Coverage is now provided for general anesthesia for dental care for young or developmentally disabled children. See page 13.
- Preventative care and rehabilitation therapy are now covered under the Point of Service (Opt-out). See page 19.
- HMO in-network out-of-pocket maximums have decreased. Point of Service (Opt-out) out-of-pocket maximums have increased. See pages 8 and 20.

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Summary of Benefits for Prudential HealthCare HMO Mid-Atlantic 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, AND SERVICES AVAILABLE AS POS BENEFITS, 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, used of operating room, intensive care and complete maternity care. **You pay** nothing	14
	Extended care	All necessary services up to 90 days per year. **You pay** nothing for the first 60 days; 50% of charges for days 61 through 90	14
	Mental Conditions	Provided on the same basis as (other) hospital care. **You pay** nothing	17
	Substance Abuse	Provided on the same basis as (other) hospital care. **You pay** nothing	17
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. Y**ou pay** a $5 copay for primary care office visits and a $10 copay for specialty care office visits; $10 copay per house call by a doctor	12
	Home Health Care	All necessary visits by nurses and health aides. **You pay** nothing	13
	Mental Conditions	Outpatient visits **you pay** 20% of charges for visits 1-5; 35% of charges for visits 6-30; and 50% of charges for each visit over 30	17
	Substance Abuse	Outpatient visits **you pay** 20% of charges for visits 1-5; 35% of charges for visits 6-30; and 50% of charges for each visit over 30	17
Emergency Care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $50 copay to the hospital for each emergency room visit and any charges for services that are not covered by this Plan	15
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $5 copay per generic prescription unit or refill or a $10 copay for a brand name drug	18
Dental Care		Accidental injury benefit; preventive dental care. **You pay** nothing	19
Vision Care		No current benefit	
Point of Service Benefits		Services of non-Plan doctors and hospitals. Not all benefits are covered. **You pay** deductibles and coinsurance	19
Out-of-pocket maximum		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $2,400 per Self Only or $4,800 per Self and Family enrollment; and $1,650 per member of $3,300 per family for POS copays and deductibles per calendar year, covered benefits will be provided at 100%. This copay maximum does not include charges for prescription drugs	8

1999 Rate Information for Prudential HealthCare HMO℠ – Mid-Atlantic

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 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	**JB1**	**$69.20**	**$23.06**	**$149.93**	**$49.97**	**$81.88**	**$10.38**
Self and Family	**JB2**	**$152.30**	**$50.77**	**$329.99**	**$110.00**	**$180.22**	**$22.85**

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