United HealthCare Plans of Puerto Rico, Inc. 1999

A Health Maintenance Organization with a Point of Service Product

Serving: The Commonwealth of Puerto Rico

Enrollment code:

7U1 Self Only

7U2 Self and Family

Enrollment in this plan is limited; see page 4 for requirements.

Visit the OPM website at: **http://www**.opm.gov/insure and this Plan's Web site at: "http://www.uhc.com"

Authorized for Distribution by the:

United States Office of Personnel Management

Federal Employees Health Benefits Program

RI 73-770

United HealthCare Plans of Puerto Rico, Inc. Street 1, Corner Road 165, Rexco Office Park, Guaynabo, Puerto Rico 00968, has entered

into a contract (CS2823) 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 United 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. **Benefits changes are effective January 1, 1999, and are shown on page 26 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 (787) 782-5792 or 1-888-882-9832 and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

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

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

General Information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment to this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

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

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. **As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on page 16 or when you self refer to point of service, or POS, benefits as described on page 21.** If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See "If you are hospitalized" on page 4.

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

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 a FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency of 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.

General Information (*continued)*

Contact your local Social Security Administration (SSA) office for information on local Medicare prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.

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

Coverage after enrollment ends

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

Former spouse coverage

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

Temporary continuation of coverage (TCC)

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

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

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

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

Notification and election requirements

Separating employees - Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 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 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 o f

General Information *(continued)*

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 when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Certificate of Creditable Coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB Plan to cover you. This certificate, along with any certificate 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 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 encouraged 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 provider under the POS option, you will pay a substantial portion of the charges and the benefits available may be less comprehensive. See page 21 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 the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventive benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

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 (787) 782-5792 or you may write the Carrier at United HealthCare Plans of Puerto Rico, Inc., PO Box 364864, San Juan, Puerto Rico, 00936-4864. You may also contact the Carrier by fax at (787) 781-9394 or at its website at http://www.uhc.com.

Information that must be made available to you includes:

-Disenrollment rates for 1998.
-Compliance with State and Federal licensing or certification requirements and the dates met. If non-compliant, the reason for non compliance.
-Accreditations by recognized accrediting agencies and the dates received.
-Carrier's type of corporate form and years in existence.
-Whether the Carriers meets State, Federal and Accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

Who provides care to Plan Members?

United HealthCare is an individual practice prepayment plan. You can receive care from any Plan doctor. A Plan doctor is a doctor of medicine (M.D.) licensed to practice in the Commonwealth of Puerto Rico who has agreed to accept the United HealthCare established fees as payment in full for surgery and certain other services. If you use a non-Plan doctor (except for speech and occupational therapy) you must pay the difference between the non-Plan doctor's charge and the amount paid to you by United HealthCare. A non-Plan doctor is any licensed doctor of medicine (M.D.) who is not a Plan doctor. Non-Plan doctors do not have to accept United HealthCare established fees as payment in full. Most doctors practicing in Puerto Rico are Plan doctors.

You can also receive services from a Plan hospital. This is a licensed general hospital in Puerto Rico which has signed a contract with United HealthCare to render hospital services to persons insured by United HealthCare. A non-Plan hospital is any licensed institution that is not a Plan hospital and that is engaged primarily in providing bed patient with diagnosis and treatment under the supervision of physicians with 24-hour-a-day registered graduate nursing service. You must pay any difference between the non-Plan hospital's charges and the amount paid to you by United HealthCare.

Benefits are paid according to the "medical benefits schedule". This is the schedule of established fees on which the Plan's payment of covered medical expense is based, when the services are rendered within the service area. The medical benefits schedule applies to Puerto Rico. When the services are rendered outside the area the Plan pays usual, customary and reasonable charges.

Role of a primary care doctor

You are encouraged to select a primary care doctor (e.g., family practitioner, internist, pediatrician, OB-GYN) for you and for each family member. Your primary care doctor can help coordinate your care.

Choosing your doctor

The Plan's provider directory lists Plan doctors, with their locations and phone numbers. 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 (787)782-5792 or 1-888-882-9832; 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

Facts about this Plan *(continued)*

directory, call the provider to verify that he or she still participates with the Plan. Important note: **When you enroll in this Plan, services (except for emergency services 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.** Members may change their Plan doctor at any time.

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

You are encouraged to contact your primary care physician when you need a referral to another Plan doctor or for hospitals or other services and to follow any arrangements made for coordinating your care.

If you have a chronic, complex, or serious medical condition that causes you to see a Plan specialist frequently, you 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, you should inform the Plan primary care doctor you select so that your care can be coordinated to the extent necessary.

Hospital care

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

Out-of-pocket maximum

Your out-of-pocket expenses for benefits under this Plan are limited to the stated copayments required for a few services when Plan providers are used. You are also responsible for any difference between a non-Plan provider's actual charge and the Plan's benefit payment.

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

Where noted throughout this brochure, the Plan covers services from non-Plan providers. When covered services are received from non-Plan providers, you should pay the provider and seek reimbursement from the Plan after you have paid the claim. When you have a claim for such services notify United HealthCare promptly and the proper forms will be sent to you within 15 days of receipt of your notice.

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

Experimental /investigational determinations

Continous advancements in health care require that new technologies be researched on a regular basis.

Our medical department, directed by the United HealthCare's corporate medical director, researches and writes technology assesments for this plan, in order to determine coverage or exclusions for new technologies.

At the discretion of this Plan's Medical Director(s), technology assesments are presented to this plan's Medical

Advisory Board and Quality Improvement Commitee. Using this and other data, the Medical Director may amend United HealthCare determined technology assesment for use by this Plan.

Facts about this Plan *(continued)*

At times, a request for a new technology that has been evaluated by United HealthCare may occur. In this case, the Medical Director(s) may request that United HealthCare perform a technology assesment. Alternatively, the topic may be researched locally, and a coverage determination made, using input from the requesting provider available literature, the opinions of local and/or national board certified physicians, and other information.

Other considerations

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

The Plan's service area

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

The service area for this Plan includes the following areas: The entire island of Puerto Rico.

Benefits for care outside the service area are limited to emergency services, as described on page 16 and to services covered under Point of Service Benefits, as described on page 21.

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

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgement of your Plan doctor, it is medically necessary for the prevention, diagnosis, 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 or a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Other sources of benefits

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

Medicare

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

Group health insurance and automobile insurance

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

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

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 unless you use a non-Plan provider for POS benefits as described on page 21. 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.

General Limitations *(continued)*

Workers' compensation

The Plan 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, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, and Indian Health Service

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

Other Government agencies

The Plan will not provide benefits for 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 subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. **If you need more information about subrogation, the Plan will provide you with its subrogation procedures.**

General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. **Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness or condition 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;
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB Program;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Procedures, treatments, drugs or devices that are experimental or investigational;
- Procedures, services, drugs and supplies related to sex transformations; and
- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term 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 office visit copay, but no additional copay for clinical laboratory tests and X-rays. You must use a United HealthCare participating laboratory and X-ray facility. 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 $15 copay for a doctor's house call and nothing for home visits by nurses and health aides.

If you use a non-Plan doctor, **you pay** for services rendered and the Plan will reimburse you 1) 90% of the Plan's established fee when services are rendered within the service area, or 2) 90% of the usual, customary and reasonable charge of the area in which the services are rendered when services are rendered outside the services area. **You also pay** a $5 copay for each office visit to a non-Plan doctor, a $15 copay per doctor's house call, and nothing for visits of nurses and health aides.

The following services are included and are subject to the office visit copay unless stated otherwise:

- Preventive care, including well-baby care and periodic check-ups
- **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.**
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures, other than clinical laboratory tests and X-rays, are subject to a 20% copay.
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. Copays are waived for maternity care. **The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary.** If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints. The Plan pays 100% of the submitted charge when the implant device is provided and billed by a Plan doctor or provider. If the implant device is provided and billed by a non-Plan doctor, provider or medical equipment supplier, the Plan will reimburse you 90% of the established fee.
- Cornea, heart, 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.
- 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
- Orthopedic devices such as braces; foot orthotics
- Prosthetic devices, such as artificial limbs and lenses following cataract removal

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Medical and Surgical Benefits *(continued)*

- Durable medical equipment, such as wheel chairs, hospital type beds and iron lungs. The item will be rented or purchased at the Plan's discretion and must be prescribed by a Plan doctor and obtained from Plan sources.
- Chiropractic services
- 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.

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures 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 the 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 and occupational) is provided on an inpatient or outpatient basis for up to two consecutive months per condition if significant improvement can be expected within two months; **you pay** $5 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 $5 per visit**. The following types of artificial insemination are covered: intravaginal insemination (IVI); intracervical insemination (ICI) and intrauterine insemination (IUI); **you pay nothing**; cost of donor sperm is not covered. Fertility drugs are not covered. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization and embryo transfer, are not covered.

Second surgical opinions - A second surgical opinion is required for certain elective surgeries. You participating doctor will inform you when a second opinion is required and provide you with a report on your condition and the need for surgery. You must contact the Plan to arrange for a second opinion to be provided by a consulting physician or Plan medical personnel.

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
- Homemaker services
- Hearing aids
- Transplants not listed as covered
- Long-term rehabilitative therapy
- Cardiac Rehabilitation

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

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 with no dollar or day 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 the Plan. **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.

Ambulance service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor. This is an indemnity benefit and is payable directly to you after you have paid the claim.

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. Authorization of Plan Doctor is required prior to admission.

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 18 for nonmedical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Blood and blood derivatives not replaced by the member
- Custodial care, rest cures, domiciliary or convalescent care
- Hospice Care
- Air Ambulance Services

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Emergency Benefits

What is a medical emergency?

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

Emergencies within the service area

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours. 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 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.

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

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers except as covered under POS benefits.

Plan pays...

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

You pay...

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

Emergencies outside the service area

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

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

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers except as covered under POS benefits.

Plan pays...

Usual, customary and reasonable charges of the area in which the emergency care services are rendered.

You pay...

The copayments shown above for within-area benefits.

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

Emergency Benefits *(continued)*

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 except as covered under POS benefits.
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 25.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

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

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

The Plan provides a 24 hour toll free number to help you obtain the most appropriate care for your mental or substance abuse related needs. Call 1-888-552-6266 for further assistance. Your plan doctor will use this number also to coordinate any of the mental or substance abuse benefits covered by this Plan.

Outpatient care

Up to 40 outpatient visits to Plan doctors or other psychiatric personnel each calendar year; **you pay** a $5 copay for each covered visit -- all charges thereafter.

Inpatient care

Up to 90 days of hospitalization each calendar year in hospitals approved to render these services; two days of partial hospitalization are equivalent to to one full day of hospitalization. For necessary professional services, the Plan pays its established fees up to the actual charge. Covered services include, but are not limited to: medical care, consultations, laboratory and x-ray; radiotherapy, physiotherapy, and psychotherapy. For special nursing care, the Plan pays the following when ordered by the attending psychiatrist, for each hour not to exceed 72 consecutive hours: $18 for a registered nurse; $12 for a licensed practical nurse; $12 for psychiatric aide. **You pay** nothing for the first 30 days – all charges thereafter.

What is not covered

- Care for psychiatric conditions that in the professional judgement 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 that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition
- Charges from a residential treatment facility
- Benefits not shown as covered above.

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 in conjunction with the mental conditions benefit shown above. Outpatient visits to Plan mental health providers for follow-up care and counseling are covered, as well as inpatient services necessary for diagnosis and treatment. The mental conditions visit/day limitations and copays apply. The Plan provides a 24 hour toll free number to help you obtain the most appropriate care for your mental or substance abuse related needs. Call 1-888-552-6266 for further assistance. Your Plan doctor will use this number also to coordinate any of the mental or substance abuse benefits covered by this Plan.

What is not covered

- Treatment that is not authorized by a Plan doctor
- Benefits not shown as covered above

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. **You pay** a $5 copay for brand-name and nothing for generic / bio-equivalent per prescription unit or refill.

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

Covered medications and accessories include:

- Drugs for which a prescription is required by Federal law
- Insulin; a copay charge 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 and acetone test tablets
- Intravenous fluids and medications for home use, implantable drugs, and some injectable drugs, are covered under Medical and Surgical Benefits

Limited Benefits

Drugs to treat sexual dysfunction are limited and subject to prior authorization. Contact the Plan for dose limits

What is not covered

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Other Benefits

Dental care

Accidental injury benefit

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

What is not covered

- Other dental services not shown as covered

Vision care

What is covered

In addition to the medical and surgical benefits provided for the diagnosis and treatment of diseases of the eye, annual eye refractions (to provide a written lens prescription) may be obtained from Plan providers. **You pay** a $5 copay per visit.

What is not covered

- Corrective lenses or frames, contact lenses nor its fittings
- Eye exercises

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Point of Service Benefits

What is covered

Members may choose to obtain benefits covered by this Plan from non-Plan doctors or hospitals without a referral and receive a lesser benefit than from participating network providers. This option is available each time a member seeks medical attention. All services, including prescription drugs prescribed by non-network providers, are covered the same as when United HealthCare Plans of Puerto Rico, Inc. participating providers are used except that precertification is required as stated below (or payment is reduced). Any day limits remain the same and note that preventive care such as physicals are not covered through non-participating providers.

Covered services are paid on a fee-for-service basis when services are received from non-Plan providers after you satisfy a $200 calendar year deductible, Self Only enrollment, or $400, Self and Family. After the deductible is met, the Plan will pay 80% of reasonable and customary covered charges. **You pay** 20% of the reasonable and customary charges and any excess of the covered charges.

Maximum benefits covered services under the out-of-network benefit are limited to a maximum Plan payment of $1,000,000.00 per member per lifetime.

Precertification requirements on some services

The purpose of precertification is to ensure that benefits are provided only for medically necessary care. The precertification process must be completed (and the deductible must be satisfied) for you to receive full POS coverage for the following benefits; inpatient hospital care; outpatient surgical procedures (except office surgery); care in a skilled nursing facility, all inpatient and outpatient care for the treatment of mental conditions or substance abuse; prosthetics and durable medical equipment; and home health care. To precertify, you or your doctor must call **1-888-552-6266** no less than four business days before the services are received. In an emergency within the Plan's Service Area, the member must notify the Plan within 24 hours after the services begin, or as soon as reasonably possible. (Outside the Service Area, network emergency benefits apply). Members who intend to use non-Plan providers for maternity benefits should notify the Plan as early as possible. Note, for Mental Health and Substance Abuse services, members must call **1-888-552-6266.**

If precertification is not obtained, benefits will only be paid at 50% of the allowable charges; **you pay** 50% of allowable charges and all charges in excess of the allowable amount. **Prosthetics and durable medical equipment will not be covered if they are not precertified**. The following information must be provided to the Plan when precertification is requested:

- Patient's name
- Patient's Social Security number
- Hospital's name
- Physician's name
- Procedure
- Expected procedure rate

Precertification is not required for: office visits and related prescription drugs; infertility diagnosis and non-surgical treatment; rehabilitative therapy including cardiac rehabilitation; accidental dental injury benefit; and growth hormone therapy.

Your out-of-pocket expenses for network-level benefits covered under this plan are limited to the stated copayments and coinsurance required for a few benefits. The out-of-pocket copayment maximum for the coinsurance you pay from non-network benefits, not including the deductible or charges you pay above the allowable amount, is $3,000.00 per Self only and $6,000.00 for Self and Family enrollment.

Notes

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 of this 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 deductible, POS maximum benefits, or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Suplemental dental care

What is supplemental dental care

A supplemental dental care program is an optional program that adheres to the mandatory basic diagnostic and dental preventive services described in the previous section of this Benefits Brochure. This program is totally optional to the participant and is only available when having the full scope of benefits (medical-surgical, drugs, etc.) or coverage is provided by the Plan. The Plan has established a mechanism were you as part of your selection for this Plan, may at your option, decide to purchase this supplemental dental benefits program for a minimal amount.

What is covered

This Plan provides coverage for the following services when provided by Plan dentists; **you pay nothing** for the services described in this paragraph. The covered benefits are as follows: Initial oral exam, periodic oral exam (twice (2) a year at intervals of no less than six (6) months) and dental cleaning (twice (2) a year at intervals of no less than six (6) months), fluoride treatment (twice (2) a year for a child under age 19 at intervals of no less than six (6) months), bitewings x-rays (once a year), periapical x-rays, panoramic x-rays (one (1) every three (3) years) and emergency oral exam (limited to one exam per condition).

This supplemental dental care program also provides you coverage for major restorative services; **you pay a twenty (20%) percent** coinsurance for the services described in this paragraph. The covered benefits are as follows: Restorations in amalgam and composite (resins and/or plastic), non surgical extractions and postoperative treatment, endodontic treatment in anterior teeth and premolars, stainless steel and plastic crowns and dental apexification surgery, including apicectomy and hemisection, denture repairs (full or partial) and bridgework (fixed or removable), emergency treatment for dental pain, infections and trauma and refills of crowns, veneers and facings.

This supplemental dental care program also provides you coverage for major restorative services; **you pay a fifty (50%) percent** coinsurance for the services described in this paragraph. The covered benefits are as follows: Surgical extractions (including pre and postoperative services), endodontic treatments in molars (three (3) or more canals), periodontal prophylaxis (one (1) per year consisting of two (2) sessions) and general anesthesia for surgical extractions.

The Plan has a maximum benefit of $900.00 per covered person per calendar year maximum that provides coverage for all these services and it reserves the right to recommend any alternate benefit procedures whenever applicable. Any excess from this amount from one same person over a single calendar year will be the responsibility of the subscriber, including but not limited also to coinsurances. Services can be obtained only through licensed dentists that participate in United HealthCare's provider network.

What is not covered

Other dental services not shown as covered, injury or illness covered by or related to the State Insurance Fund Act or Automobile Accident Social Protection Act, services related to cosmetic procedures, services provided prior to the effective date of this non FEHB program, charges for services related to the temporomandibular joint (TMJ), claims submitted to United HealthCare more than six (6) months after termination of treatment, bridgeworks, posts or dentures, except for their repairs, inlays, crowns and veneers in precious and semiprecious metals, orthodontic treatment, instructions about oral hygiene and diet, tartar control programs, myofunctional therapy, experimental procedures, any hospital charge and additional dentist's fees related to treatment provided in the hospital, oral tissue grafts, charges for services or supplies for which the patient is not bound to pay for in absence of a dental pain, space maintainers, sealants, oral and/or maxillofacial surgery procedures or procedures for the treatment of periodontic conditions that are not specifically mentioned by name.

How do I enroll

To enroll in this supplemental dental care program, you must call **1-888-761-4139** in order for the Plan to send you by mail or deliver to your nearest location an enrollment kit were additional instructions will be found. Detailed explanation of benefits, limitations, exclusions, eligibility rules and others will be found on this kit. You can also fax us your request to **(787) 782-3555.**

Benefits on this page are not part of the FEHB contract

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's FEHB Service Team Office during business hours at 1-888-761-4139 or Tele-Salud, a 24 hour service at 1-888-552-6266 or you may write to the Plan at PO Box 364864, San Juan, Puerto Rico 00936-4864. You may also contact the Plan by fax at (787) 781-9394.

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 to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

Within 30 days after receipt of 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 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 3, P.O. Box 436, Washington, DC 20044.

How to Obtain Benefits *(continued)*

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a 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 United Health Care Changes January 1999

Program-wide changes

Several changes have been made to comply with the President's mandate to implement the commendations 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 16).

The medical management of mental conditions will be covered under this Plan's Medical and Surgical Benefits provisions. Related drug 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 Condition visit limit.

Coverage for drugs for sexual dysfunction are shown under Prescription Drugs Benefits. See page 19.

Summary of Benefits for United HealthCare Plans of Puerto Rico, Inc. 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 Hospital Care	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.	**15**
Extended Care	All necessary services, no dollar or day limit. **You pay** nothing.	**15**
Mental Conditions	Diagnosis and treatment of acute psychiatric conditions for up to 90 days of inpatient care per year. **You Pay** nothing.	**18**
Substance Abuse	Covered under Mental Conditions.	**18**
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 $5 copay per office visit; copays are waived for maternity care; $15 per house call by a doctor.	**13-14**
Home Health Care	All necessary visits by nurses and health aides. **You pay** nothing.	**13-14**
Mental Conditions	Up to 40 outpatient visits per year. **You pay** a $5 copay per visit.	**18**
Substance Abuse	Covered under Mental Conditions Benefits.	**18**
Emergency care	Reasonable charges for services and supplies required becauseof a medical emergency. **You pay** a $5 copay to the hospital for each emergency room visit and any charges for services that are not covered by this Plan.	**16**
Prescription drugs	Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $5 copay for brand-name drugs and nothing for eneric / bio-equivalent drugs, per prescription, unit or refill.	**19**
Dental care	Accidental injury benefit; **you pay** nothing.	**20**
Vision care	One refraction annually. **You pay** a $5 copay per visit.	**20**
Out-of-pocket maximum	Your out-of-pocket expenses for benefits under this Plan are limited to the stated copayments required for a few benefits.	**8**

1999 Rate Information for United HealthCare Plans of Puerto Rico, Inc.

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 enrollemnt.

Postal rates apply to most carrier U.S. Postal Service employees, but do not apply to non-carrier 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	**7U1**	**54.51**	**18.17**	**118.10**	**39.37**	**64.50**	**8.18**
Self and Family	**7U2**	**117.56**	**39.19**	**254.72**	**84.91**	**139.12**	**17.63**