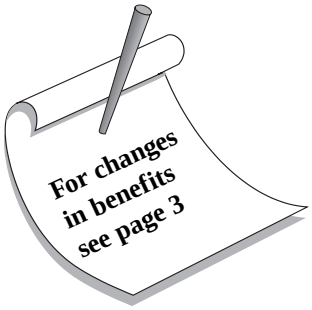
2000

Prudential HealthCare HMO®

Prudential Health Care Plan, Inc.

A Health Maintenance Organization



Serving: Houston and San Antonio, Texas Areas

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

Enrollment code for Houston:
UP1 Self only
UP2 Self and family

This plan has commendable accreditation from the NCQA. See the *2000 Guide* for more information on NCQA.

Enrollment code for San Antonio:
VX1 Self only
VX2 Self and family

This plan has commendable accreditation from the NCQA. See the *2000 Guide* for more information on NCQA.

SPECIAL NOTICE: Prudential HealthCare HMO®-Houston and Prudential HealthCare HMO®-San Antonio have been consolidated into a single benefit package. Please read your brochure carefully so that you are aware of all benefit changes.

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

and

our Plan's website at http://www.aetnaushc.com/pruhealthcare

Authorized for distribution by the:

UNITED STATES OFFICE OF
PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE

FEHB
Federal Employees
Health Benefits Program

RI 73-048

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Introduction

Prudential Health Care Plan, Inc.,
Prudential HealthCare HMO®
1425 Union Meeting Road
P.O.Box 3013
Blue Bell, PA 19422

This brochure describes the benefits you can receive from **Prudential HealthCare Plan Inc., hereafter referred to as Prudential HealthCare HMO®**, under its contract (CS 1774) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 3. Premiums are listed at the end of this brochure.

Plain language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to **Prudential HealthCare HMO®** as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How to use this brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. Health Maintenance Organizations (HMO). This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.

2. How we change for 2000. If you are a current member and want to see how we have changed, read this section.

3. How to get benefits. Make sure you read this section; it tells you how to get services and how we operate.

4. What to do if we deny your claim or request for service. This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.

5. Benefits. Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.

6. General exclusions — Things we don't cover. Look here to see benefits that we will not provide.

7. Limitations — Rules that affect your benefits. This section describes limits that can affect your benefits.

8. FEHB FACTS. Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals, and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventative care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance listed in this brochure. When you receive emergency services you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How we change for 2000

Program-wide changes

To keep your premium as low as possible OPM has set a minimum copay of $10 for all primary care office visits.

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program. (See Section 3, How to get benefits, for more information.)

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to it. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

- We consolidated Prudential HealthCare HMO® -Houston and Prudential HealthCare HMO®- San Antonio into a single benefits package known as Prudential HealthCare HMO. For enrollees who live in the San Antonio area, the enrollment codes are VX1 (Self only) and VX2 (Self and Family). The enrollment codes for members who live or work in the Houston service area are UP1 for Self Only and UP2 for Self and Family. There are numerous benefit changes. Please read your brochure very carefully.
- For San Antonio members (VX1 and VX2), your share of the non-postal premium increased by 15% for either Self Only or Self and Family. In the Houston service area, your share of the non-postal premium increased by 23.9% for Self Only (UP1) and by 52.6% for Self and Family (UP2).
- The office visit copay is $10.00 under the Medical and Surgical Benefits, and Substance Abuse Benefits. Previously the office visit copay was $5.00. See pages 9 and 15.
- Your prescription drug copays are based on the Plan's prescription drug formulary. Your copay per prescription unit or refill for up to a 30-day supply will be $5.00 generic formulary, $10.00 name brand formulary, or $20.00 non-formulary. We have eliminated the procedure for requesting non-formulary drugs. You may obtain up to a 90-day supply of certain maintenance drugs with a single copay through the mail-order pharmacy. See page 15 of the Prescription Drug Benefits.
- The amount that you pay for the diagnosis and treatment of infertility has increased from 25% to 50%. See page 10.

Section 2. How we change for 2000 *continued*

Changes to this Plan
continued

- The out-of-pocket maximum is 200% of the total premium per year. Last year, the out-of-pocket maximum for Houston was $1000 for Self only and $2,500 for Self and Family. Previously, the out-of-pocket maximum in San Antonio was $3,492 for Self only and $9,075 for Self and Family.
- You have up to 25 outpatient mental health care visits per calendar year. You will pay $35 for each covered visit. Previously, members in San Antonio had 20 outpatient visits. See page 14.
- The hospital emergency room copay is $75.00 and the urgent care center copay is $10.00. Previously, the hospital emergency room copay for San Antonio was $50.00 and the urgent care copay was $5.00. Houston's urgent care copay was previously $5.00. See page 13 under the Emergency Benefits.
- Covered ambulance transport will be subject to a $25.00 copay. Previously, the copay was $50.00 for San Antonio members.
- You pay 25% of the charges for covered durable medical equipment, prosthetic devices, and orthopedic devices (such as braces). Previously, San Antonio members paid 30% for these items. Houston previously covered prosthetic devices in full.
- Smoking cessation therapy that requires a prescription is covered under the Prescription Drug Benefits at the applicable generic, name brand, and non-formulary copay. Coverage is limited to one 90-day course of treatment per lifetime administered by a Plan doctor.

Section 3. How to get benefits

What is this Plan's service area?

To enroll with us, you must live or work in our Houston service area (UP) or live or work in our San Antonio (VX) service area. You must enroll in the code we have designated for your area. This is where our providers practice.

Enrollment code UP - Houston Service Area
You must live or work in one of the following counties to enroll in this service code. Our Houston service area (UP1 and UP2) includes the City of Houston and all of Fort Bend, Galveston, Harris, Montgomery, and Walker counties and portions of Austin, Brazoira, Cambers, Colorado, Grimes, Liberty, Matagorda, San Jacinto, Waller, Washington, and Wharton counties inclusive of the following zip codes and communities:

77001-77099 (Houston), 77201-77275 (Houston, Nassau Bay), 77277 (Houston), 77279-77282 (Houston), 77284 (Houston), 77287-77293 (Houston), 77297-77304 (Houston, Conroe), 77306 (Conroe), 77327 (Cleveland), 77331 (Coldspring), 77336-77339 (Huffman, Tomball, Humble), 77345-77346 (Humble), 77355-77359 (Magnolia, Montgomery, New Caney, New Waverly, Oakhurst), 77362 (Pinehurst), 77363 (Plantersville), 77365 (Porter), 77371-77373 (Shephard, Splendora, Spring), 77375 (Tomball), 77378-77389 (Conroe, Spring, Willis), 77396 (Humble), 77401 (Bellaire), 77411 (Howellville), 77413 (Barker), 77417 (Beasley), 77418 (Bellville), 77420 (Boling), 77423 (Brrokshire), 77426 (Chappell Hill), 77429-77430 (Cypress, Damon) 77433-77435 (Cypress, Eagle Lake, East Bernard), 77441 (Fukshear), 77444 (Guy), 77445 (Hempstead), 77447 (Hockley), 77449-77450 (Katy), 77459 (Missouri City), 77461 (Needville), 77466(Pattison), 77468 (Pledger), 77469 (Richmond), 77471 (Rosenberg), 77474 (Sealy), 77477-77479 (Stafford, Sugar Land), 77481 (Thompsons), 77484 (Walker), 77485 (Wallis), 77486 (West Columbia), 77488 (Wharton), 77489 (Missouri City), 77491-77494 (Katy), 77501-77507 (Pasadena), 77510-77511 (Santa Fe, Alvin), 77514 (Anahuac), 77515 (Angleton), 77517-77518 (Santa Fe, Baycliff), 77520-75222 (Baytown), 77530 (Channelview), 77531 (Clute), 77532 (Crosby), 77534 (Danbury), 77535 (Dayton), 77536 (Deer Park), 77539 (Dickenson), 77541 (Freeport), 77545-77547 (Fresno, Friendswood, Galena Park), 77550-77551 (Galveston), 77554 (Galveston), 77560 (Hankamer), 77652-77653 (Highlands, Hitchcock), 77564 (Hull), 77565 (Kemah), 77566 (Lake Jackson), 77568 (Lamarque), 77571-77574 (La Porte, League City), 77575 (Liberty), 77577-77578 (Liverpool, Manvel), 77580 (Mt. Belview), 77581 (Pearland), 77583-77584 (Rosharon, Pearland), 77586-77587 (Seabrook, South Houston), 77590-77592 (Texas City), 77597 (Wallisville), 77598 (Webster), 77560 (Port Bolivar), 77868 (Navasota), 77873 (Richards, 78933 (Cat Spring).

Section 3. How to get benefits *continued*

What is this Plan's service area? *continued*

Enrollment code VX - San Antonio Service Area
You must live or work in one of the following counties or zip codes to enroll in this service code. Our San Antonio service area (VX1 and VX2) includes the city of San Antonio and all of Bexar, Comal, Wilson, and Guadaloupe counties and portions of Atascosa, Bandera, Frio, Karnes, Kendall and Medina counties inclusive of the following zip codes and communities:

78011 (Charlotte), 78026 (Jourdanton), 78050 (Leming), 78052 (Lytle), 78053 (Mc Coy), 78064 (Pleasanton), 78065 (Poteet), 78003 (Bandera), 78063 (Pipe Creek), 78002 (Atascosa) 78006 (Boerne), 78015 (Fair Oaks Ra), 78023 (Helotes, 78054 (Macdona), 78069 (Somerset), 78073 (Von Ormy), 78101 (Adkins), 78109 (Converse), 78112 (Elmendorf), 78148-78149 (Universal City), 78152 (Saint Hedwig), 78201-78265 (San Antonio), 78283 (San Antonio) 78285-78299 (San Antonio), 78080 (Spring Branch), 78130-78133 (New Braunfels), 78163 (Wetmore), 78623 (Fischer), 78005 (Bigfoot), 78057 (Moore), 78601 (Pearsall), 78108 (Cibolo), 78115 (Geronimo), 78123 (Mc Queeney), 78124 (Marion), 78154 (Schertz), 78155-78156 (Seguin), 78638 (Kingsbury), 78113 (Falls City), 78004 (Bergheim), 78027 (Kendalia), 78074 (Waring), 78009 (Castroville), 78016 (Devine), 78039 (La Coste), 78056 (Mico), 78059 (Natalia), 78066 (Rio Medina), 78861 (Hondo), 78886 (Yancey), 78114 (Floresville), 78121 (La Vernia), 78143 (Pandora), 78147 (Poth), 78160 (Stockdale), 78161 (Sutherland).

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care. We will not pay for any other health care services.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

How much do I pay for services?

You must share the cost of some services. This is called a copayment (a set dollar amount, i.e. $10). Please remember you must pay this amount when you receive services, except for laboratory tests and X-rays.

After you pay 200% of the annual premium for one family member or 200% of the annual premium (this includes your premium and the government's share) for two or more family members, you do not have to make any further payments for certain services (provided or arranged by the Plan) for the rest of the year. This is called a catastrophic limit.

Be sure to keep accurate records of your copayments and coinsurance, since you are responsible for informing us when you reach the limits.

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Who provides my health care?

Houston area (UP1 and UP2)
Prudential HealthCare HMO is Houston's oldest health maintenance organization (HMO). As a Plan member, you may use the MacGregor Medical Association (MMA) physicians or Independent Provider Network (IPN) Primary Care Physicians, listed in the provider directories.

If you select an MMA physician, you have access to over 200 doctors at 19 full service health centers. These centers are conveniently located throughout the Houston area. You do not have to designate a primary care doctor if you use MMA. You may schedule an appointment with any MMA doctor by calling the centralized appointment desk at (713)741-2273.

If you select an IPN primary care physician, you have access to over 1,200 primary care physicians and over 2,500 specialists. You may designate your IPN primary care doctor by calling Prudential's Customer Service Department at 800-856-0764. You may schedule an appointment with your IPN doctor by calling that doctor directly. You may transfer care from IPN to MMA or from MMA to IPN by calling Customer Service for a change effective immediately.

Section 3. How to get benefits *continued*

Who provides my health care? *continued*

We have 44 participating hospitals in the Houston area available to you as authorized by your primary care doctor. Please refer to the provider directories for specific doctor, hospital, or pharmacy locations.

San Antonio area (VX1 and VX2)
Prudential HealthCare HMO is a mixed model HMO that has provided medical benefits to residents of San Antonio and surrounding communities for over 12 years. We have over 500 primary care doctors and over 1,000 specialty care doctors in our physician network. Physicians are located throughout the service area and provide convenient, quality medical care to our members. Our hospital network consists of 26 area hospitals. Prudential HealthCare HMO members have access to pharmacies throughout the service area. Please refer to the provider directory for specific doctor, hospital, and pharmacy locations.

In Houston and San Antonio, your Primary Care Physician will direct your care to a specialist, hospital or ancillary provider that is contained within his or her chosen network. The Provider Directory accurately reflects the network of specialists, hospitals, and ancillary providers that your doctor may refer you to for care. Please refer to your Provider Directory for more specific information.

What do I do if my primary care physician leaves the Plan?

Call us at 1-800-856-0764. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care.

What do I do if I'm in the hospital when I join this Plan?

First, call our customer service department at 1-800-856-0764. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center, or
- The day your benefits from your former plan run out, or
- The 92nd day after you became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

How do I get specialty care?

Your primary care physician will arrange your referral to a specialist. You must receive a referral from your primary care physician before seeing any other doctor or obtaining special services. The only exceptions are when there is a medical emergency or when a primary care physician has designated another doctor to see his or her patients. Also, a woman may self refer for covered services to her participating Obstetrician/Gynecologist. For all other services, referral to a participating specialist is given at the primary care physician's discretion. If non-Plan specialists or consultants are required, the primary care physician will arrange appropriate referrals. We will provide benefits for covered services only when the services are medically necessary to prevent, diagnose, or treat your illness or condition.

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

If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan.

Section 3. How to get benefits *continued*

What do I do if I am seeing a specialist when I enroll?

Your primary care physician will decide what treatment you need. If they decide to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

What do I do if my specialist leaves the Plan?

Call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

How do you authorize medical services?

Your Plan physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice.

How do you decide if a service is experimental or investigational?

We do not cover procedures, services, or supplies that are experimental or investigational. In order to determine whether or not a procedure, service, or supply is experimental or investigational, we gather appropriate information for a decision that will be made by medical professionals. The information we collect may include medical records, current reviews of medical literature and scientific evidence, results of current studies or clinical trials, research protocols, reports or opinions of authoritative medical bodies, opinions of independent outside experts and approvals granted by regulatory bodies. Your provider may sometimes ask that you sign a form acknowledging that the procedure, service, or supply is experimental or investigational. This form and any related protocol may also be part of the information we consider. After reviewing all pertinent information, we make our determination and notify you of our decision. Please contact customer service at 800-856-0764 for more specific information.

Section 4. What to do if we deny your claim or request for service

If we deny services or won't pay your claim, you may ask us to reconsider our decision. Your request must:

1. Be in writing,
2. Refer to specific brochure wording explaining why you believe our decision is wrong; and
3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;
2. Pay the claim;
3. Arrange for a health care provider to give you the service; or
4. Ask for more information

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

Section 4. What to do if we deny your claim or request for service *continued*

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life threatening condition and you haven't responded to my request for service?

Call us at 800-856-0764 and we will expedite our review.

What if you have denied my request for care and my condition is serious or life threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's health benefits Contract Division 3 at (202) 606-0755 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

1. A statement about why you believe our decision is wrong, based on specific benefit provisions in this brochure;
2. Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
3. Copies of all letters you sent us about the claim;
4. Copies of all letters we sent you about the claim; and
5. Your daytime phone number and the best time to call.

If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Where should I mail my disputed claim?

Send your request for OPM review to: Office of Personnel Management, Office of Insurance Programs, Contract Division III, P.O. Box 436, Washington, D.C. 20044.

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our decision, your only recourse is to sue.

If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services or supplies.

What laws apply if I file a lawsuit?

Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Section 4. What to do if we deny your claim or request for service *continued*

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. Medical and Surgical Benefits

What is covered

We cover a comprehensive range of preventive, diagnostic and treatment services by Plan doctors and other Plan providers. This includes all necessary office visits. You pay a **$10** office visit copay, but nothing for laboratory tests and X-rays. Within the Service Area, house calls will be provided if in the judgment of the Plan doctor such care is necessary and appropriate; you pay a **$10** copay for a doctor's house call, nothing for home visits by nurses and health aides.

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

- Preventive care, including well-baby care and periodic check-ups.
- Sigmoidoscopy screening for colorectal cancer at age 50 and above every 5 years.
- 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, 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 **$10** copay is waived after the first prenatal office visit. 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 stays will be extended if medically necessary. If you terminate your enrollment in the Plan 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, and insertion of IUDs.
- Diagnosis and treatment of diseases of the eye.
- Vision and hearing screenings up to age 18.
- Allergy testing and treatment, including testing and treatment materials; you pay 50% of charges. We cover the cost of allergy serum in full. Allergy injections performed in a doctor's office are subject to the $10 office visit copay.
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Cornea, heart, heart/lung, kidney, liver, lung (single or double), pancreas, and pancreas-kidney 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 Plan's Medical Director. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Section 5. Medical and Surgical Benefits *continued*

What is covered *continued*

- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital for up to 48 hours after the procedure.
- Dialysis; you pay nothing.
- Chemotherapy, radiation therapy, and inhalation therapy; you pay nothing.
- Surgical treatment of morbid obesity; you pay nothing.
- Orthopedic devices, such as braces, foot orthotics. You pay 25% of charges.
- Prosthetic devices, such as artificial limbs, breast prostheses and surgical bras (as well as their replacement) and initial lenses or eyeglasses following cataract removal. You pay 25%.
- Durable Medical equipment, such as hospital beds and wheelchairs. You pay 25% of charges.
- Oxygen and rental of equipment for its administration.
- 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. You pay nothing.
- 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.
- Diabetic supplies including needles, glucose test tablets and test tape, Benedicts' solution or equivalent, acetone test tablets, lancets and test strips. You pay nothing.

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. Temporomandibular joint disease is covered when determined to be of a medical rather than dental nature. You pay nothing. 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.

Reconstructive surgery will be provided to correct a condition resulting from an abnormal congenital and/or 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. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis. You pay a $10 copayment 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, including prescription drugs and artificial insemination. The covered artificial insemination procedures are intravaginal insemination (IVI); intracervical insemination (ICI); and intrauterine insemination (IUI)]. You pay 50% of charges. We do not cover the cost of donor sperm. We do not cover the harvesting, storage and/or manipulation of eggs and sperm. Injectable fertility drugs are covered. You pay 50% of charges. Oral fertility drugs are covered under the Prescription Drug Benefit. All other assisted reproductive technology (ART) procedures, such as in vitro fertilization and embryo transfer, etc., are not covered.

Serious Mental Illness treatment is covered up to 45 days of inpatient care and 60 outpatient visits per calendar year. Serious Mental Illness means the following psychiatric illnesses as defined in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of mental Disorders: schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hypomanic, manic and mixed), major depression disorders (bipolar and depressive); schizoaffective disorder (bipolar or depressive); pervasive development disorders; obsessive-compulsive disorders, and depression in childhood and adolescence. You pay nothing for inpatient care and a $10 copay for each covered outpatient visit up to 60 visits, all charges thereafter. Mental illnesses that do not meet the definition of serious mental illness are covered under Mental Conditions/Substance Abuse benefits.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided at a Plan facility. You pay nothing.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Section 5. Medical and Surgical Benefits *continued*

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.
- Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia), farsightedness (hyperopia), and astigmatism.
- Hearing aids, including examinations for the fitting of them; the cost of cochlear implants.
- Homemaker services.
- Blood and blood derivatives replaced by or for the patient.

Section 5. Hospital/Extended Care Benefits

What is covered

Hospital care

We provide 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

We provide a comprehensive range of benefits for up to 100 days per condition for all such confinements which are due to the same or related causes and which are separated by less than three months. Coverage is provided when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a 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.

Hospice Care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient hospice care and 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. Each person is entitled to a maximum benefit of $7,400 per period of care. Up to $200 in counseling services may be provided to the family unit of the terminally ill patient.

Ambulance service

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

Limited benefits

Inpatient dental procedures

We cover hospitalization for certain dental procedures when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure. Although we will cover the hospitalization, we do not cover the cost of the professional dental services. Conditions for which we cover hospitalization would include hemophilia and heart disease. However, 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.

Serious Mental Illness

We provide a comprehensive range of benefits for inpatient care for up to 45 days when you are hospitalized for serious mental illness under the care of a Plan doctor. You pay nothing. Each full day of treatment in a Psychiatric Day Treatment Facility, Residential Treatment Center for Children and Adolescents or Crisis Stabilization Unit will be considered a half of one day of treatment during a Hospital Inpatient stay.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Section 5. Hospital/Extended Care Benefits *continued*

Serious Mental Illness *continued*

Serious Mental Illness means the following psychiatric illnesses as defined in the most recent edition of the American Psychiatric Association's "Diagnostic and Statistical Manual of Mental Disorders": schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hypomanic, manic and mixed), major depressive disorders (bipolar and depressive); schizoaffective disorders (bipolar or depressive); pervasive developmental disorders; obsessive-compulsive disorders, and depression in childhood and adolescence. Mental illnesses that do not meet the definition of serious mental illness are covered under Mental Conditions/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 replaced by or for the patient.

Section 5. Emergency Benefits

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that 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 we 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 us. You or a family member must notify us within 48 hours (unless it was not reasonable possible to do so). It is your responsibility to ensure that we have been timely notified.

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

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

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

We pay...

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

You pay...

$75 per hospital emergency room visit or $10 per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, we waive the emergency care copay.

Emergencies outside the service area

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

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

We pay...

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

You pay...

$75 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 for the $10 copay to apply. If the emergency results in admission to a hospital, we waive the emergency care copay.

What is covered

- Emergency care at a doctor's office or an urgent care center/minor emergency 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.
- Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area.

Filing claims for non-Plan providers

With your authorization, we 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

Section 5. Emergency Benefits *continued*

receipts to us along with an explanation of the services and the identification information from your ID card.

We will send payment to you (or the provider if you did not pay the bill), unless we deny benefits for the claim. If we deny benefits, we will send you a written notice of our decision, including the reasons for the denial and the provisions of the contract on which we based our decision. If you disagree with us, you may ask us to reconsider our decision in accordance with the disputed claims procedure described on page 7.

Portability

If you are away from home and require medical care other than routine physicals, immunizations and non-emergency maternity care, you can access a network facility in the area you are visiting. You will receive this care at the maximum benefit level 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 (or medical group) to obtain permission for out-of-area care. In life-threatening emergencies, we recommend that you seek appropriate treatment immediately. However, you or a member of your family must notify your primary care doctor within 48 hours concerning the emergency care you 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 physician. 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.

Section 5. Mental Conditions/Substance Abuse Benefits

In the Houston area, members must contact University Behavioral Health at (713) 666-3794 for access to mental health/substance abuse services.

In the San Antonio area, members must contact Alamo Mental Health at (210) 614-8400 for access to mental health/substance abuse.

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)

Serious Mental Illness treatment is covered under the Medical/Surgical Benefits or Hospital/Extended Care Benefits. Serious Mental Illness means the following psychiatric illnesses as defined in the most recent edition of the American Psychiatric Association's Diagnostic and Statistical Manual of mental Disorders: schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hypomanic, manic and mixed), major depression disorders (bipolar and depressive); schizoaffective disorder (bipolar or depressive); pervasive development disorders; obsessive-compulsive disorders, and depression in childhood and adolescence.

Outpatient care

Up to 25 visits for individual counseling with Plan doctors, consultants or other psychiatric personnel each calendar year; you pay a $35 copay for each covered visit - all charges thereafter.

Inpatient care

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

Intermediate care

Intermediate care for mental health accumulates towards the 30-day inpatient care hospital

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Section 5. Mental Conditions/Substance Abuse Benefits *continued*

Intermediate care *continued*

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

What is not covered

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

Substance Abuse

What is covered

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

Outpatient care

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

Inpatient Care

Hospitalization necessary for the diagnosis and treatment of Substance Abuse; you pay nothing.

What is not covered

- Treatment that is not authorized by a Plan doctor

Section 5. Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30 day supply or one commercially prepared unit (i.e. one inhaler, one vial ophthalmic medication or insulin). You pay a $5 copay per prescription unit or refill for generic formulary drugs, or a $10 copay per prescription unit or refill for name brand formulary drugs, or **a $20 copay per prescription unit or refill for non-formulary drugs.** However, in no event will the copay exceed the cost of the prescription.

Maintenance drugs are used for the treatment of the following chronic medical conditions: chronic obstructive pulmonary disease; clotting drugs; congestive heart failure; coronary artery disease (angina); diabetes; glaucoma; hypertension; thyroid disease; and seizure disorders. We may also include other conditions.

Up to a 90-day supply of maintenance drugs and oral contraceptive drugs prescribed by a Plan doctor may be obtained from our mail-order pharmacy. You pay a $5 copay per prescription unit or refill for generic formulary drugs, or a $10 copay per prescription unit or refill for name brand formulary drugs, or a $20 copay per prescription unit or refill for non-formulary drugs.

Drugs are prescribed by Plan doctors and dispensed in accordance with our drug formulary.

Non-formulary drugs will be covered when prescribed by a Plan doctor subject to the $20 non-formulary copay. If you would like to obtain additional information about our formulary, please call Prudential HealthCare customer service at 1-800-856-0764 or visit our website at www.aetnaushc.com/pruhealthcare.

Formulary development:

Our 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 committee 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.

The following are examples of what a copay applies to:

- Up to a 30-day supply of tablets, capsules and liquids to be taken orally or as indicated for use by the Food and Drug Administration (FDA). For example, Diflucan VC is FDA

Section 5. Prescription Drug Benefits *continued*

Examples *continued*

indicated as a single-dose treatment and a copay will be charged for each tablet. The treatment usage for many antibiotics will be for a 10-day supply or less for which one copay would apply.
- a manufacturer's standard 10 milliliter vial of insulin;
- insulin syringes, a copay applies to each package of 100;
- a package of no more than 15 milliliters of any optic or opthalmic product;
- a manufacturer's smallest standard package of nasal or oral inhaler;
- a manufacturer's smallest standard package of nebulizer solution;
- 1 manufacturer's smallest standard package of liquid or solid rectal or vaginal medication
- 1 manufacturer's smallest standard package containing no more than 60 milliliters of topical solutions or lotions;
- 1 manufacturer's smallest standard package containing no more than 60 grams of topical ointments or creams;
- Up to a 30 day supply of patches, a copay applies to each manufacturer's standard package;
- 1 package of oral contraceptives
- 1 diaphragm unit

Covered medications and accessories include:

- Drugs for which a prescription is required by law;
- Oral contraceptives; up to a 90-day supply per refill of maintenance and oral contraceptive drugs may be obtained with a copay applied to each 30-day supply filled at the local participating pharmacy;
- Contraceptive devices, including diaphragms;
- Insulin with a copay charge applied to each vial;
- Disposable needles and syringes included with the insulin prescription
- Oral drugs prescribed for the treatment of infertility.

Diabetic supplies (except insulin), disposable needles and syringes needed for injecting medication other than insulin, intravenous fluids and medications for home use, implantable drugs (such as Norplant®), and injectable drugs (such as Depo Provera® and some fertility drugs) are covered under the Medical and Surgical Benefits.

Limited benefits

Sexual dysfunction drugs have dispensing limitations. For complete details, please call Prudential HealthCare customer service at 800-856-0764.

Smoking cessation aids:
Smoking cessation therapy that requires a prescription is covered, subject to the following limitations. You pay a $5 copay for each generic formulary supply and a $10 copay for each name brand formulary supply and a $20 copay for each non-formulary supply.

What is not covered

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

Section 5. Other Benefits

Dental care

Accidental injury benefit

Restorative services and supplies necessary to promptly repair or replace sound natural teeth are covered. Dental implants are not 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

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (which include the written lens prescription) for eyeglasses, glaucoma testing, dilation from Plan providers. You pay a $10 copay per visit.

What is not covered

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

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB program but 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; any charges for these services do no count toward any FEHB deductibles or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedures.

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

Dental Program

The Dental Program is a comprehensive dental plan with no claims form or deductibles. It is not insurance; it's a discount dental program, with more than 10,000 participating dentists across the country. These dentists have agreed to provide services to program participants at reduced rates - including periodic exams, cleanings...even orthodontia care.

For as little as $5.00 per month ($6.00 for families), you will have access to a full range of dental services at a substantial discount. You can enroll by submitting a completed application and a full year's premium, $60.00 for an individual and $72.00 for a family, by the open season deadline. (Please note, this is not a payroll deducted plan.) Applications and more details about the Dental Program are included in your Prudential HealthCare open enrollment packet.You may contact Benefit Network Systems at 1-800-391-9721 for more information.

Vision Program

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

Medicare Prepaid Plan Enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 18, annuitants and former spouses with the FEHBP coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 1-800-772-3496 in the Houston area or 1-800-781-7952 in the San Antonio area for information on the Medicare prepaid plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 1-800-772-3496 in the Houston area or 1-800-781-7952 in the San Antonio area for information on benefits available under the Medicare HMO.

Benefits on this page are not part of the FEHB contract

Section 6. General exclusions - Things we don't cover

The exclusions in this section apply to all benefits. Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness or condition.

We do not cover the following:

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Experimental or investigational procedures, treatments, drugs or devices;
- 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;
- Procedures, services, drugs and supplies related to sex transformations;
- Services or supplies you receive from a provider or facility barred from the FEHB Program; and
- Expenses you incurred while you were not enrolled in this Plan.

Section 7. Limitations - Rules that affect your benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800/638-6833.). For information on the Medicare + Choice plan offered by this Plan, see page 17.

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

Circumstances beyond our control

Under certain extraordinary circumstances, we may have to delay your services or be unable to provide them. In that case, we will make all reasonable efforts to provide you with necessary care.

Section 7. Limitations - Rules that affect your benefits *continued*

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. We will cover the cost of treatment that exceeds the amount you received in the settlement. If you do not seek damages, you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

TRICARE

TRICARE is the health care program for members, eligible dependents, and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we are the primary payer. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits.

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

We do not cover services and supplies that a local, State, or Federal Government agency directly or indirectly pays for.

Section 8. FEHB FACTS

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov) lists the specific types of information that we must make available to you.

If you want specific information about us, call 800/856-0764, or write to Prudential Healthcare, 1425 Union Meeting Road, P.O.Box 3013, Blue Bell, PA 19422. You may also contact us by fax at 215/775-5870, or visit our website at www.aetnaushc.com/pruhealthcare.

Where do I get information about enrolling in the FEHB Program?

Your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans and other materials you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- The next Open Season for enrollment.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

When are my benefits and premiums effective?

The benefits in this brochure are effective on January 1. If you are new to this plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin January 1.

What happens when I retire?

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage, which is described later in this section.

Section 8. FEHB FACTS *continued*

What types of coverage are available for my family and me?

Self-Only coverage is for you alone. *Self and Family* coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth or add a child to your family. You may change your enrollment 31 days before to 60 days after you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

Your employing or retirement office will not notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in another FEHB plan.

Are my medical and claims records confidential?

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract,
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions,
- OPM and the General Accounting Office when conducting audits,
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

We will not refuse to cover the treatment of a condition that you or a family member had before you enrolled in this Plan solely because you had the condition before you enrolled.

When you lose benefits

What happens if my enrollment in this Plan ends?

You will receive an additional 31 days of coverage, for no additional premium, when:
- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for former spouse coverage or Temporary Continuation of Coverage.

What is former spouse coverage?

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get more information about your coverage choices.

What is TCC?

Temporary Continuation of Coverage (TCC). If you leave Federal service or if you lose coverage because you no longer qualify as a family member, you may be eligible for TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct. Get the RI 79-27, which describes TCC, and the RI 70-5, the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees from your employing or retirement office.

Section 8. FEHB FACTS *continued*

What is TCC?
continued

Key points about TCC:

•You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline.

How can I convert to individual coverage?

You may convert to an individual policy if:

- Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert.
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you if individual coverage is available. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will not notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

How can I get a Certificate of Group Health Plan Coverage?

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. You must arrange for the other coverage within 63 days of leaving this Plan. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health related conditions based on the information in the certificate.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may request a certificate from them, as well.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800/856-0764 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Notes

Notes

Summary of Benefits for Prudential HealthCare HMO® - 2000

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

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** nothing.	11
	Extended care	All necessary services, up to 100 days per condition. **You pay** nothing	11
	Serious Mental Illnesses	Diagnosis and treatment of Serious Mental Illnesses is covered up to 45 days of inpatient care per year. **You pay** nothing.	11
	Other Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. **You pay** nothing.	14
	Substance Abuse	Hospitalization necessary for diagnosis and treatment. **You pay** nothing	15
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 $10 copay per office visit; $10 per house call by a doctor	9
	Home health care	All necessary visits by nurses and health aides. **You pay** nothing	10
	Serious Mental illness	Diagnosis and treatment of Serious Mental Illness is covered up to 60 visits. **You pay** a $10 copay per visit	10
	Other Mental conditions	Up to 25 outpatient visits per year. **You pay** a $35 copay per visit	14
	Substance abuse	All necessary outpatient visits are covered. **You pay** a $10 copay per visit.	15
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. You pay a $75 copay to the hospital for each emergency room visit or a $10 urgent care provider office visit and any charges for services that are not covered by this Plan	13
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $5 copay per prescription unit or refill for a generic formulary drug and a $10 copay for a brand name formulary drug and a $20 copay for a non-formulary drug.	15
Dental care		Accidental injury benefit; **you pay** nothing. Preventive dental care; no current benefit	16
Vision care		One refraction annually. **You pay** a $10 copay per visit	16
Out-of-pocket maximum		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of 200 % of annual premiums for Self Only 200% of annual premiums per Self and Family enrollment per calendar year (including your premium and the Government's share), covered benefits will be provided at 100%. This copay maximum does not include charges for vision care or prescription drugs	5

2000 Rate Information for
Prudential HealthCare HMO®

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. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee, but not a member of a special postal employment class, refer to the category definitions in,"The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees," RI 70-2 to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	**Code**	**Gov't Share**	**Your Share**	**Gov't Share**	**Your Share**	**USPS Share**	**Your Share**	**USPS Share**	**Your Share**
San Antonio Area									
Self Only	**VX1**	**$64.78**	**$21.59**	**$140.36**	**$46.78**	**$76.65**	**$9.72**	**$76.65**	**$9.72**
Self and Family	**VX2**	**$168.29**	**$56.09**	**$364.62**	**$121.54**	**$199.14**	**$25.24**	**$199.14**	**$25.24**
Houston Area									
Self Only	**UP1**	**$65.61**	**$21.87**	**$142.16**	**$47.38**	**$77.64**	**$9.84**	**$77.64**	**$9.84**
Self and Family	**UP2**	**$175.97**	**$78.26**	**$381.27**	**$169.56**	**$207.74**	**$46.49**	**$201.02**	**$53.21**

RRD # 8104860