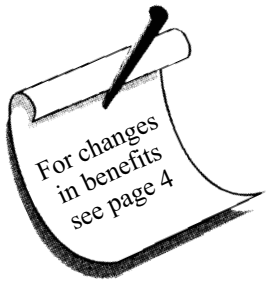
PacifiCare®

PacifiCare of Colorado, Inc. 2000 Health Plan

A Health Maintenance Organization



Serving: The Front Range of Colorado

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

Enrollment code:

High Option

D61 Self Only
D62 Self and Family

Standard Option
D64 Self Only
D65 Self and Family

For Commercial/Medicare
HMO and POS products

Visit the OPM website at http://www.opm.gov/insure
and
our website at http:// www.pacificare.com/colorado

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UNITED STATES OFFICE OF
PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE

Federal Employees
Health Benefits Program

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Introduction

PacifiCare of Colorado
6455 South Yosemite Street, Englewood, CO 80111

This Brochure describes the benefits you can receive from PacifiCare of Colorado, Inc. under its contract (CS 1761) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Heath 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 4. 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 PacifiCare of Colorado 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 rewritten 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 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 preventive 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 premiums 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

The prescription drug benefit now has 3 levels of formulary/non-formulary copayments: $5, $10, $20 for **High Option,** and $10, $20, $30 for **Standard Option**. Prior-authorization is no longer required.

Insulin pumps and insulin pump supplies are now covered under the durable medical equipment benefit.

The entire dental copayment list is now shown.

Your share of the standard option premium will increase by 10% for Self Only or 10% for Self and Family.

Your share of the high option premium will increase by 12% for Self Only or 12% for Self and Family.

Section 3. How to get benefits

What is this Plan's service area?

To enroll with us, you must live in our service area. This is where our providers practice. Our service area is:

The Colorado counties of Adams, Arapahoe, Bent, Boulder, Cheyenne, Clear Creek, Crowley, Denver, Douglas, Elbert, El Paso, Fremont, Gilpin, Grand, Huerfano, Jefferson, Kiowa, Kit Carson, Lake, La Plata, Larimer, Lincoln, Logan, Morgan, Otero, Park, Phillips, Pueblo, Sedgwick, Summit, Teller, Washington, Weld and Yuma.

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 lives 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 either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services.

After you pay $3,600 in copayments or coinsurance for one family member or $10,000 for two or more family members, you do not have to make any further payments for certain services for the rest of the

How much do I pay for services? *continued*

year. This is called a catastrophic limit. However, copayments or coinsurance for your prescription drugs, dental services and non-authorized/non-referred services do not count toward these limits and you must continue to make these payments.

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?

PacifiCare of Colorado, Inc. is a Mixed Model HMO, which means that we contract both with physicians who are in private practice in their own offices throughout the 34-county service area, as well as participating medical groups practicing in conveniently located group practice centers. There are approximately 1,450 primary care physicians (PCPs) and over 2,600 referral specialists participating with PacifiCare of Colorado. Each member can select his or her own primary care doctor.

Our participating physicians are organized into Integrated Care Teams – groups of PCPs and specialists who have joined together to contract with PacifiCare. PCPs belong to just one Integrated Care Team, but many specialists belong to more than one team. When you need specialty care, your PCP will most likely refer you to a specialist affiliated with the PCP's own Integrated Care Team. However, your PCP does have the option to refer you to any participating PacifiCare specialist when he or she determines it is appropriate.

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

Call us. 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 800/877-9777. 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 apply only to the person who is hospitalized.

How do I get specialty care?

Your primary care physician will arrange your referral to a specialist. However, you may see a participating primary care dentist without a referral, access your mental health and substance abuse benefits without a referral by contacting PacifiCare Behavioral Health at 888/777-2735, and access participating OB/GYNs without a referral for anything that is obstetrical or gynecological in nature. A member may also use their eye refraction benefit without a referral, by contacting VSP at 888/426-4877.

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 (the physician may have to get an authorization or approval beforehand).

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 he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, or the physician medical group (Integrated Care Team) within which your PCP works, 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 able to continue seeing your provider for up to 90 days after we notify you that we are terminating the 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 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?

Our National and Regional Medical Committees determine whether or not treatments, procedures and drugs are no longer considered experimental or investigational. Our determinations are based on the safety and efficacy of new medical procedures, technologies, devices and drugs.

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

If we deny your 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.

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.

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

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

Call us at 800/877-9777 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 IV at (202) 606-0737 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 did not answer your question 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.

What address should I send my disputed claim to?

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division IV, 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.

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

What laws apply if I file a lawsuit? *continued*

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.

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 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

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits.

High Option – You pay a $10 copay per office visit; $10 copay for a doctor's house call; no copay for home visits by nurses and therapists.

Standard Option – You pay a $15 copay per office visit; a $100 copay for outpatient surgery and 23-hour observation; $15 copay for a doctor's house call; no copay for home visits by nurses and therapists.

The following services are included:

- Preventive care, including well-baby/well-child care and periodic check-ups
- Mammograms are covered as follows: for women age 35 through 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 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 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; family planning services; Norplant, a surgically implanted contraceptive; Injectable contraceptive drugs; and Intrauterine Devices (IUDs)
- Diagnosis and treatment of diseases of the eye
- The insertion of internal prosthetic devices, such as pacemakers, lenses following cataract removal, cochlear implants, surgically implanted breast prostheses following mastectomy, and artificial joints.
- Cornea, heart, heart/lung, 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, testicular, mediastinal, retroperitoneal and ovarian germ cell tumors, breast cancer, multiple myeloma and epithelial ovarian cancer.

What is covered
continued

Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Related medical and hospital expenses of the donor are covered.

- 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
- Blood and blood plasma
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity based on criteria established by the Plan
- Home health services of nurses and therapists, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need. Mothers with newborns released from the hospital in accordance with PacifiCare of Colorado guidelines are entitled to one visit at home by a nurse, as well as the services of a homemaker for four hours on two days within 30 days following delivery.
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers.

Limited benefits

Allergy testing and treatment are provided. **You pay** $10 copay (**High Option**) or $15 copay (**Standard Option**) for a comprehensive diagnostic allergy evaluation. In addition, **you pay** a $10 copay (**High Option**) or $15 copay (**Standard Option**) for each doctor's office visit, or **you pay** $5 per visit for an injection when a physician is not seen.

Durable medical equipment, limited to apnea monitors, bilirubin lights or blankets, bone stimulators, continuous passive motion machines (CPM), feeding pumps, hospital beds, insulin pump supplies (including cartridges, extension tubing, batteries, infusion sets, and customary dressings provided by the pump supplier to secure infusion sets), lymphedema pumps, nebulizers, positive airway pressure devices (C-PAP) (Bi-PAP), suction machines, traction equipment, ventilators, external extremity prosthetics or oxygen is covered up to $1,500 per member per calendar year when the use of the equipment will permit care in other than an acute care or rehab facility. Additionally, **surgical bras**, including external prosthesis, will be covered up to $250 per member per contract year. **Orthopedic braces**, and podiatric shoe inserts meeting criteria are covered up to a combined maximum of $500 per member per calendar year. Coverage is provided for one **peak flow meter** per member per lifetime and one glucometer per member per lifetime. Coverage is also provided for **insulin pumps** meeting criteria, not subject to the $1,500 maximum described above. **You pay** nothing.

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 treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Reconstructive surgery will be provided to correct a condition that has resulted in a functional defect or that has resulted from an injury or surgery that has produced a major effect on the member's appearance and 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 symmetrical appearance.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis; outpatient therapy is limited to whichever is greater, 20 visits or two months per condition, if significant improvement can be expected within two months. **You pay** nothing for inpatient or home therapy; **you pay** a $10 copay (**High Option**) or a $15 copay (**Standard Option**) per outpatient session. Speech therapy is limited to care required immediately following an acute episode

Section 5 — Medical and Surgical Benefits *continued*

Limited benefits *continued*

for stroke, surgery to the larynx, accidental brain injury (not birth related), and hearing loss in 3-5 year old children, based on criteria. 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, as well as **artificial insemination**, are covered; **you pay** a 50% copay; cost of donor sperm is not covered. The following types of artificial insemination are covered: intravaginal insemination (IVI); intracervical insemination (ICI) and intrauterine insemination (IUI). Fertility drugs are not covered. Other **assisted reproductive technology (ART) procedures**, such as in vitro fertilization and embryo transfer, are not covered.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided at an approved facility for short-term follow-up care up to 90 sessions; **you pay** nothing.

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
- Blood derivatives not replaced by member
- Hearing aids
- Long-term rehabilitative therapy
- Chiropractic services
- Homemaker services, except for mothers with newborns, and services of home health aides
- Obesity treatment, except for surgical treatment of morbid obesity
- Premenstrual (PMS), lactation, headache, eating disorder and other educational clinics
- Foot orthotics, except as covered under Durable medical equipment
- Total Parenteral Nutrition (TPN)

Section 5 — 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.

High Option – You pay nothing.

Standard Option – You pay a $300 deductible per person per year, $500 maximum per family per year.

All necessary services are covered, including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units

Extended care

The Plan provides a comprehensive range of benefits for up to 120 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. **You pay** nothing for up to 120 days per year, all charges thereafter. **All necessary services are covered,** including:

Section 5 — Hospital/Extended Care Benefits *continued*

Extended care *continued*

- 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.

Subacute care facility services following hospitalization, including accommodations, meals, general nursing care, medical supplies and equipment ordinarily furnished by the facility and prescribed drugs and biologicals are covered up to sixty (60) days per contract year at an approved subacute care facility.

Hospice Care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility when approved by the PacifiCare of Colorado Medical Director. Services include inpatient and outpatient care and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance service

Benefits are provided for air and ground ambulance transportation ordered or authorized by a Plan doctor; **you pay** a $25 copay per trip.

Limited benefits

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 or treatment in a Plan rehab facility (either inpatient or outpatient) is not medically appropriate. If treated in a Plan rehab facility for detoxification, **you pay** nothing (**High Option**); **you pay** $100 (**Standard Option**). See pages 13 and 14 for nonmedical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Blood not replaced by member
- Custodial care, rest cures, domiciliary or convalescent care
- Hospitalization for any dental procedures

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

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 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. If you cannot reach your primary care doctor (or his/her coverage) call PacifiCare at 800/877-6685 for assistance. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member **must** notify the Plan within 48 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

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

Section 5 — Emergency Benefits *continued*

Emergencies within the service area

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.

Plan pays . . .

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers or per urgent care center visit where a facility charge is made.

You pay . . .

A $25 copay per physician office visit, or per urgent care center visit where no facility charge is made, or a $50 copay per hospital emergency room visit or per urgent care center visit where a facility charge is made, for emergency care services that are covered benefits of this Plan. If the emergency results in an admission to a hospital, the copay is waived. **Standard Option** members also pay a $300 deductible per person per contract year (up to a maximum of $500 per family per year).

Emergencies outside the service area

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

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

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

Plan pays . . .

Reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers. In addition to coverage of emergency services, follow-up care to emergency services received outside the service area or urgently needed services are covered up to a maximum PacifiCare of Colorado payment of $400 per person per calendar year.

You pay . . .

A $25 copay per physician office visit, or per urgent care center visit where no facility charge is made, or a $50 copay per hospital emergency room visit or per urgent care center visit where a facility charge is made, for emergency care services that are covered benefits of this Plan. If the emergency results in an admission to a hospital, the emergency care copay is waived. **Standard Option** members also pay a $300 deductible per person per contract year (up to a maximum of $500 per family per year) for any inpatient services.

What is covered

- Emergency or urgent care at a doctor's office or at an urgent care center, including follow-up care to emergency services received outside the service area
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ground or air ambulance service approved by the Plan; **you pay** a $25 copayment

What is not covered

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

Filing claims for non-Plan providers

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

Section 5 — Emergency Benefits *continued*

Filing claims for non-Plan providers *continued*

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 pages 6, 7 and 8.

Section 5 — 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)

No primary care physician referral is necessary to access mental health and substance abuse services. To access these benefits, call PacifiCare Behavioral Health at 888/777-2735.

The following six conditions will be covered as medical, rather than mental health: schizophrenia, schizoaffective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder and panic disorder.

Outpatient care

Visits are based on medical necessity with no pre-determined limit on the number of visits allowed. **You pay** a $25 copayment per visit.

Inpatient care

Coverage of inpatient days will be based on medical necessity with no pre-determined limit on the number of days allowed.

High Option – You pay nothing.

Standard Option – You pay a $300 deductible per person per year (up to a maximum of $500 per family per year) for any inpatient services.

What is not covered

- Care for psychiatric conditions that in the professional judgment of Plan providers 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 provider 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

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

Outpatient care

Up to 90 outpatient visits each calendar year for treatment at a rehab center approved by the Plan; **you pay** nothing for up to 90 visits – all charges thereafter.

The substance abuse benefit may be combined with the outpatient mental conditions benefit shown above, provided such treatment is necessary as a mental health service and is approved by the Plan, to permit additional outpatient visits subject to the applicable mental conditions benefit copayments.

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

Substance abuse *continued*

Inpatient care

Up to 45 days of substance abuse rehabilitation (intermediate care) programs each calendar year in a rehab center approved by the Plan; **you pay** nothing during the benefit period – all charges thereafter.

Rehabilitation services are limited to one course of treatment, either inpatient or outpatient, per member per calendar year. There is a combined inpatient and outpatient lifetime maximum of two courses of treatment.

What is not covered

- Treatment that is not authorized by a Plan provider
- All charges if the member does not complete the treatment program
- Substance abuse treatment on court order or as a condition of parole or probation, unless determined by a Plan provider to be necessary and appropriate.

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 the manufacturer's standard trade-package size, not to exceed one pint (16 oz.) of liquid; 60 grams of ointment, creams or topical preparation; or one commercially prepared unit (i.e., one inhaler, one vial). 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. Prior-authorization is no longer needed, as there are now different copayments for formulary and non-formulary medications. Quantity limitations and benefit plan exclusions still apply.

The PacifiCare Formulary is a list of over 1600 prescription drugs that physicians use as a guide when prescribing medications for patients. The Formulary plays an important role in providing safe, effective and affordable prescription drugs to PacifiCare members. It also allows us to work together with physicians and pharmacies to ensure that our members are getting the drug therapy they need. A Pharmacy and Therapeutics Committee consisting of physicians and pharmacists evaluate prescription drugs based on safety, effectiveness, quality treatment and overall value. The committee considers first and foremost the safety and effectiveness of a medication before reviewing the cost.

Please Note: PacifiCare of Colorado does not coordinate benefits for outpatient prescription drugs.

High Option – You pay a $5 copayment for a generic prescription on the formulary, a $10 copayment for a brand name prescription on the formulary, or a $20 copayment for a covered prescription that is not on the formulary.

Standard Option – You pay a $10 copayment for a generic prescription on the formulary, a $20 copayment for a brand name prescription on the formulary, or a $30 copayment for a covered prescription that is not on the formulary.

Maintenance medications requiring a 90-day supply, or more, can be filled through a mail-order prescription drug program. You pay the copay that applies to your enrollment option for each 30-day supply. You pay 2 formulary copays per 90-day supply, or up to 4 pre-packaged units, for a formulary medication. You pay 3 non-formulary copays minus $15 for a 90-day supply, or up to 4 pre-packaged units, for a non-formulary medication. Contact PacifiCare of Colorado's Customer Service Department at 800/877-9777 for more information - and to receive a mail-order form.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Oral contraceptive drugs; contraceptive diaphragms; and cervical caps (subject to name brand drug copayments)
- Implanted time-release medications, such as Norplant and injectable contraceptive drugs are covered. Please see Medical and Surgical Benefits, "What is covered," on page 8.

Section 5 — Prescription Drug Benefits *continued*

What is covered *continued*

- Insulin, with a copay charge applied to every two vials. You can receive up to six vials of insulin through the mail-order program. **You pay** two copays for formulary insulin, or 3 non-formulary copays minus $15 for a non-formulary insulin.
- Injectable drugs (except insulin), when preauthorized; **you pay** a $10 copay per prescription unit or refill under both options
- Disposable needles and syringes needed to inject covered prescribed medication; needles and syringes dispensed in the manufacturer's standard trade-package will be subject to the name brand copayment.
- Intravenous fluids and medication for home use are covered under Medical and Surgical Benefits (covered under Home Health Services – see page 9)
- Commercially prepared progesterone and estrogen products that meet prior authorization requirements.

Limited Benefits

- Diabetic glucose and ketone test strips and lancets are covered and dispensed in the manufacturer's standard trade-size package. You pay the applicable copay per manufacturer's standard trade-size package unit, up to 100 test strips, or 200 lancets, per 30-day supply.
- Drugs to treat sexual dysfunction are covered when plan criteria is met. Contact the plan for dose limits. **You pay** 50% of the cost of the medication per prescription unit or refill up to the dosage limits and all charges above that.

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Contraceptive devices (except injectables, diaphragms, intrauterine devices (IUDs) and cervical caps)
- Smoking cessation drugs and medication, including nicotine patches, except through the StopSmoking program
- Drugs for weight reduction
- Lifestyle enhancement drugs, including but not limited to drugs to enhance hair growth, anti-aging and mental performance
- Fertility drugs
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Convenience packaged medications, including but not limited to, Insulin penfil and Questran individual packages

Section 5 — Other Benefits

Dental Care

This plan provides the following comprehensive program of dental coverage through participating Plan dentists. This listing represents a description of the benefits and exclusions. For more detailed information regarding covered services and claims related concerns, call PacifiCare Dental Customer Services at 800/228-3384.

Choosing your dentist

Please select a dentist, from the list of Dental Providers available in your area, for each member of your family. Your dental benefits and services are available only through the participating dentist you selected, except for out-of-area emergencies. However, you may change dentists by calling PacifiCare Dental Customer Services.

Dental Care *continued*

Receiving care

Member fees are due at the time of service.

NOTE: Your dentist may prescribe certain procedures not covered under your Plan benefit. Non-member fees will be charged for such services. Where UCR is shown, the procedure is not a covered benefit, and you pay the dentist's usual, customary and reasonable fee for that service.

Specialty care

If you receive care from a specialist, you pay a 50% member payment (High Option) and a 60% member payment (Standard Option) of the PacifiCare contracted specialists fee schedule.

PacifiCare Dental maintains a panel of qualified Dental Specialists to provide you with the treatment that is beyond the scope of the General Dentist. Once PacifiCare has reviewed and approved the recommended specialty referral, PacifiCare will coordinate the referral to the closest specialist in your area.

What is covered

The copayments due at your PacifiCare primary care dentists office are:

	High Option You Pay	Standard Option You Pay
Visits		
Office Visit, per visit charge in addition to procedure	$ 5	$ 5
(may be referred to as a "sterilization" charge in some offices)		
After hours visit, in addition to service provided	$ 30	$ 30
Missed appointment – without 24 hours notice (copay per each 30 minutes of appointment time)	$ 20	$ 20
Preventive		
Emergency treatment, palliative	$ 10	$ 10
Routine teeth cleaning, once every 6 months	$ 0	$ 10
Topical application to age 14	$ 0	$ 7
Oral Hygiene Instructions	$ 0	$ 0
Diagnostic (film allowance includes exam and diagnosis)		
Single film	$ 0	$ 4
Additional, up to 12 films	$ 0	$ 3
Full mouth series (including bite-wings, if necessary)	$ 0	$ 17
Intra-oral, occlusal view	$ 0	$ 4
Bite-wing films, 2 films	$ 0	$ 5
Bite-wing films, 4 films	$ 0	$ 9
Panographic-type film	$ 0	$ 20
Restorative Dentistry (fillings)		
Amalgam Restorations		
Primary teeth, 1 surface	$ 5	$ 16
Primary teeth, 2 surfaces	$ 8	$ 20
Primary teeth, 3 surfaces	$ 11	$ 25
Primary teeth, 4 or more surfaces	$ 13	$ 28
Permanent teeth, 1 surface	$ 6	$ 18
Permanent teeth, 2 surfaces	$ 9	$ 22
Permanent teeth, 3 surfaces	$ 12	$ 26
Permanent teeth, 4 or more surfaces	$ 14	$ 30
Composite Resins (tooth colored fillings, fee includes acid etching and/or bonding)		
1 Surface anterior	$ 12	$ 20
2 Surfaces anterior	$ 17	$ 28
3 Surfaces anterior	$ 22	$ 36
4 Surfaces anterior	$ 25	$ 42
Pin retention, per tooth (not including restoration)	$ 15	UCR
Sealants per tooth	$ 10	$ 10
Sedative base	$ 0	$ 10
Oral Surgery		
Extractions (fee includes local anesthesia and routine post-operative visits)		
Uncomplicated, single extraction	$ 7	$ 18
Each additional uncomplicated extraction	$ 7	$ 18

Dental Care *continued*

Oral Surgery *continued*		
Surgical removal of an erupted tooth	$ 12	$ 28
Removal of impacted tooth (soft tissue)	$ 50	$ 60
Removal of impacted tooth (partially bony)	$ 70	$ 85
Removal of impacted tooth (completely bony)	$ 90	$ 110
Other Procedures		
Post-operative visit, complications (i.e. osteitis)	$ 0	$ 0
Biopsy and microscopic examination	$ 20	UCR
Alveoloplasty (edentulous), per quadrant	$ 70	$ 85
Alveoloectomy per quadrant	$ 50	$ 65
Intra-oral incision and drainage of abscess (soft tissue)	$ 30	UCR
Frenectomy	$ 30	$ 45
Removal of exostosis (tori)	$ 50	UCR
Anesthesia		
Additional charges for general anesthetics, nitrous oxide, anesthetists or anesthesiologists are the responsibility of the patient.		
Local anesthesia	$ 0	$ 0
Periodontics		
Periodontal maintenance procedures (following active surgical and adjunctive periodontal therapies)	$ 40	$ 50
Scaling and root planing per quadrant	$ 40	$ 50
Full mouth debridement	$ 40	$ 50
Correction of occlusion per quadrant, minor spot grinding (equilibration not a covered benefit)	$ 18	$ 26
Gingivectomy per quadrant, includes post-surgical visits	$ 150	$ 175
Osseous or muco-gingival surgery per quadrant (includes post-surgical visits)	$ 275	$ 300
Gingivectomy treatment per tooth	$ 30	$ 35
Gingival flap procedures (includes RP) Quad	$ 135	UCR
Endodontics		
Direct pulp capping	$ 6	$ 12
Therapeutic pulpotomy (in addition to restoration) per treatment	$ 6	$ 20
Indirect pulp capping (recalcification), including temporary restoration	$ 10	$ 15
Root Canal Therapy		
Anterior RCT	$ 85	$ 110
Bicuspid RCT, 1-2 canals	$ 110	$ 160
Molar RCT, 1 canal	$ 85	$ 110
Molar RCT, 2 canals	$ 110	$ 160
Molar RCT, 3 canals	$ 165	$ 220
Molar RCT, 4 canals	$ 185	$ 250
Apicoectomy and/or retrograde therapy-per tooth	$ 160	$ 180
Apicoectomy, separate procedure, per tooth	$ 100	$ 120
Hemisection, root amputation	$ 60	UCR
Crown and Bridge		
Crowns*		
Plastic, permanent, processed	$ 80	$ 120
Porcelain jacket	$ 200	$ 260
Porcelain with metal	$ 200	$ 260
Full cast metal	$ 190	$ 240
3/4 metal	$ 190	$ 240
Crown build up, extensive amalgam/composite, including pins	$ 45	UCR
Stainless steel, primary	$ 40	$ 50
Stainless steel, permanent	$ 40	$ 50
Preformed post and build up	$ 45	UCR
Cast post with core or coping	$ 75	UCR
Crown recementation (or inlay)	$ 10	$ 15
Bridge recementation	$ 15	$ 20
Pontics* (artificial tooth on a fixed bridge)		
Cast, metal	$ 190	$ 240
Porcelain with metal	$ 200	$ 260

Dental Care *continued*

What is covered *continued*

Prosthetics (removable)**

Dentures*

Dentures, partial dentures and reline allowances include adjustments for a 90-day period following installation. Fees for specialized techniques involving precision dentures, personalization or characterization are in addition to those listed.

Complete upper or lower denture	$ 240	$ 300
Immediate upper or lower denture	$ 260	$ 320
Partial acrylic upper or lower base (teeth/clasps extra)	$ 80	$ 100
Partial, upper or lower with chrome cobalt alloy palatal or lingual bar and acrylic saddles (teeth/clasps extra)	$ 295	$ 350
Unilateral partial base	$ 80	$ 100
Anterior stayplate base/temporary	$ 60	$ 75
Teeth and clasps extra per unit (for partials, stayplates, etc.)	$ 10	$ 15
Denture/partial adjustment	$ 10	$ 15
Office reline, cold cure acrylic	$ 45	$ 85
Denture reline, laboratory	$ 75	$ 110
Tissue conditioning, per denture	$ 15	UCR
Denture duplication (jump case), per denture	$ 80	$ 110
Simple stress breakers	$ 25	$ 30
Repairs*		
Denture/partial resin base (no teeth involved)	$ 30	$ 40
Replace missing or broken teeth, each	$ 20	$ 25
Replace missing or broken clasp, each	$ 30	$ 35
Space Maintainers		
Removable, plastic	$ 40	$ 50
Fixed, unilateral band type	$ 40	$ 50
Fixed, stainless steel crown type	$ 40	$ 50
Fixed, lingual, palatal bar type or bilateral	$ 40	$ 50

*Where precious metal is used, additional copayment will be required.

**Additional fees will be required for laboratory services for removable prosthetics, not to exceed $80.

Emergency benefit outside the service area

Coverage is limited to palliative treatment of infection and pain. Definitive treatment is not covered. The out-of-area coverage reimburses the usual and customary fee up to a maximum of $50 per occurrence. PacifiCare must be notified within 30 days.

In-Area emergency

In emergency situations, PacifiCare Dental primary care dentists shall furnish such care as needed immediately or, if appropriate, not more than 24 hours after the request. Dental emergencies are defined as conditions where hemorrhage, acute pain or infection of dental origin exists.

During Normal Business Hours: Contact your primary care dental office. If you are unable to contact your primary care dental office, please call PacifiCare Dental at 800/228-3384 and a Dental Customer Services Representative will assist you.

After Normal Business Hours: Contact your primary care dental office. If you are unable to contact your primary care dental office, you may seek emergency care only at any licensed dental office. PacifiCare Dental will reimburse you up to $50.

For emergency care requiring an after-hours appointment, you may be assessed a $30/visit charge in addition to any copayment.

Out-of-Area emergency

Out-of-area emergencies are covered as follows: if the member develops a condition or sustains an injury while temporarily outside of the PacifiCare of Colorado service area, the need for such care was not reasonably foreseeable, and it is not feasible for the member to call PacifiCare and present him/herself to a PacifiCare dentist.

Reimbursement for emergencies

Claims for emergency benefits should be filed with PacifiCare Dental Services, P.O. Box 483, Tustin, CA 92781 within 30 days after the emergency care, and must provide sufficient information to verify entitlement to payment. Include:

- covered member's name and ID number
- dentist's name

Dental Care *continued*

Reimbursement for emergencies *continued*

- nature of problem
- date of treatment
- treatment given
- itemized charges
- copy of receipt

What is not covered

- Care by non-Plan dentists except for authorized referrals or emergencies
- Cosmetic dental care
- Hospital and medical charges of any kind, including dental services rendered in a hospital
- General anesthesia, including intravenous or inhalation sedation, except when medically necessary for extractions only
- Loss or theft of dentures, appliances or bridgework
- Dental treatment started prior to the member's eligibility to receive benefits under this Plan or started after the member's termination.
- Other dental services not shown as covered.

Orthodontics

Through a PacifiCare panel Orthodontist, plan members are eligible to receive up to a 2-year orthodontic treatment provided by a PacifiCare contracted provider. **You pay** orthodontic charges of $1950 for members under 19 years of age, and $2200 for members 19 years or older, plus $300 start-up fees, $250 retention fees and X-ray costs.

What is covered

- Comprehensive orthodontic care at a panel orthodontic office for a usual and customary 24 month treatment plan.
- The "start-up" services shall include initial examination, study models, diagnosis, consultation and placement of orthodontic appliances (braces).
- The "retention" services may include impressions for post-treatment retainers, placement of retainers, retainer adjustments, and post-treatment supervision as needed. The normal "retention" fee is $250 and shall not exceed this amount. This amount is limited to the customary 24 month retention phase.
- The orthodontist has agreed that any course of orthodontic treatment initiated under this plan shall be completed, at the election of the member, under the terms, conditions, and fees provided herein, should the member become ineligible as a Plan member prior to completion of orthodontic treatment.
- A qualified member with cleft lip/palate is not subject to the limits of this Plan and the benefit for the services of a specialist shall apply as stated at the beginning of the dental benefit description.
- Administrative Fee: If you do not keep an appointment and fail to notify the provider office of cancellation 24 hours in advance, you may be assessed a service charge.

Limitations

- Orthodontic treatment must be provided by a member of the PacifiCare orthodontic panel.
- Cases that are other than "basic and usual" may require additional charges.
- If a member does not require treatment or elects not to have treatment, after the doctor has completed a diagnosis and consultation, the patient may be charged a consultation fee of $85.

Orthodontics *continued*

What is not covered

- X-ray fees (orthodontic).
- Start-up and retention as described under Orthodontic Benefits.
- Lost, stolen or broken appliances.
- Procedures not listed or procedures required in addition to basic, usual and customary orthodontic services including palatal expansion devices, functional appliances and myofunctional therapy.
- Work in progress (i.e. cases banded prior to inception of eligibility).
- Orthodontic emergencies or changes in treatment necessitated by accidents of any kind, adverse growth patterns or poor patient cooperation.
- Orthodontic treatment and/or surgical procedures for skeletal abnormalities such as micrognathia, facial asymmetrical and facial deformities.
- Treatment related to temporomandibular joint disorders.
- Any procedures considered within the field of general dentistry and those not usually performed in the orthodontic office.
- Severe or mutilated malocclusions that are not amiable to ideal orthodontic therapy.
- Orthodontic treatment of impacted teeth requiring surgical exposure.
- Cosmetic braces (plastic, ceramic, sapphire, lingual, etc.).

Vision Care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, eye refractions (to provide a written lens prescription) may be obtained every 24 months from Plan providers. You may go directly to a participating VSP case manager without a PCP referral or authorization from VSP. For a list of participating providers call VSP at 888/426-4877. **You pay** a $10 copay (**High Option**) or a $15 copay (**Standard Option**) per refraction.

What is not covered

- Corrective lenses or frames
- Eye exercises
- Radial keratotomy and Excimer Laser Surgery

Smoking Cessation Clinics

What is covered

PacifiCare of Colorado is pleased to offer StopSmoking – a one-year self-directed, self-paced smoking cessation program – to our members. The StopSmoking program includes regularly scheduled motivational phone calls with a trained smoking cessation specialist, and a StopSmoking kit complete with video and audio tapes and brochures to guide smokers to quit. There is a one-time charge of $20 for enrollment in the StopSmoking program.

After enrollment in the program, a letter is sent to your PCP to inform him or her of your participation. Additionally, with a prescription from your PCP, Federal members in the StopSmoking program have coverage for two smoking cessation aid products: Habitrol, a transdermal patch used in nicotine replacement therapy, or Zyban, a prescription drug that has been shown effective in reducing the urge to smoke. Up to a 30-day supply of any dosage will be covered for a $20 copayment. Coverage of these aids is available for up to 90 days per year, limited to 3 years per lifetime.

To enroll in the StopSmoking program, or for more information, please call 800/513-5131.

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 this Plan. The cost of the benefits described on this page is not included in the FEHB premium; any charges for these services do not count toward any FEHB deductibles, out-of-pocket maximum copay charges, etc. These benefits are not subject to the FEHB disputed claims procedures.

Medicare prepaid plan enrollment – This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 22, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later 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.

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 800/771-4347 for information on the benefits available under the Medicare HMO.

Secure Horizons, offered by PacifiCare, is a health care management program for Medicare-eligible enrollees. In the State of Colorado, over 70,000 seniors are currently covered. These enrollees live within our approved Medicare Service area, which includes the counties of Adams, Arapahoe, Boulder, Crowley, Denver, Douglas, El Paso, Fremont, Huerfano, Jefferson, Larimer, Otero, Pueblo, Teller and Weld.

For individuals with Medicare Parts A and B, the Secure Horizons product ranges from no premium to $35 per member per month. These low premiums are possible because we are administering Medicare benefits in a defined service area with a select group of physicians, hospitals and ancillary providers. The range in your actual cost is dependent upon the county in which you reside.

Outside of the low monthly premium, some of the other Secure Horizons highlights are:

- No deductibles
- Coverage for preventive care: eye exams, hearing exams, mammograms, and physical examinations
- Hospitalization covered in full
- Low, predictable copayments
- Coverage for outpatient prescription medications
- Coverage for basic dental procedures
- Health education and risk appraisals
- No paperwork
- Coverage for eyewear (prescription glasses or contacts)

Contact us at 800/771-4347 for information on the Medicare prepaid plan and the cost of that enrollment.

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 the 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 800/638-6833. For information on the Medicare+Choice plan offered by this Plan, see page 21.

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.

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

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.

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 800/877-9777, or write to 6455 South Yosemite Street, Englewood, Colorado 80111. You may also contact us by fax at 303/714-3977 or visit our website at www.pacificare.com/colorado.

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 on 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.

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,
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims,
- 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.

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.

Section 8. FEHB Facts *continued*

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 800/877-9777 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, DC 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.

Summary of Benefits for PacifiCare of Colorado — 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	High Option pays/provides	Page	Standard Option 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.	10	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** a $300 deductible per member (a maximum of $500 per family) per year.	10
Extended Care	All necessary services for up to 120 days per year. **You pay** nothing.	10	All necessary services for up to 120 days per year. **You pay** nothing.	10
Mental Conditions	Diagnosis and treatment of acute psychiatric conditions. **You pay** nothing	13	Diagnosis and treatment of acute psychiatric conditions. **You pay** a $300 deductible per member (maximum of $500 per family) per year.	13
Substance Abuse	Up to 45 days per year in a substance abuse treatment program. **You pay** nothing	14	Up to 45 days per year in a substance abuse treatment program. **You pay** nothing.	14
Outpatient care	Comprehensive range of services, such as diagnosis and treatment of illness or injury, including specialist's care, preventive care, including well-baby/well-child care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** a $10 copay per office visit and for house calls by a doctor.	8	Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care, preventive care, including well-baby/well-child care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** a $15 copay per office visit and for house calls by a doctor; a $100 copay for outpatient surgery and 23-hour observation.	8
Home Health Care	All necessary visits by nurses and therapists. **You pay** nothing.	9	All necessary visits by nurses and therapists. **You pay** nothing.	9
Mental Conditions	Number of visits is based on medical necessity. **You pay** a $25 copay per visit.	13	Number of visits is based on medical necessity. **You pay** a $25 copay per visit.	13
Substance Abuse	Up to 90 outpatient visits per year. **You pay** nothing.	13	Up to 90 outpatient visits per year. **You pay** nothing.	13
Emergency care	Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $50 copay to the hospital for each emergency room visit and any charges for services which are not covered by this Plan.	11	Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $50 copay to the hospital for each emergency room visit and any charges for services which are not covered by this Plan.	11
Prescription drugs	Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** up to a $5 copay per prescription unit or refill for generic drugs on the formulary, a $10 copay for name brand drugs on the formulary, and a $20 copay for covered non-formulary drugs; a $10 copayment for injectables (except insulin). Maintenance medications can be filled through mail-order program.	14	Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** up to a $10 copay per prescription unit or refill for generic drugs on the formulary, a $20 copay for name brand drugs on the formulary, and a $30 copay for covered non-formulary drugs; a $10 copayment for injectables (except insulin). Maintenance medications can be filled through mail-order program	14
Dental care	Preventive dental care and comprehensive range of restorative, orthodontic, and other services. **You pay** copays for most services.	15	Preventive dental care and comprehensive range of restorative, orthodontic, and other services. **You pay** copays for most services.	15
Vision care	One refraction every 24 months. **You pay** a $10 copay per refraction.	20	One refraction every 24 months. **You pay** a $15 copay per refraction.	20
Out-of-pocket maximum	Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $3,600 per Self Only or $10,000 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include prescription drugs or dental services.	4	Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $3,600 per Self Only or $10,000 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include prescription drugs or dental services.	4

2000 Rate Information for
PacifiCare of Colorado, 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 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
Denver/Pueblo/Col.Springs/FtCollins/LaPlata									
High Option Self Only	**D61**	**$65.65**	**$21.88**	**$142.24**	**$47.41**	**$77.68**	**$9.85**	**$77.68**	**$9.85**
High Option Self and Family	**D62**	**$169.86**	**$56.62**	**$368.03**	**$122.68**	**$201.00**	**$25.48**	**$201.00**	**$25.48**
Denver/Pueblo/Col.Springs/FtCollins/LaPlata									
Standard Option Self Only	**D64**	**$51.32**	**$17.11**	**$111.20**	**$37.07**	**$60.73**	**$7.70**	**$60.73**	**$7.70**
Standard Option Self and Family	**D65**	**$133.00**	**$44.33**	**$288.17**	**$96.05**	**$157.38**	**$19.95**	**$157.38**	**$19.95**