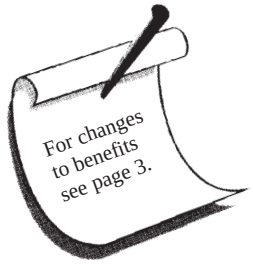
PacifiCare® of California

PacifiCare® of California 2000

A Health Maintenance Organization



Serving: Northern and Southern California

Enrollment code:
CY1 Self Only
CY2 Self and Family

See the FEHB Guide
for more information on NCQA.

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

Visit the OPM website at http://www.opm.gov/insure
and
this Plan's website at http://www.pacificare.com

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United States Office of Personnel Management Retirement and Insurance

Federal Employees Health Benefits Program

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Table of Contents

Introduction

This Brochure describes the benefits you can receive from PacifiCare California Health Maintenance Organization (HMO) under its contract (CS 1937) 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 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 shorter sentences.

We refer to PacifiCare California 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 HMO's 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 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 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 listed in this brochure. When you receive emergency services you may have to submit claim forms.

You should join an HMO because you enjoy 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 copayment 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 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

- Your share of the premium will increase by 4.1% for Self Only or will decrease by 0.3% for Self and Family
- Woman may receive self-referred gynecological care directly from a participating OB/GYN or Family Practitioner within the selected primary medical group.
- The reconstructive surgery benefit now covers disfiguring congenital defects or developmental abnormalities for which surgical repair leads to improvement of the defect and/or appearance of the member.
- Cardiac rehabilitation immediately following a heart transplant, bypass surgery or a myocardial infarction is provided with no day limit for a $10 copayment per visit.
- Chiropractic services from a participating chiropractor are covered up to 20 visits per calendar year for a $5 copayment per visit.
- General anesthesia for certain dental procedures is covered for members under age 7 or developmentally disabled.
- The maintenance medication quantity is decreased to a 30-day supply for one copayment when purchased at the pharmacy.
- If you request a name brand drug, **you pay** the $5 copayment plus the difference between the cost of the brand name drug and the generic per prescription unit or refill.
- Smoking cessation drugs and medication, including nicotine patches, are covered if the member participates in the Stop Smoking program with a $20 copayment for 30-day supply.
- Effective January 1, 2000, the Plan will no longer provide service for the following counties: Amador, Colusa, Glenn, Humbolt, Lake, Mendocino, Monterey, Nevada, Sutter, Tehama and Yuba.

Section 3 — How to get benefits

What is this Plan's service area?

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

The California counties of Alameda, Butte, Contra Costa, Fresno, Kern, Kings, Los Angeles (except Catalina Island), Madera, Marin, Mariposa, Merced, Napa, Orange, Sacramento, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Ventura, Yolo, and portions of the following counties as defined by zip codes:

El Dorado: 95613, 95614, 95619, 95623, 95633-36, 95643, 95651, 95656, 95664, 95667, 95672, 95682, 95684, 95709, 95726

Imperial: 92227, 92231-33, 92243-44, 92249, 93350, 92251, 92257, 92259, 92273, 92281

Placer: 95602-04, 95626, 95631, 95648, 95650, 95658, 95661, 95663, 95668, 95677, 95678, 95681, 95703, 95713, 95717, 95722, 95736, 95746, 95747, 95765

Riverside: 91718-20, 91752, 91760, 92201-03, 92210, 92211, 92220, 92223, 92225, 92226, 92230, 92234-36, 92239-41, 92253-55, 92258, 92260-64, 92270, 92272, 92274-76, 92282, 92292, 92302-03, 92313, 92320, 92330-31, 92343, 92344, 92348, 92353, 92355, 92360, 92362, 92367, 92369, 92370, 92379, 92380-81, 92383, 92387, 92388, 92390, 92395, 92396, 92500-99

San Bernardino: 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-59, 91761-64, 91784, 91785- 8I6, 92252, 92256, 92277, 92278, 92284, 92285, 92286, 92301, 92305, 92307-08, 92310-18, 92321, 92322, 92324-27, 92329, 92333-37, 92339-42, 92345-47, 92350, 92352, 92354, 92356-59, 92365, 92368, 92369, 92371-78, 92382, 92385, 92386, 92391-94, 92397-99, 92400-99

San Luis Obispo: 90031, 90032, 93401-93412, 93420-93424, 93426, 93428, 93430, 93432, 93433, 93435, 93442-49, 93451-53, 93461, 93465, 93483

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 dependent 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 share the cost of some services. This is called a copayment (a set dollar amount) or a coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services.

After **you pay** $800 per self only or $2,400 per family, you do not have to make any more payments for certain services for the rest of the year. This is called a catastrophic limit. However, copayments or coinsurance for your prescription drugs and dental services do not count towards 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 California is a mixed model Plan (MMP). This means the doctors provide care in contracted medical centers or in their own offices. There are about 11,232 primary care physicians and 19,788 specialists participating in this Plan.

Section 3 — How to get benefits *continued*

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 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 1-800-624-8822. 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, except for OB/GYN physician services, which can be directly accessed on an unlimited basis without obtaining a referral.

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).

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 they can refer you to 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.

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.

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

Call us at 1-800-624-8822 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.

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

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 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 to OPM?

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 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.

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 physicians and other Plan providers. This includes all necessary office visits; **you pay** a $10 office visit copayment, but no additional copayment for laboratory tests and X-rays. Within the service area, house calls will be provided if in the judgment of the Plan physician such care is necessary and appropriate; **you pay** a $10 copayment for a physician's house call, and no charge for home visits by nurses and health aides.

The following services are included:

- Preventive care, including well-baby care and periodic check-ups - **you pay** nothing for well baby and child care from birth to age 2.
- 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.
- Immunizations and boosters as recommended by the American Academy of Pediatrics - **you pay** nothing for children birth to age 2.
- Consultations by specialists

Section 5 — Medical and Surgical Benefits *continued*

What is covered? *continued*

- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan physician - **you pay** nothing. 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.
- Self-referred gynecological physician care provided by an OB/GYN or Family Practitioner within your selected primary medical group; **you pay** a $10 copayment per exam.
- Voluntary family planning services including injectable contraceptive drugs such as Depo Provera and implantable contraceptive devices such as Norplant and IUD's
- Sterilization - **you pay** a $50 copayment for a vasectomy; **you pay** a $100 copayment for a tubal ligation.
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Heart, cornea, kidney, heart/lung, liver, lung (single or double) and pancreas transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer, multiple myeloma epithelial ovarian cancer, and testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan. Bone Marrow searches are limited to $10,000 or fifty (50) potential donors, whichever occurs first.
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Chemotherapy, radiation therapy and inhalation therapy
- Surgical treatment of morbid obesity
- Orthopedic devices, such as braces; foot orthotics
- Prosthetic devices, such as artificial limbs, lenses following cataract removal and breast prostheses and surgical bras as well as their replacement following a mastectomy.
- Durable medical equipment, such as wheelchairs and hospital beds
- Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan physician, 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 physicians and other Plan providers, at no additional cost to you.
- Disposable needles and syringes needed for injecting covered prescribed medication.
- Cardiac rehabilitation immediately following a heart transplant, bypass surgery or a myocardial infarction.

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or areas surrounding the teeth are not covered, including shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, and 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 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.

Section 5 — Medical and Surgical Benefits *continued*

Limited benefits *continued*

Short-term rehabilitative therapy or sub-acute care (physical, speech and occupational) is provided on an inpatient or outpatient basis, with no day limit when medically necessary; **you pay** $10 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 but not limited to sperm count, hysterosalpingography, endometrial biopsy or oral fertility drugs); **you pay** 50% of charges. Other fertility drugs are not covered. The following types of artificial insemination are covered: intravaginal insemination (IVI); intracervical insemination (ICI); intrauterine insemination (IUI); **you pay** 50% of charges; cost of donor sperm is not covered. Other assisted reproductive technology (ART) procedures such as in-vitro fertilization, and embryo transfer are not covered.

Chiropractic services are available through American Specialty Health Plans (ASHP) and ChiroCare Sierra. You will have direct access to a participating chiropractor without a referral from a Primary Care Physician. **You pay** a $5 copayment per visit, up to 20 visits per calendar year.

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

Section 5 — Hospital/Extended Care Benefits

What is covered?

Hospital care

The Plan arranges for a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan physician. **You pay** nothing per inpatient admission. All necessary services are covered, including:

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

Extended care

The Plan arranges for a comprehensive range of benefits up to 100 consecutive days per disability per calendar year when full-time skilled nursing or transitional care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan physician and approved by the Plan. **You pay** nothing per inpatient admission. 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 physician.

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility up to a 180 day limit per lifetime. Services include inpatient and outpatient care and family counseling; these services are provided under the direction of a Plan physician who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance care

Benefits are provided for ambulance transportation ordered or authorized by a Plan physician, when utilized in an emergency, or through the “911” emergency response system.

Section 5 — Hospital/Extended Care Benefits *continued*

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan physician determines there is a need for general anesthesia; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition, unless the member is under the age of 7 or developmentally disabled.

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 physician determines that outpatient management is not medically appropriate. See page 12 for non-medical Substance Abuse Benefits.

What is not covered?

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

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

In emergencies, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify your primary care physician within 48 hours unless it is not reasonably possible to do so. It is your responsibility to ensure that your primary care physician has been timely notified.

If you need to be hospitalized, your primary care physician should be notified within 24 hours or on the first working day following your admission, unless it was not reasonably possible to notify your primary care physician within that time. If you are hospitalized in non-Plan facilities and Plan physicians 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.

Plan pays...

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

You pay...

$35 per hospital emergency room visit or urgent care center visits for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copayment is waived.

Section 5 — Emergency Benefits *continued*

Emergencies outside the service area

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

If you need to be hospitalized, the Plan should be notified within 24 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 physician 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.

Plan pays...

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

You pay...

$35 per hospital emergency room visit or urgent care center visit for emergency services which are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copayment is waived.

What is covered?

- Emergency care at a physician's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including physician services
- Ambulance services when member reasonably believes services are necessary.

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
- Routine follow-up care

Filing claims for non-Plan providers

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

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 6.

Section 5 — Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered?

To the extent shown below, this Plan arranges for the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders: Care must be arranged in advance by the PacifiCare Behavioral Health Employee Assistance Program (EAP) by calling 1-800-234-5465.

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

Outpatient care

Up to 40 outpatient visits to Plan physicians, consultants or other psychiatric personnel each calendar year; **you pay** nothing for visits 1 through 5; $10 per visit for visits 6-10; $15 per visit for visits 11-20; and $20 per visit for visits 21-40.

The first 20 visits must be authorized by calling PacifiCare Behavioral Health EAP at 1-800/234-5465; visits 21-40 must be authorized by your primary care physician. The EAP will coordinate the transition of care. It is important to know that we cannot guarantee that the provider rendering care for the second 20 visits will be the same one that provided care during the first 20 visits.

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

Inpatient care

Up to 30 days of hospitalization each calendar year; **you pay** nothing for the first 30 days - all charges thereafter. All inpatient care must be pre-authorized by calling PacifiCare Behavioral Health EAP at 1-800-234-5465.

What is not covered?

- Care for psychiatric conditions that in the professional judgment of Plan physicians 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 physician to be necessary and appropriate
- Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition
- Treatment for any learning, developmental disability or reading disorder
- Counseling for adoption, custody, family planning or pregnancy in the absence of a psychiatric diagnosis generally recognized and accepted by the medical community and limited to a DSM-IV psychiatric diagnosis
- Spiritual counseling, dance, poetry, music or art therapy
- Certain organic and non-organic therapies (call PacifiCare Behavioral Health (PBHI) for specifics)
- Personal enhancement or wellness and development

Substance abuse

What is covered?

This Plan arranges for medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition. Services for the psychiatric aspects are provided in conjunction with the mental condition benefits shown above. Outpatient visits to Plan mental health providers for follow-up care and counseling are covered, as well as inpatient services necessary for diagnosis and treatment. The mental conditions benefits visit/day limitations and copayments apply to any covered substance abuse care.

What is not covered?

- Rehabilitative care in a specialized facility for substance abuse Treatment that is not authorized by a Plan physician.

Section 5 — Prescription Drug Benefits

What is covered?

Prescription drugs prescribed by a Plan or referral physician and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply; drugs are prescribed by Plan physicians and dispensed in accordance with the Plan's drug formulary. Non-formulary drugs will be covered when prescribed by a Plan doctor.

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. PacifiCare will not cover a non-Formulary prescription recommended by a participating physician, unless the non-Formulary drug is pre-authorized. A participating physician may initiate the pre-authorization request simply by phoning or faxing in the request. Requests are generally processed within ten minutes. Although, a few require up to two working days when additional information is needed from the doctor.

Section 5 — Prescription Drug Benefits *continued*

What is covered? *continued*

For drugs otherwise excluded from coverage, pre-authorization of non-Formulary drugs will occur in the following instances:

- No Formulary alternative is appropriate.
- You have tried the Formulary drugs and they have not been effective or you have been experiencing side effects or interactions with other drugs. The physician is asked to provide a copy of the medical chart notes specifically stating treatment failure with the Formulary alternatives.
- You have been under treatment and remain stable on a non-Formulary prescription drug and a conversion to a Formulary drug would be medically inappropriate.
- Your physician provides evidence to PacifiCare in the form of documents, records, or clinical trials, which establishes that use of the requested non-Formulary drug over the Formulary drug is medically necessary as determined by PacifiCare.

You pay a $5 copayment for generic and a $10 copayment for name brand drugs per prescription unit or refill on the formulary. Maintenance medications may be dispensed for up to a 30-day supply for the cost of one copayment.

When generic substitution is permissible (i.e., generic drug is available and the prescribing doctor does not require the use of the brand name drug), but you request the brand name, you may purchase the brand name drug instead of the generic drug by paying your $5 copayment plus the difference between the cost of the brand name and the generic drug per prescription unit or refill.

Up to a 90-day supply of maintenance medications may be obtained through mail order for the cost of two copayments. For information on the mail order drug benefit, contact the Plan's Member Services Department at 1-800-624-8822.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Oral contraceptive drugs
- Prescription diaphragms
- Insulin
- Diabetic supplies, limited to insulin syringes, and blood test tape and lancets
- Intravenous fluids and medication for home use (covered under Medical and Surgical Benefits as a home health service, see page 8)
- Prenatal vitamins
- Inhaler extender devices, anaphylaxis prevention kits (including but not limited to, epipen, anakits and anagard)
- Smoking cessation drugs and medication, including nicotine patches if the member participates in the Plan's Stop Smoking program. **You pay** a $20 copayment for a 30-day supply.

Limited benefits

- Drugs to treat sexual dysfunction are covered when Plan's medical 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 non-prescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for an emergency.
- Medical supplies such as dressings and antiseptics
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Fertility drugs (except oral which are covered under Diagnosis and Treatment of Infertility, page 9)
- Dietary supplements; vitamins and fluoride supplements (except prenatal)
- Diet Pills
- Lifestyle enhancing drugs

Section 5 — Other Benefits

Dental care

Accidental injury Benefit

Oral surgical procedures will be provided in an outpatient or inpatient setting when approved by the Plan in connection with the following; Stabilization and emergency treatment within forty-eight (48) hours of an acute accidental injury to sound natural teeth, jaw bone, or surrounding tissue. 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, this Plan provides the following vision care benefits from Plan providers. **You pay** a $10 copayment per visit.

- Annual eye refraction, including the written lens prescription for eyeglasses
- Initial placement of post cataract extraction contact lens in surgically affected eye

What is not covered?

- Eye exercises
- Replacement of initial lens following cataract surgery
- Eyewear, contact lenses and contact lens exams.

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with FEHB Program, but are made available to all enrollees and family 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 not count toward any FEHB deductibles, out-of-pocket maximum, copay charges, etc. These benefits are not subject to the FEHB disputed claims procedures.

PacifiCare 590 Dental Plan

This dental HMO plan offers limited copayments, no deductibles, and no annual maximum *(except for specialty referral)* as long as you see a participating plan provider.

You can review this brief summary of benefits and copayments. For a more detailed explanation of benefits please refer to the dental information enclosed in your member material. For more comprehensive information, please call us at PacifiCare Dental & Vision at **1-800-228-3384**.

Member Pays:

Diagnostic: Office visit .....No Charge
Diagnostic: X-rays, single film .....No Charge
Preventive: Teeth cleaning (two per 12 months) ....No Charge
Restorative Dentistry: Amalgam restorations -
One tooth surface (cavities involving primary and permanent teeth) .....$ 4
Oral Surgery: Extraction (uncomplicated) $10
Endodontics: Root canals (anterior/bicuspid/molar) $80/100/140
Periodontics: Gingival curettage, surgical per quad. $40
Crowns and Pontics: Porcelain crown* $120
Prosthetics: Complete upper or lower denture.....$175
Orthodontics: Class I, II, or III.....$1,895
**not for molars; plus actual lab cost of gold if applicable.*

PacifiCare Vision Eyewear Only Plan

Enjoy great savings on prescription eyewear. (Before you use the Eyewear Only Plan, your eye exam must be obtained through your medical plan.) Then, select your eyewear (glasses or contacts). If you choose eyewear from a provider on our directory and stay within the frame allowance, you can obtain eyewear at virtually no cost. If you choose eyewear more expensive frames or see a provider not on our list, you will have to pay additional, but discounted costs.

Premiums

Combined 590 Dental & Vision Monthly Premium
Single.....$ 18.63
Couple.....$ 34.07
Family.....$ 51.97
590 Dental Only Monthly Premium
Single.....$ 14.67
Couple.....$ 28.33
Family.....$ 41.75
Vision Only Monthly Premium
Single.....$ 4.75
Couple .....$ 9.50
Family.....$ 14.25

NEW! Plan B Federal Dental Plan

Now available exclusively for PacifiCare of California health plan members. This plan allows you to see any dentist in our directory. You are not assigned a primary dentist. The following fees apply only if service is performed by a general dentist. Fees in a specialist's office will be higher.

Member Pays:

Diagnostic: Office visit.....$5
Diagnostic: X-rays, single film.....$5
Preventive: Teeth cleaning (two per 12 months) $5
Restorative Dentistry: Amalgam restorations -
One tooth surface (cavities involving primary and permanent teeth) .....$ 5
Oral Surgery: Extraction (uncomplicated) $72
Endodontics: Root canals (anterior/bicuspid/molar) $309/422/490
Periodontics: Gingival curettage, surgical per quad. $89
Crowns and Pontics: Porcelain fused to metal* $524
Prosthetics: Complete upper or lower denture.....$600
Orthodontics: Class I, II, or III.....$1,895
**not for molars; plus actual lab cost of gold if applicable.*

Plan B Monthly Premium

Single.....$ 3.06
Couple.....$ 7.91

How to Enroll

To Enroll, complete the PacifiCare Dental & Vision *Member Enrollment* form (note your selected 590 dental provider) and pre-authorized payment plan agreement. *Member Enrollment* forms received by the 20th of the month will become effective the 1st of the following month.

This sheet lists only a summary of benefits and copayments. For a more detailed explanation of benefits, please refer to the dental and vision information enclosed in your member material.

For questions, please call **PacifiCare Dental and Vision's Member Service at 1-800-228-3384.**

Visit our website at www.pacificare.com/dentalvision

Medicare Prepaid Plan Enrollment - This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on Page 17, 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. 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 1-800-322-8877 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 1-800-322-8877 for information on the benefits available under the Medicare HMO.

Benefits on this page are not part of the FEHB contract

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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, emergencies or urgently needed care (see Emergency Benefits) or eligible self referred services;
- 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;
- 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 the medical services and we will coordinate the payments. On occasion, you may need to file 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 15.

Other group insurance coverage

When anyone has coverage with us and 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 also provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must 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.

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.

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

Workers' compensation

We do not cover services that:

- You need because of work place 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 this Plan and Medicaid covers you.

Other Government Agencies

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

If you have a malpractice claim.

If you have a malpractice claim because of services you did or did not receive from a Plan provider, it must go to binding arbitration. Contact us about how to begin our binding arbitration process.

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 1/800-624-8822 or write to 5701 Katella Avenue Cypress, CA 90630. You may also contact us by fax at 671/646-6923, or visit our website at www.pacificare.com

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.

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 dependant 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 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 a 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-809, 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.

Section 8 — FEHB FACTS *continued*

What is former spouse coverage:

If you 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 Federal 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 are 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 after the event:

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

Section 8 — FEHB FACTS *continued*

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 this certificate.

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

Department of Defense/FEHB Demonstration Project

What is the Department of Defense (DoD) and FEHB Program Demonstration Project?

The National Defense Authorization Act for 1999, Public Law 105-261, established the DoD/FEHBP Demonstration Project. It allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years beginning with the 1999 Open Season for the year 2000. Open Season enrollments will be effective January 1, 2000. DoD and OPM have set-up some special procedures to successfully implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible?

DoD determines who is eligible to enroll in FEHB. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare,
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare,
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried, or
- You are a survivor dependent of a deceased active or retired uniformed service member, and
- You live in one of the eight geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

Where are the demonstration areas?

- Dover AFB, DE
- Commonwealth of Puerto Rico
- Fort Knox, KY
- Greensboro/Winston Salem/High Point, NC
- Dallas, TX
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- New Orleans, LA

When can I join?

Your first opportunity to enroll will be during the 1999 Open Season, November 8, 1999, through December 13, 1999. Your coverage will begin January 1, 2000. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877-DOD-FEHB (1-877-363-3342).

You may select coverage for yourself (self-only) or for you and your family (self and family) during the 1999, 2000, and 2001 Open Seasons. Your coverage will begin January 1 of the year following the Open Season that you enrolled.

If you become eligible for the DoD/FEHBP Demonstration Project outside of Open Season, contact the IPC to find out how to enroll and when your coverage will begin.

Department of Defense/FEHB Demonstration Project *continued*

When can I join? *continued*

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2000 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHBP Demonstration Project," on the OPM web site at www.opm.gov.

Am I eligible for Temporary Continuation of Coverage (TCC)?

See Section 10, FEHB Facts, for information about TCC. Under this Demonstration Project the only individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHBP Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHBP Demonstration Project.

TCC is not available if you move out of a DoD/FEHBP Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

Do I have the 31-day extension and right to convert?

These provisions do not apply to the DoD/FEHBP Demonstration Project.

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 1-800-932-3004 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 PacifiCare® of California 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 pay/provides	Page
Inpatient Care	**Hospital**	Comprehensive range of medical and surgical services with no dollar or day limit. Includes in-hospital physician 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	7
	Extended Care	All necessary services, up to 100 consecutive days per disability. **You pay** nothing	9
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. **You pay** nothing	11
	Substance Abuse	Covered under mental conditions	12
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 immunizations, as recommended by the American Academy of Pediatrics; laboratory tests and X-rays; complete maternity care. **You pay** $10 copayment per office visit; $10 copayment per house call by a physician	7
	Home Health Care	All necessary visits by nurses and home health aids. **You pay** nothing	8
	Mental Conditions	Up to 40 outpatient visits per year. **You pay** varying copayments	11
	Substance Abuse	Covered under mental conditions	12
Emergency Care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $35 copayment for each emergency room or urgent care center visit and any charges for services that are not covered benefits of this Plan.	10
Prescription Drugs		Drugs prescribed by a Plan physician and obtained at a participating pharmacy. **You pay** $10 copayment for generic and a $10 copayment for brand name drugs per prescription unit or refill; mail order drugs are also covered	12
Dental Care		Accidental injury benefit. **You pay** nothing	14
Vision Care		One refraction annually. **You pay** a $10 copayment per visit	14
Chiropractic Services		Direct access to Chiropractor. **You pay** $5; 20 visits per calendar year	9
Out-of-pocket Maximum		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $800 per individual or up to $2,400 per family per calendar year, covered benefits will be provided at 100%. This copayment maximum does not include prescription drugs and preventive dental care benefits	4

2000 Rate Information for PacifiCare® of California

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 postal employees. If you are a career 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
Most of California									
Self Only	CY1	$58.37	$19.46	$126.47	$42.16	$69.07	$8.76	$69.07	$8.76
Self and Family	CY2	$144.90	$48.30	$313.95	$104.65	$171.47	$21.73	$171.47	$21.73