The Health Plan of the Upper Ohio Valley

http://www.healthplan.org

Customer Service 1.800.624.6961; 1.800.426.9013

2014

A Health Maintenance Organization (High Option)

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See pages 7 for details.

Serving: Northeast and Eastern Ohio, and 55 counties in West Virginia

IMPORTANT
- Rates: Back Cover
- Changes for 2014: Page 14
- Summary of benefits: Page 72

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 13 for requirements.

This commercial HMO plan has an excellent accreditation from the NCQA. See the 2014 Guide for more information on accreditation.

Enrollment code for this Plan:
U41 Self Only
U42 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-553

Important Notice from The Health Plan About
Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that The Health Plan's prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and The Health Plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1.800.772.1213 (TTY: 1.800.325.0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1.800.MEDICARE (1.800.633.4227), (TTY: 1.877.486.2048).

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Introduction

This brochure describes the benefits of The Health Plan HMO under our contract (CS 2616) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This plan is underwritten by The Health Plan. Customer service may be reached at 1.800.624.6961 (St. Clairsville office) or 1.800.426.9013 (Massillon office) or through our website at www.healthplan.org. The addresses for the administrative offices are:

St. Clairsville, Ohio:

The Health Plan of the Upper Ohio Valley Inc. (The Health Plan HMO)
52160 National Road, East
St. Clairsville, Ohio 43950

Massillon, Ohio:

The Health Plan/HomeTown Regional Office
100 Lillian Gish Blvd.
P.O. Box 4816
Massillon, Ohio 44648

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2014, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2014, and changes are summarized on page 13. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; “we” means The Health Plan HMO.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers authorized health benefits plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider 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 1.800.624.6961 (St. Clairsville office) or 1.800.426.9013 (Massillon office) and explain the situation.
  - - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

1.877.499.7295

OR go to www.opm.gov/oig

You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying or obtaining service or coverage for yourself or for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.

- Ask your doctor, “Who will manage my care when I am in the hospital?”
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

- www.ahrq.gov/consumer. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use The Health Plan preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don’t expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called “Never Events”. When a Never Event occurs, neither your FEHB plan nor you will incur cost to correct the medical error.

FEHB Facts

Coverage information

No pre-existing condition limitation	We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.
Minimum Essential Coverage (MEC)	Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
Minimum Value Standard (MVS)	The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.
Where you can get information about enrolling in the FEHB Program	See www.opm.gov/healthcare-insurance for enrollment information as well as: • Information on the FEHB Program and plans available to you • A health plan comparison tool • A list of agencies who participate in Employee Express • A link to Employee Express • Information on and links to other electronic enrollment systems Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you: • 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 • What happens when your enrollment ends • When the next Open Season for enrollment begins 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. For information on your premium deductions, you must also contact your employing or retirement office.
Types of coverage available for you and your family	Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 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 that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

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

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/ payroll office, or retirement office.

Family Member Coverage

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/healthcare-insurance.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;

- If you have a Self-Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self-Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2014 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2013 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

When you 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 (TCC).

When you lose benefits

When FEHB coverage 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.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31st day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC).

Upon divorce

If you are divorced from a Federal employee, or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/healthcare-insurance/healthcare/plan-information/guides.

Temporary Continuation of Coverage (TCC)

If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

You may not elect TCC if you are fired from your Federal or Tribal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

We also want to inform you that the Patient Protection and Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules.

Finding replacement coverage

You may convert to a non-FEHB 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 or Tribal service, your employing office will notify you of your right to convert. 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.

In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance in finding coverage, please contact us at 1.800.624.6961 (St. Clairsville office) or 1.800.426.9013 (Massillon office) or visit our website at www.healthplan.org.

Health Insurance Market Place

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that offers limited federal protections for health coverage availability and continuity to people who lose employer group 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. Your new plan must reduce or eliminate waiting periods, limitations or exclusions for health-related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/healthcare-insurance; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about federal and state agencies you can contact for more information.

Section 1. How this plan works

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of the most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance and deductibles described in this brochure. When you receive emergency services from non-Plan providers, 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.

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

How we pay providers

We contract with individual physicians, medical groups and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. We pay our physicians under a fee-for-service basis, meaning that our physicians get paid only when they provide service to you.

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, providers and facilities. OPM's FEHB Web site (www.opm.gov/healthcare-insurance) lists the specific types of information that we must make available to you. Some of the required information is listed below.

We are considered an Individual Practice Association (IPA) type of HMO, providing medical services by contracting with over 2,000 primary care and specialty care physicians and 40 hospitals. We serve the residents of Northeast Ohio, Eastern Ohio and all of West Virginia.

- We are a 501(c)(4) Not-for-Profit organization.
- We are federally qualified and state-certified.
- We hold Certificates of Authority in 55 West Virginia counties and 26 Ohio counties.
- We have commendable accreditation from the National Committee for Quality Assurance (NCQA).
- We began operations in 1979.

If you want more information about us, call 1.800.624.6961, or write to The Health Plan, 52160 National Road, East, St. Clairsville, Ohio, 43950. You may also contact us by fax at 740.695.5297 or visit our Web site at www.healthplan.org.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area encompasses these counties:

In Ohio: Ashland, Carroll, Columbiana, Coshocton, Cuyahoga, Geauga, Holmes, Knox, Lorain, Mahoning, Medina, Portage, Richland, Stark, Summit, Trumbull, Tuscarawas, Wayne, Belmont, Guernsey, Harrison, Jefferson, Monroe, Muskingum, Noble and Washington.

In West Virginia: Barbour, Berkeley, Boone, Braxton, Brooke, Cabell, Calhoun, Clay, Doddridge, Fayette, Gilmer, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Jackson, Jefferson, Kanawha, Lewis, Lincoln, Logan, Marion, Marshall, Mason, McDowell, Mercer, Mineral, Mingo, Monongalia, Monroe, Morgan, Nicholas, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Putnam, Raleigh, Randolph, Ritchie, Roane, Summers, Taylor, Tucker, Tyler, Upshur, Wayne, Webster, Wetzel, Wirt, Wood, and Wyoming.

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 or urgent care. We will not pay for any other health care service outside our service area unless the services have prior plan approval.

If you or a covered family member moves outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if you 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 moves, you do not have to wait until Open Season to change plans. Contact your employment or retirement office.

Section 2. Changes for 2014

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes for 2014

Changes to this Plan

- Your share of the non-Postal premium will increase for Self Only and increase for Self and Family. See page 73.
- **Autism Behavior Analysis (ABA)** - The plan will now provide coverage for ABA for children with autism in the State of West Virginia. The benefit will be limited to a maximum of $30,000 per contract year for three consecutive years from the date treatment commences. Conclusion of the third year, the benefit will be limited to a maximum of $2,000 per month per contract year with a 30% coinsurance. The treatment must be under the direction of a Board Certified Behavior Analyst (BCBA); deductible waived.
- **Habilitative Services** - In compliance with PPACA, the plan will now provide coverage for habilitative services. See *Speech therapy* and *Physical and occupational therapy* for more details.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us in the St. Clairsville office at 1.800.624.6961 or in the Massillon office at 1.800.426.9013, or write us at:

St. Clairsville Office:

The Health Plan of the Upper Ohio Valley Inc. (The Health Plan HMO)

52160 National Road East

St. Clairsville, Ohio 43950

Massillon Office:

The Health Plan/HomeTown Regional Office

100 Lillian Gish Blvd.

P.O. Box 4816

Massillon, Ohio 44648

You may also request replacement cards through our Web site at www.healthplan.org.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance. If you use our Open Access program you can received covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. A Provider Search is also on our Web site. We have provider directories available for download and print in the area and surrounding areas that you live in.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician from our provider directory. This decision is important since your primary care physician provides or arranges for most of your health care. If you do not select a primary care physician, it may result in non-payment of claims.

- **Primary care**

Your primary care physician can be a family practitioner, general practitioner, general internal medicine, or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one. You and each family member may change primary care physicians once per month.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see an OB/GYN without a referral if you select one as your secondary care physician.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex or serious medical condition, your primary care physician will work with us to 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.
- Your primary care physician will create your treatment plan. The physician may have to get an authorization or approval from us beforehand. If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. 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, 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.
- If you are seeing a specialist and your 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.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
  - reduce our service area and you enroll in another FEHB plan;

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1.800.624.6961 (St. Clairsville office) or 1.800.426.9013 (Massillon office). If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

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

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services.*

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

- Transplants
- Elective Admissions (including behavioral health)
- Tertiary Care
- Hysterectomy
- Imaging (PET, PET-CT Fusion, SPECT of Brain)
- Chiropractic Care
- Podiatric Care
- Audiology
- Hyperbaric Oxygen
- TMJ Care
- All Genetic Testing
- Urinary/Fecal Incontinence Treatment
- Wound Care Clinic
- Outpatient Behavioral Health Services (except psychistrists and biologically based mental illnesses)
- Bariatric Surgery
- Cosmetic Procedure
- Varicose Vein Treatment
- Botox Injections
- Infertility
- Speech Therapy
- Home Health Systems
- Hospice
- Home Infusion Therapy
- Durable Medical Equipment greater than $500
- Non-Emergent Ambulance

Other services may require preauthorization. If you, or your physician, have a question regarding preauthorization, please contact a Plan Customer Service Representative at 740.695.7902, 1.888.847.7902, TDD: 740.695.7919, 1.800.322.3925 (St. Clairsville office) or 330.837-6880, 1.800.426.9013, TDD: 1.877.236.2291 (Massillon office).

NOTE: TRUE EMERGENCY OR URGENT SERVICES ARE COVERED WITHOUT REGARD TO PREAUTHORIZATION.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 740.695.7902, 1.888.847.7902, TDD: 740.695.7919, 1.800.322.3925 (st. Clairsville office) or 330.837.6880, 1.800.426.9013, TDD: 1.877.236.2291 (Massillon office) before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of planned days of confinement.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

	You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1.800.624.6961 (St. Clairsville office) or 1.800.426.9013 (Massillon office). You may also call OPM's Health Insurance 3 at 202.606.0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1.800.624.6961 (St. Clairsville office) or 1.800.426.9013 (Massillon office). If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).
• **Concurrent care claims**	A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect. If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.
• **Emergency inpatient admission**	If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
• **Maternity care**	You do nothing. Your OB/GYN coordinates this care with the Hospital and The Health Plan.
• **If your treatment needs to be extended**	If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.
What happens when you do not follow the precertification rules when using non-network facilities	Unless it is an emergency, you pay all costs.
Circumstances beyond our control	Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.
If you disagree with our pre-service claim decision	If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below. If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.
• **To reconsider a non-urgent care claim**	Within six months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure. In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.

   You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

   If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

  In the case of an appeal of a pre-service urgent care claim, within six months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

  Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

  After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your cost for covered services

This is what you will pay out-of-pocket for covered care.

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance and copayments) for the covered care you receive.
Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services. Copayments do not begin until you meet your deductible, unless there is no deductible for that service. Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay $250 per admission.
Deductible	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments and coinsurance does not count toward any deductible. • The calendar year deductible is $250 per self-enrollment and $750 per family enrollment. Under a family enrollment, the deductible is satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $750. Note: If you change plans during Open Season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.
Coinsurance	Coinsurance is the percentage of our negotiated fee that you must pay for your care. Coinsurance does not begin until you have met your calendar year deductible. Example: You pay 30% of our allowable charges for durable medical equipment.
Your catastrophic protection out-of-pocket maximum	After your (copayments and coinsurance) total $2,000 per self-enrollment or $6,000 per family (3 or more people) enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments/coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments/coinsurance for these services: • Prescription drugs (will count in 2015) • Dental services (accidental in nature) Be sure to keep accurate records of your copayments/coinsurance since you are responsible for informing us when you reach the maximum.
When Government facilities bill us	Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

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Section 5. Benefits - OVERVIEW

This plan only offers a High Option. Benefit packages are described in Section 5.

The High Option Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about High Option benefits contact us at 1.800.624.6961 (St. Clairsville offive) or 1.800.426.9013 (Massillon office) or on our Web site at www.healthplan.org.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- The calendar year deductible is: $250 per self-enrollment and $750 per family (3 or more people) enrollment. The calendar year deductible applies to almost all benefits in this section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including Medicare.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	**High Option**
Professional services of physicians • In physician's office • Office medical consultations • At home	$10 per visit to your primary care physician $20 per visit to a specialist (No deductible)
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Second surgical opinion	Nothing
Lab, X-ray and other diagnostic tests	**High Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	20% of our allowance

Benefit Description	You pay After the calendar year deductible…
Preventive care, adult	**High Option**
Routine physical every year which includes: Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test - Sigmoidoscopy screening - every five years starting at age 50 - Colonoscopy screening - every 10 years starting at age 50	Nothing (No deductible)
Routine Prostate Specific Antigen (PSA) test - one annually for men age 40 and older	Nothing (No deductible)
Well woman care including, but not limited to: • Routine pap test • Human papillomavirus testing for women age 30 and up once every three years • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence	Nothing (No deductible)
Routine mammogram - covered for women age 35 and older, as follows: • From age 35 through 39, one during this five-year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing (No deductible)
• Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Nothing (No deductible)
Note: A complete list of preventive care services recommended under the USPSTF is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm	
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel	*All charges*

Benefit Description	You pay After the calendar year deductible…
Preventive care, children	**High Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing (No deductible)
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22)	Nothing (No deductible)
Note: A complete list of preventive care services recommended under the USPSTF is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm	
Maternity care	**High Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at high risk • Delivery • Postnatal care	Nothing for prenatal care or the first postpartum care visit; $20 per office visit for all postpartum care visits thereafter Nothing for inpatient professional delivery services (No deductible)
Breastfeeding support, supplies and counseling for each birth	Nothing
Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 17 for other circumstances, such as extended stays for you or your baby • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury	

Benefit Description	You pay After the calendar year deductible…
Family planning	**High Option**
Contraceptive counseling on an annual basis	Nothing
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit	No cost sharing for ACA approved family planning benefits
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling* • *Paternity testing* • *Estrogen & Androgen pellet implants*	*All charges*
Infertility services	**High Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Basic healthcare services such as diagnostic and exploratory procedures to determine infertility including surgical procedures to correct medically diagnosed diseases or conditions of the reproductive organs	30% of our allowance
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *In vitro fertilization* - *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *Surrogate parenting* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	**High Option**
• *Fertility drugs (oral, topical or injectible)* • *Experimental services*	*All charges*
Allergy care	**High Option**
• Testing and treatment • Allergy injections	$10 per visit to your primary care physician $20 per visit to a specialist
Allergy serum	Nothing (No deductible)
Not covered: sublingual allergy desensitization	*All charges*
Treatment therapies	**High Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 37	20% of our allowance
• Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Applied Behavior Analysis (ABA) Therapy for Autism Spectrum Disorder	$10 per visit to your primary care physician $20 per visit to a specialist
• Growth Hormone Therapy (GHT) Note: We cover GHT under our prescription benefits only when we preauthorize the treatment. See *Covered medications and supplies* in Section 5 (f). For preauthorization, call 1.800.624.6961 (St. Clairsville office) or 1.800.426.9013 (Massillon office). We will ask you to submit information that establishes the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring preauthorization* in Section 3	25% or $200 whichever is less for up to a 30-day supply at a specialty pharmacy. (See Section 5(f) *Prescription drug benefits*)

Benefit Description	You pay After the calendar year deductible…
Physical and occupational therapies	**High Option**
Outpatient visits (the greater of two months or 20 visits per condition) and inpatient visits (60 days per calendar year) for the services of each of the following: • Qualified physical therapists • Occupational therapists Note: We only cover therapy when a provider orders the care	$10 per office visit $20 per outpatient visit Nothing per visit during covered inpatient admission
Cardiac rehabilitation at a plan-approved facility for up to 12 weeks or 36 visits per heart attack or heart surgery	$10 per outpatient visit
Pulmonary rehabilitation at a plan-approved facility for up to 12 weeks or 36 visits per calendar year	$10 per outpatient visit
Habilitative Services	$20 copay per outpatient visit per therapy type. Visits over 21 will require 50% coinsurance per visit per therapy type Members pay nothing per visit during inpatinet admission
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	**High Option**
Outpatient visits (the greater of two months or 20 visits per condition) and inpatient visits (60 days per calendar year)	$20 per outpatient visit Nothing per inpatient visit
Habilitative Services - limited to the lesser of maintenance level not to exceed 20 visits per occurrence	$20 per visit per occurrence for outpatient Nothing for inpatient visit
Hearing services (testing, treatment and supplies)	**High Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children*	$10 per visit to your primary care physician $20 per visit to a specialist
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices*	30% of our allowance Must meet plan guidelines

Hearing services (testing, treatment and supplies) - continued on next page

Benefit Description	You pay After the calendar year deductible…
Hearing services (testing, treatment and supplies) (cont.)	**High Option**
Not covered: • *Hearing services that are not shown as covered*	*All charges*
Vision services (testing, treatment and supplies)	**High Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Eye exam provided by PCP, to determine the need for vision correction for children through age 17 (see *Preventive care, children*) • Ophthalmologist visits for diagnosis and treatment of diseases of the eye (requires prior approval)	$10 per visit to your primary care physician $20 per visit to a specialist
Not covered: • *Eyeglasses, frames or contact lenses and examinations for them, after age 17* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	**High Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes Note: See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts	$20 per office visit (No deductible)
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of fallen arches, weak, strained or flat feet or bunions or spurs, and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Strapping or taping of the feet* • *Hygienic and preventive maintenance care such as, cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients and any other service performed in the absence of localized illness, injury or symptoms involving the foot*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Orthopedic and prosthetic devices	**High Option**
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • External hearing aids • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prostetic devices as hospital benefits; see Section 5 (c) for payment information. See 5 (b) for coverage of surgery to insert the device • Foot orthotics • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	30% of our allowance
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose and other supportive devices* • *Replacement of prosthetics provided prior to the end of their expected life (except for replacement due to growth or development in children up to age 18)*	*All charges*
Durable medical equipment (DME)	**High Option**
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Hospital beds • Standard model wheelchairs • Crutches • Walkers • Ostomy and catheter supplies • Insulin pumps Note: DME must be medically necessary and be pre-authorized by us prior to dispensing. DME is limited to standard model only	30% of our allowance
• Blood glucose monitors	Nothing

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay After the calendar year deductible…
Durable medical equipment (DME) (cont.)	**High Option**
Note: We require the use of specific blood glucose monitors	Nothing
Not covered: • *Replacement of DME prior to the end of its expected life (except for replacement due to growth or development in children up to age 18)* • *Batteries for DME items, such as hearing aids, tens units, wheelchairs and glucometers* • *Equipment or supplies primarily used for patient comfort or convenience* • *Home modifications* • *Supplies such as tape, alcohol, cotton swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads or ice bags* • *Professional medical equipment such as blood pressure units or stethoscopes*	*All charges*
Home health services	**High Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide • Services include oxygen therapy, intravenous therapy and medications Note: We must pre-authorize Home health services prior to services being rendered	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative*	*All charges*
Chiropractic	**High Option**
• Manipulation of the spine and extremities • Adjunctive procedure such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application • Up to 20 visits per calendar year with approved referral from your PCP	$20 per office visit (No deductible)
Not covered: • *Non-subluxation services*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Alternative treatments	**High Option**
Biofeedback therapy (for incontinence only)	30% of our allowance
Not covered: • *Acupuncture services* • *Naturopathic services* • *Hypnotherapy* • *Biofeedback (except for incontinence)* • *Massage therapy* • *Christian Science Treatment* • *All other alternative treatment services not listed as covered*	*All charges*
Educational classes and programs	**High Option**
Coverage is provided for:	Nothing for counseling for up to two quit attempts per year
• Tobacco Cessation programs, including individual/group/telephone counseling, over- the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence	Nothing for OTC and prescription drugs approved by the FDA to treat tobacco dependence
• Work Site Smoking Cessation classes – This program is available when requested by your employer and is provided by our nurse educator. If you are interested in these classes, please call us at 1.800.624.6961 or 740.695.3585 for more information. *{See http://www.surgeongeneral.gov/tobacco for more info}*	$10 per office visit
• Diabetes self management • Childhood obesity education	Nothing

Section 5(b). Surgical and anesthesia services provided by physicians and other healthcare professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- The calendar year deductible is: $250 per self-enrollment and $750 per family enrollment. The calendar year deductible applies to almost all benefits in this section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other healthcare professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Surgical procedures	**High Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) -- a condition in which an individual weighs 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information	$10 per visit to your primary care physician $20 per visit to a specialist Nothing for hospital visits **Note: These five criteria must be met for The Health Plan's approval of bariatric surgery: 1)** Extreme obesity; **2)** Medically appropriate for the individual to have surgery; **3)** Surgery is to correct illness, which caused the obesity or was aggravated by the obesity; **4)** Complete medical history and clinical support to cover procedure; **5)** Follow medical guidelines for the coverage
• Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	**High Option**
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*
Reconstructive surgery	**High Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birthmarks; webbed fingers and webbed toes All stages of breast reconstruction surgery following a mastectomy, such as: • Surgery to produce a symmetrical appearance of breasts; • Treatment of any physical complications, such as lymphedemas; • Breast prostheses and surgical bras and replacements (see *Prosthetic devices*) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Oral and maxillofacial surgery	**High Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Other surgical procedures that do not involve the teeth or their supporting structures; and • Treatment for temporomandibular (TMJ) disorders (non-dental)	$10 per visit to your primary care physician $20 per visit to a specialist Nothing for hospital visits
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone)* • *Non-medical TMJ services*	*All charges*
Organ/tissue transplants	**High Option**

These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. See *Other services* under You need prior Plan approval for certain services on page 17.
• Cornea
• Heart
• Heart/lung
• Intestinal transplants
  • Small intestine
  • Small intestine with the liver
  • Small intestine with multiple organs, such as the liver, stomach and pancreas
• Kidney
• Liver
• Lung: single/bilateral/lobar
• Pancreas
• Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis
	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures • Autologous tandem transplants for: - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Nothing
Blood or marrow stem cell transplants limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description Physicians consider many features to determine how diseases will respond to different types of treatment. Some of th features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which disease may respond to treatment without transplant and which diseases respond to transplant These blood or marrow stem cell transplants are subject to medical necessity and experimental/investigational review by the Plan • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Infantile malignant osteopetrosis - Kostmann's syndrome - Leukocyte adhesion deficiencies	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
- Marrow failure and related disorders (i.e., Fanconi's PNH, Pure Red Cell Aplasia) - Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Sickle cell anemia - X-linked lymphoproliferative syndrome • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Ependymoblastoma - Ewing's sarcoma - Multiple myeloma - Medulloblastoma - Neuroblastoma - Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors	Nothing
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan Refer to *Other services* in Section 3 for prior authorization procedures: • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed)	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
- Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Amyloidosis - Neuroblastoma	Nothing
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial The Plan shall not deny the cost of any routine patient care administered to an Insured participating in any stage of an eligible cancer clinical trial if that care would be otherwise covered if the Insured was not participating in a clinical trial	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	**High Option**
Routine care is all health care services consistent with the coverage provided in this health benefit plan for the treatment of cancer, including the type and frequency of any diagnostic modality, this is typically covered for a cancer patient who is not enrolled in a cancer clinical trial, and that was not necessitated soley because of the trial • Autologous Transplants for - Advanced Childhood kidney cancers - Advanced Ewing sarcoma - Aggressive non-Hodgkin lymphomas - Childhood rhabdomyosarcoma - Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma)	Nothing
National Transplant Program (NTP)	Nothing
Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant conors in addition to the testing of family members.	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**High Option**
Professional services provided in - • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	Nothing
Professional services provided in: • Office	$10 per visit to your primary care physician $20 per visit to a specialist

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- The calendar year deductible is: $250 per self-enrollment and $750 per family enrollment. The calendar year deductible applies to almost all benefits in this section. We added "(No deductible)" to show when the calendar year does not apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge(i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR ELECTIVE HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Note: The calendar year deductible applies unless we say below: "(No Deductible)".	
Inpatient hospital	**High Option**
Room and board, such as: • Ward, semi-private, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semi-private room rate	$250 per admission
Other hospital services and supplies, such as: • Operating, recovery, maternity and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings, splints, casts and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced	$250 per admission
Not covered:	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High Option**
• *Custodial care, rest cures, domiciliary or convalescent care* • *Non-covered facilities* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**
• Operating, recovery and other treatment rooms • Prescribed drugs and medicines • Administration of blood, blood plasma and other biologicals • Blood and blood plasma, if not donated or replaced • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures	Nothing
• Diagnostic laboratory tests, X-rays and pathology services • Pre-surgical testing	20% of our allowance
Extended care benefits/Skilled nursing care facility benefits	**High Option**
Skilled nursing facility (SNF): Up to 120 days per calendar year when full-time nursing care and confinement to an SNF is medically appropriate. All necessary services are covered, such as: • Bed, board and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the SNF when prescribed by your physician	$35 per day
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Non-covered facilities*	*All charges*

Benefit Description	You pay
Hospice care	**High Option**
• Supportive and palliative care for a terminally ill member, including home care and family counseling Note: These services are provided when your physician certifies that the member is in the terminal stages of illness, with a life expectancy of approximately six months or less	Nothing
Not covered: • *Independent nursing, homemaker services* • *See "not covered" under SNF benefits Private nursing care*	*All charges*
Ambulance	**High Option**
• Local professional ambulance service when medically appropriate	$50 per service

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $250 per self-enrollment and $750 per family enrollment. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.

Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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 we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

In extreme emergencies, contact the local emergency system (i.e., 9-1-1 telephone system). If you are in an emergency situation, you should follow these steps:

- **First:** When practical, call your primary care physician - day or night. He or she can direct you to the appropriate care and can assure the proper follow-up to that care.
- **If your primary care physician cannot be reached**, call our 24-hour emergency number, 1.800.624.6961 (St. Clairsville office) or 1.800.426.9013 (Massillon office). You will be put in contact with our nurse on call and receive directions on what to do.
- **In a situation when a telephone call is impractical or impossible**, go directly to one of our nearest participating hospital emergency rooms, if possible. Identify yourself as a Health Plan member. You or a family member must contact us within 48 hours of the visit, unless it was not reasonably possible to do so. It is your responsibility to ensure that we have been notified in a timely manner. You should also inform your physician of the situation so that he/she may properly coordinate your care.

Emergencies within our service area: If you are in an emergency situation within our service area, please follow the above steps under "What to do in case of emergency." If you need to be hospitalized, we must be notified within 48 hours or on the first working day following the admission, unless it was not reasonably possible to notify us within that timeframe. If you are hospitalized in a non-Plan facility and your physician believes care can be better provided in a Plan facility, 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. Any follow-up care recommended by non-Plan providers must be approved by us or provided by Plan providers.

Emergencies outside our service area: If you are in an emergency situation outside our service area, please follow the above steps under "What to do in case of emergency." If you need to be hospitalized, we must be notified within 48 hours or on the first working day following the admission, unless it was not reasonably possible to notify us within that timeframe. If your 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. Any follow-up care recommended by non-Plan providers must be approved by us or provided by Plan providers.

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area	**High Option**
Emergency care at a doctor's office	$10 per visit to your primary care physician $20 per visit to a specialist (No deductible)
Emergency care at an urgent care center	$50 per visit (No deductible)
Emergency care as an outpatient at a hospital, including doctors' services	$75 per visit (No deductible)
Note: We waive the ER copay if you are admitted to the hospital	
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	**High Option**
Emergency care at a doctor's office	$10 per visit to a primary care physician $20 per visit to a specialist (No deductible)
Emergency care at an urgent care center	$50 per visit (No deductible)
Emergency care as an outpatient at a hospital, including doctors' services	$75 per visit (No deductible)
Note: We waive ER copay if you are admitted to the hospital	
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	**High Option**
Professional ambulance service when medically appropriate Note: See 5(c) for non-emergency service	$50 per service

Section 5(e). Mental health and substance abuse benefits

You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $250 per self-enrollment and $750 per family enrollment. The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay After the calendar year deductible…
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Professional Services	**High Option**
When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists	Your cost-sharing responsibilities are no greater than for other illnesses or conditions
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment	$10 per visit (No deductible)

Professional Services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Professional Services (cont.)	**High Option**
• Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	$10 per visit (No deductible)
Diagnostics	**High Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing, if you receive these services during your office visit: otherwise $10 per visit
Inpatient hospital or other covered facility	**High Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	$250 per admission
Outpatient hospital or other covered facility	**High Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment	$250 per admission
Not Covered	**High Option**
• Services that are not part of a pre-authorized approved treatment plan	All charges

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible on prescription drugs.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription?** A licensed physician must write the prescription – or – a plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy or by mail order.
- **We use a formulary.** Drugs are prescribed and dispensed in accordance with our drug formulary. A drug formulary is a list of brand-name drugs that we cover. The formulary is reviewed and updated, and is subject to change. We cover non-formulary drugs prescribed by a Plan doctor. If your physician believes a name-brand product is necessary or there is no generic available, your physician may prescribe a name-brand drug from our formulary list. This list of name-brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To request a prescription drug brochure or formulary, call 1.800.624.6961 (St. Clairsville office) or 1.800.426.9013 (Massillon office). You may also choose to receive a non-formulary prescription and pay the higher third-tier copay.
- **There are dispensing limitations.** Generally, we allow dispensing of FDA-approved drugs up to a 31 day supply per copay. Limits may be applied to assure that dispensing of medication conforms to the approved federal labeling of the formulary drug. Furthermore, if you have your prescription filled too early, it will not be allowed. You must use three-fourths of the days supplied before a refill will be allowed.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

You can save money by using generic drugs. You and your physician have the option to request a name-brand even if a generic is available. However, using the most cost-effective medication saves money.

- **When you have to file a claim.** If you are in a situation outside our service area for which you cannot go to a plan pharmacy, and a physician has prescribed covered medication that is urgently needed, please go to any pharmacy and purchase the medication. Return your receipt to The Health Plan and you will be reimbursed in full, less the applicable copay amount.
- **In cases of active military duty (or in time of national emergency).** Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call our Member Services Department at 1.800.624.6961 (St. Clairsville office) or 1.800.426.9013 (Massillon office).

Benefit Description	You pay
Note: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Covered medications and supplies	**High Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal Law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Insulin • Diabetic supplies limited to glucose test tablets and test tape, Benedict's solution or equivalent and acetone test tablets • Disposable needles and syringes for the administration of covered medications • Prenatal vitamins • Vitamin D for adults age 65 and older • Intravenous fluids and medications for home use; some injectable drugs (such as Depo Provera) are covered under medical services and supplies • Sexual dysfunction drugs have dispensing limitations. Contact the Plan for details. • Specialty drugs are those high cost medications including drugs manufactured by biotechnology. These drugs may be administered by injection, oral, transdermal or inhaled. Specialty drugs are used to treat very specific diseases and require extensive management for safety and effectiveness. Dosages need to be monitored for effect and adjustments may be needed for adequate response to affectively treat the disease. Specialty drugs require complex dispensing techniques and dispensing may be limited to pharmacies with specific skills and distribution programs to assure proper delivery of these medications. Specialty drugs require ***prior authorization*** to assure the patient is an appropriate candidate for the drug. Approval periods for authorization may vary according to agent prescribed. Additionally, oversight is an integral part of the prior authorization process. The Plan will monitor the use of these drugs for the following: - Dose optimization - Appropriate monitoring (including required lab studies) - Patient compliance to prescribed therapy - Proper disposal of ancillary material used in the delivery of the medications (i.e., syringes) - Drug interaction monitoring	**Retail Pharmacy (up to a 31-day supply):** $15 per prescription unit or refill for generic drugs $30 per prescription unit or refill for formulary brand-name drugs $50 per prescription unit or refill for non-formulary brand-name drugs **Home Delivery Mail Order Pharmacy (up to a 90-day supply for maintenance medications):** $30 per prescription unit or refill for generic drugs $60 per prescription unit or refill for formulary brand-name drugs $100 per prescription unit or refill for non-formulary brand-name drugs **Specialty Pharmacy (up to a 30-day supply):** 25% or $200 whichever is less for a specialty drug

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High Option**
Women's contraceptive drugs and devices • The "morning after pill" is considered preventive service under contraceptives, with no cost to the member if prescribed by a physician and purchased at a network pharmacy. Note: Over-the-counter contraceptive drugs and devices approved by the FDA require a written prescription by an approved provider	Nothing
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Smoking cessation drugs and medications, including nicotine patches* • *Drugs for weight control* • *Fertility drugs* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* *Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit (see page 34)*	*All charges*

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with other coverage.
- Plan dentists must provide or arrange your care.
- The calendar year deductible is: $250 per self-enrollment and $750 per family enrollment. The calendar year deductible applies to all benefits in this section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- We cover hospitalization days for oral surgical procedures only when certified by the primary care physician as being medically necessary to safeguard your life and approved by us. See Section 5(c) for inpatient hospital benefits. We do not cover dental procedures.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	**High Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Services have to be initiated and rendered within six months of the accident	Nothing
Dental benefits	**High Option**
We have no other dental benefits	

We have no other contractual dental benefits. See Non-FEHB benefits available to Plan members on the next page.

Section 5(h). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file a FEHB disputed claim about them. Fees you pay for these servies do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at 1.800.624.6961 (St. Clairsville office) or 1.800.426.9013 (Massillon office) or visit their Web site at www.healthplan.org.

Medicare Advantage Plan: This Plan offers Medicare recipients the opportunity to enroll in one of its Medicare Advantage plans: SecureCare HMO or SecureChoice PPO. Our service area for Medicare Advantage is different then our FEHB program service area. You must have Medicare parts A & B to enroll in a Medicare Advantage plan. For more information, please contact us at 1.877.847.7915/TTY 1.800.622.3925 (St. Clairsville office) or 1.877.236.2290/TTY 1.877.236.2291 (Massillon office), Monday through Friday, 8:30 a.m. to 5 p.m.

Vision Care Services: **VSP Choice Access - Vision Program**

- VSP is the nation's largest eye care provider with over 41,000 participating points of care in retail and medical locations.
- Members save 15% to 35% off eye exams and eye glasses by using the VSP Choice Access Plan.
- To locate a participating VSP doctor, visit www.vspchoiceaccess.com or call 1.800.290.0523. Members must present their membership card at the time of visit to receive discount. The total bill, less applicable savings are to be paid by member at the time service is provided.
- Members will receive a discount, or pay the maximum amount based on the regional fee schedule averages; whichever amount is less. Depending on the doctor's location, the maximum costs and savings will vary.

National Lasik Network (LCA)

- The National Lasik Network offers discounts on LASIK eye surgery at over 570 locations nationwide
- Receive discounts of 15% off standard prices OR 5% off promotional prices
- At select locations, receive attractive, "set prices" starting as low as $695 per eye
- For more information or to locate a provider, please call 1.866.921.2106 or visit

This plan is not insurance.*Product not available in MT, VT and WA*. For more information on this benefit, please contact us at 1.800.624.6961 (St. Clairsville office) or 1.800.426.9013 (Massillon office).

Dental Benefit: The Plan provides dental coverage under Delta Dental PPO (Point-of-Service), a national point-of-service preferred provider organization administered by Delta Dental. You may go to any licensed dentist, but you may lower your out-of-pocket costs by going to a PPO dentist. If you do not go to a PPO dentist, you will be covered by Delta Dental Premier, Delta Dental's carefully managed fee-for-service program. However, you might have to pay more. For more information on this **free benefit**, please contact us at 1.800.624.6961 (St. Clairsville office) or 1.800.426.9013 (Massillon office).

The Health Plan Customer Service toll-free numbers:

1.800.624.6961 (St. Clairsville office) or 1.800.426.9013 (Massillon office)

www.healthplan.org

Section 6. General exclusions – services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose or treat your illness, disease, injury or condition.For information on obtaining prior approval for specific services, such as transplants. See Section 3** ***When you need prior Plan approval for certain services.***

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*)
- Services, drugs or supplies you receive while you are not enrolled in this Plan
- Services, drugs or supplies not medically necessary
- Services, drugs or supplies not required according to accepted standards of medical, dental or psychiatric practice
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants)
- Services, drugs or 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
- Services, drugs or supplies related to sex transformations
- Services, drugs or supplies you receive from a provider or facility barred from the FEHB Program
- Services, drugs or supplies you receive without charge while in active military service
- Extra care costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs related to conducting a clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes

Section 7. Filing a claim for covered services

This section primarily deals with post-service claims (claims for services, drugs, or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs, or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and hospital benefits; other supplies or services

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500 (Health Insurance Claim Form). Your facility will file on the UB-04 form. For claims questions and assistance, contact us at 1.800.624.6961 (St. Clairsville office) or 1.800.426.9013 (Massillon office) or at our Web site at www.healthplan.org.

When you must file a claim – such as for services you receive outside the Plan's service area – submit it on the CMS-1500 or a claim form that includes the information listed below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to the St. Clairsville Office:

The Health Plan

Attn: Claims Department

52160 National Road, East

St. Clairsville, Ohio 43950

Or to the Massillon Office:

The Health Plan/HomeTown Regional Office

Attn: Claims Department

100 Lillian Gish Blvd

P.O. Box 4816

Massillon, Ohio 44648

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing availability, upon request, of the diagnosis and procedure codes.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.healthplan.org.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Services Department by writing The Health Plan St. Clairsville office: 52160 National Road East, St. Clairsville, Ohio 43950 or our Massillon office: 100 Lillian Gish Blvd., P.O. Box 4816, Massillon, Ohio 44648 or calling us at 1.800.624.6961 (St. Clairsville office) or 1.800.426.9013 (Massillon office).

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration decision will not afford deference to the initial decision and will be conducted by a plan representative who is neither the individual who made the initial decision that is the subject of the reconsideration, nor the subordinate of that individual.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within six months from the date of our decision; and b) Send your request to us at: The Health Plan at our St. Clairsville Office: 52160 National Road East, St. Clairsville, Ohio 43950 or our Massillon Office: 100 Lillian Gish Blvd., P.O. Box 4816, Massillon, Ohio 44648; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional for member), if you would like to receive our decisions via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.

Step	Description
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's 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, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, 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 decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life-threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 1.800.624.6961 (St. Clairsville office) or 1.800.426.9013 (Massillon office). We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at 1.202.606.0737 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visits the NAIC website at www.NAIC.org.

When we are the primary payor, we will pay the benefits described in this brochure.

When we are the secondary payor, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

- **TRICARE and CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, 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 unless you involuntarily lose coverage under TRICARE or CHAMPVA.

- **Workers' Compensation**

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- 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 OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

- **Medicaid**

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, 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 unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state or federal government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for injuries or illness for which another party may be responsible, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

The words "Third Party," "Any Party" or "Responsible Party" includes not only the insurance carrier(s) for the responsible party, but also any uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile insurance coverage or any other first party insurance coverage. The words "Member," "you" and "your" include anyone on whose behalf the Plan pays or provides any benefits.

If you do not seek damages, you must agree to let us try. This is called subrogation.

You specifically acknowledge our right of subrogation. When we provide health care benefits for injuries or illnesses for which another responsible party is or may be responsible, we shall be subrogated to your rights of recovery against any responsible party to the extent of the full cost of all benefits provided by us, to the fullest extent permitted by law. We may proceed against any responsible party with or without your consent.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket costs.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan does not cover these costs.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials, this plan does not cover these costs.

When you have Medicare

- **What is Medicare?**

Medicare is a Health Insurance Program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1.800.MEDICARE (1.800.633.4227). (TTY 1.800.486.2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1.800.772.1213 (TTY 1.800.325.0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits three months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1.800.772.1213, (TTY 1.800.325.0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you first become eligible, you may be charged a Medicare Part B late enrollment penalty of a 10% increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medciare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare plan – You probably will never have to file a claim form when you have both our Plan and the Original Medicare plan.

- When we are the primary payor, we process the claim first.
- When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. To find out if you need to do something about filing your claim, call us at 1.800.624.6961 (St. Clairsville office) or 1.800.426.9013 (Massillon office), or email us at info@healthplan.org.

We do not waive any costs if the Original Medicare plan is your primary payor.

You can find more information about how our plan coordinates benefits with Medicare in the Evidence of Coverage (EOC) at www.healthplan.org.

- **Tell us about your Medicare coverage**

You must tell us if you or a family member has Medicare coverage and let us obtain information about services denied or paid by Medicare if we ask. You must also tell us about other coverage you or your family members may have as this coverage may affect the primary/ secondary status of this Plan and Medicare.

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1.800.MEDICARE (1.800.633.4227), (TTY 1.877.486.2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: You may enroll in our Medicare Advantage plan, called SecureCare, and also remain enrolled in our FEHB plan. In this case, no copayments or coinsurance are waived for your FEHB coverage.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, 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 unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

- **Medicare prescription drug coverage (Part D)**

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Clinical Trials Cost Categories

An approved clinical trial includes a phase I, phase II, phace III, or phase IV clinicla trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration ; or is a drug trial that is exempt from the requirement of an investigational new drug application.

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 21.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 21.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance and copayments) for the covered care you receive.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Treatment or services that are designed mainly to help the patient with daily living activities.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 21.

Experimental or investigational services

Services, devices or drugs that we determine are not nationally accepted in conjunction with accredited specialty consultants, government agencies and other regulatory agencies.

Group health coverage

Healthcare coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical or other healthcare services or supplies.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity

A service, device or drug that meets its standardized medical criteria, derived from recognized accredited national sources. It is important to know that your physician may recommend a service, device or drug that may sometimes not qualify as being medically necessary. Medical necessity is determined by our medical staff, in coordination with local or regional members of the medical community or academic faculties.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance based on our contracted amounts with our providers.

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Us/We Us and We refer to The Health Plan HMO.

You You refers to the enrollee and each covered family member.

Urgent care claims A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1.800.624.6961 (St. Clairsville office) or 1.800.426.9013 (Massillon office). You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that compliment your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no government contribution.

Important information about three Federal programs that complement the FEHB program

First, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. Participating employees save an average of about 30% on products and services they rountinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person. The maximum annual election for a dependent care flexible spending account (DCFSA) is $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or other insurance.

  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage, or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1.877. FSAFEDS (1.877.372.3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1.800.952.0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.

FEDVIP is available to eligible Federal and Postal Service employees, retirees and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and X-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 12-month waiting period. Beginning in 2014, most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for your choice of either lenses and frames or for contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM Web site at www.opm.gov/dental and www.opm.gov/vision. This site also provide links to each plan's Web site, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1.877.888.3337 (TTY 1.877.889.5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living - such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aids, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1.800.LTC.FEDS (1.800.582.3337) (TTY 1.800.843.3557), or visit www.ltcfeds.com.

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Do not rely completely on the page listings in this index; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for High Option of the Health Plan HMO - 2014

- Do not rely on this chart alone. All benefits are provided in full unless indicated and are subject to the definitions, limitations and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the calendar year deductible.

Benefits	You pay	Page
Medical services provided by physicians*:		25
• Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $20 specialist.	25
Services provided by a hospital*:		42
• Inpatient	$250 per admission.	42
• Outpatient	Nothing.	43
Emergency benefits:		45
• In-area	$75 per visit.	46
• Out-of-area	$75 per visit.	46
Mental health and substance abuse treatment*:	Regular cost-sharing.	47
Prescription drugs:		49
• Retail pharmacy	Retail (31-day supply) $15 copay generic $30 copay formulary brand $50 non-formulary brand	50
• Mail order	Mail Order (90-day supply) $30 copay generic $60 copay formulary brand $100 non-formulary brand	50
Dental care:	No contractual benefit. See Non-FEHB page for **free** dental coverage.	52 53
Vision care*:	$10 primary care; $20 specialist.	53
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)**:**	Nothing after $2,000/Self-Only or $6,000/Family enrollment per year. Some costs do not count toward this protection.	21

2014 Rate Information

For 2014 health premium information, please see:
http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.