

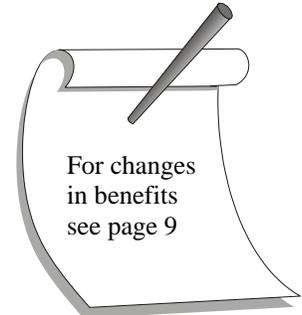


BlueCHOICE®

<http://www.bcbsmo.com>

2005

A Health Maintenance Organization



Serving: St. Louis, Central, and Southwest areas in Missouri and St. Clair and Madison counties in Illinois

Enrollment in this plan is limited. You must live in our Geographic service area to enroll. See page 8 for requirements.



This plan has excellent accreditation from the NCQA. See the *2005 Guide* for more information on accreditation.

Enrollment code for this Plan:

- 9G1 Self Only**
- 9G2 Self and Family**



Federal Employees Health Benefits Program

Authorized for distribution by the:



United States Office of Personnel Management

Center for Retirement and Insurance Services
<http://www.opm.gov/insure>



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

Welcome to the 2005 Open Season! By continuing to introduce pro-consumer health care ideas, the Office of Personnel Management (OPM) team has given you greater, cost effective choices. This year several national and local health plans are offering new options, strengthening the Federal Employees Health Benefits (FEHB) Program and highlighting once again its unique and distinctive market-oriented features. I remain firm in my belief that you, when fully informed as a Federal subscriber, are in the best position to make the decisions that meet your needs and those of your family. Plan brochures provide information to help subscribers make these fully informed decisions. Please take the time to review the plan's benefits, particularly Section 2, which explains plan changes.

Exciting new features this year give you additional opportunities to save and better manage your hard-earned dollars. For 2005, I am very pleased and enthusiastic about the new High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. This combination of health plan and savings vehicle provides a new opportunity to save and better manage your money. If an HDHP/HSA is not for you and you are not retired, I encourage you to consider a Flexible Spending Account (FSA) for health care. FSAs allow you to reduce your out-of-pocket health care costs by 20 to more than 40 percent by paying for certain health care expenses with tax-free dollars, instead of after-tax dollars.

Since prevention remains a major factor in the cost of health care, last year OPM launched the *HealthierFeds* campaign. Through this effort we are encouraging Federal team members to take greater responsibility for living a healthier lifestyle. The positive effect of a healthier life style brings dividends for you and reduces the demands and costs within the health care system. This campaign embraces four key "actions" that can lead to a healthy America: be physically active every day, eat a nutritious diet, seek out preventative screenings, and make healthy lifestyle choices. Be sure to visit *HealthierFeds* at www.healthierfeds.opm.gov for more details on this important initiative. I also encourage you to visit the Department of Health and Human Services Web site on Wellness and Safety, www.hhs.gov/safety/index.shtml, which complements and broadens healthier lifestyle resources. The site provides extensive information from health care experts and organizations to support your personal interest in staying healthy.

The FEHB Program offers the Federal team the widest array of cost-effective health care options and the information needed to make the best choice for you and your family. You will find comprehensive health plan information in this brochure, in the 2005 Guide to FEHB Plans, and on the OPM Web site at www.opm.gov/insure. I hope you find these resources useful, and thank you once again for your service to the nation.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay C. James".

Kay Coles James

Director



Notice of the United States Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the United States Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government health care oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.

- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the Web. You may also call 202-606-0745 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
United States Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the United States Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice are effective April 14, 2003.

Table of Contents

Introduction.....	3
Plain Language.....	3
Stop Health Care Fraud!.....	3
Preventing medical mistakes.....	4
Section 1. Facts about this HMO plan.....	6
How we pay providers.....	6
Your Rights.....	6
Service Area.....	8
Section 2. How we change for 2005.....	9
Program-wide changes.....	9
Changes to this Plan.....	9
Section 3. How you get care.....	10
Identification cards.....	10
Where you get covered care.....	10
• Plan providers.....	10
• Plan facilities.....	10
What you must do to get covered care.....	10
• Primary care.....	10
• Specialty care.....	11
• Hospital care.....	12
Circumstances beyond our control.....	12
Services requiring our prior approval.....	12
Section 4. Your costs for covered services.....	13
Copayments.....	13
Deductible.....	13
Coinsurance.....	13
Your catastrophic protection out-of-pocket maximum.....	13
Section 5. Benefits – OVERVIEW (<i>See page 9 for how our benefits changed this year and page 68 for a benefits summary.</i>).....	14
Section 5(a) Medical services and supplies provided by physicians and other health care professionals.....	16
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	28
Section 5(c) Services provided by a hospital or other facility, and ambulance services.....	33
Section 5(d) Emergency services/accidents.....	36
Section 5(e) Mental health and substance abuse benefits.....	39
Section 5(f) Prescription drug benefits.....	40
Section 5(g) Special features.....	44
• Flexible Benefits Option.....	44
• Services for deaf and hearing impaired.....	44
• Away From Home Care [®]	44
• Blue Quality.....	44
• BabyConnection.....	44
• TakeCharge [®] Asthma Program.....	45
• TakeCharge [®] Diabetes Program.....	45
• TakeCharge [®] Congestive Heart Failure Program.....	45
• Postpartum Depression Screening Program.....	45
Section 5(h) Dental benefits.....	46
Section 5(i) Non-FEHB benefits available to Plan members.....	47

Section 6. General exclusions – things we don’t cover	48
Section 7. Filing a claim for covered services	49
Section 8. The disputed claims process	51
Section 9. Coordinating benefits with other coverage	53
When you have other health coverage	53
What is Medicare?	53
• Should I enroll in Medicare?	53
• The Original Medicare Plan (Part A or Part B)	54
• Filing a claim	54
• Medicare Advantage	56
TRICARE and CHAMPVA	56
Workers’ Compensation	56
Medicaid	57
When other Government agencies are responsible for your care	57
When others are responsible for injuries	57
Section 10. Definitions of terms we use in this brochure	58
Section 11. FEHB Facts	60
Coverage information	60
• No pre-existing condition limitation	60
• Where you can get information about enrolling in the FEHB Program	60
• Types of coverage available for you and your family	60
• Children’s Equity Act	61
• When benefits and premiums start	61
• When you retire	61
When you lose benefits	61
• When FEHB coverage ends	61
• Spouse equity coverage	62
• Temporary Continuation of Coverage (TCC)	62
• Converting to individual coverage	62
• Getting a Certificate of Group Health Plan Coverage	62
Section 12. Two Federal Programs complement FEHB benefits	63
The Federal Flexible Spending Account Program – <i>FSAFEDS</i>	63
The Federal Long Term Care Insurance Program	66
Index	67
Summary of benefits for BlueCHOICE - 2005	68
2005 Rate Information for BlueCHOICE	70

Blue Cross Blue Shield of Missouri is the name RightCHOICE® Managed Care, Inc. (RIT) uses to do business in most of Missouri. In Missouri, RIT administers the FEHB program. HMO Missouri, Inc. does business as BlueCHOICE. RIT and HMO Missouri, Inc. are independent licensees of the Blue Cross and Blue Shield Association.

Introduction

This brochure describes the benefits of *BlueCHOICE HMO* under our contract (CS 2838) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by the Healthy Alliance Life Insurance Company. The address for administrative offices is:

BlueCHOICE
1831 Chestnut Street
St. Louis, Missouri 63103-2275

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, 2005, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2005, and changes are summarized on page 9. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means BlueCHOICE.
- 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.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

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:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized 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.
- 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 1-800-932-4480 and explain the situation.

If we do not resolve the issue:

CALL — THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR 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); or
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- 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.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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.**

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
- Tell them about any drug allergies you have.
- Ask about side effects and what to avoid while taking the medicine.
- Read the label when you get your medicine, including all warnings.
- Make sure your medicine is what the doctor ordered and know how to use it.
- Ask the pharmacist about your medicine if it looks different than you expected.

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 you are taking.

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.htm. 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/consumer.html. 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.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this HMO plan

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 us for a copy of our 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 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.

How we pay providers

We contract with individual physicians, medical groups, hospitals and other types of providers 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. We reimburse primary care physicians through capitation, which includes the majority of services the primary care physician renders. We compensate certain services, such as immunizations or cardiac diagnostic testing in the office as fee for service.

Who provides my health care?

This plan is an individual-practice Plan. All participating doctors practice in their own offices in the community. Unless it is an emergency, benefits are available only from doctors, hospitals and other health care providers that are in the BlueCHOICE network. The Plan arranges with doctors and hospitals to provide medical care for both the prevention of disease and the treatment of serious illness.

You must select a primary care doctor for each covered family member. Approximately 1,500 primary care physicians participate in BlueCHOICE. For most care, you must contact your primary care doctor for a referral or authorization before seeing any other doctor for specialty care or nonemergency hospital services. A wide variety of specialists are participating Plan doctors. Many are Board certified as indicated in the BlueCHOICE directory. If you need hospital care, your Plan primary care doctor will admit you to a participating hospital where he/she has admitting privileges.

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/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

About the plan and care management: We have nearly 70 years of experience in the health insurance industry. We began as St. Louis Blue Cross in 1936. In 1945, Missouri Medical Service, commonly known as Blue Shield, began business in the St. Louis area. The two companies merged in 1986, forming Blue Cross and Blue Shield of Missouri, a not-for-profit health service corporation. In 1994, Blue Cross and Blue Shield of Missouri formed a new managed care company, Alliance Blue Cross Blue Shield.

Effective November 30, 2000, Blue Cross and Blue Shield of Missouri and its for-profit managed care subsidiary, Alliance Blue Cross Blue Shield, merged into a single, for-profit, publicly traded Delaware corporation. The insurance-related business that was part of the old Blue Cross and Blue Shield of Missouri has been transferred to and assumed by Healthy Alliance Life Insurance Co., a wholly owned subsidiary of Blue Cross and Blue Shield of Missouri, as part of the reorganization.

BlueCHOICE, the for-profit HMO subsidiary of Blue Cross and Blue Shield of Missouri, began operations in 1988. Blue Cross and Blue Shield of Missouri, BlueCHOICE and Healthy Alliance Life Insurance Co. are independent licensees of the Blue Cross and Blue Shield Association.

On January 31, 2002, RightCHOICE Managed Care Inc. and WellPoint Health Networks Inc. merged. WellPoint, which is based in Thousand Oaks, California, serves the health care needs of 15.5 million medical members and 46.2 million specialty members nationwide through Blue Cross of California, Blue Cross Blue Shield of Georgia, Blue Cross Blue Shield of Wisconsin, HealthLink, UNICARE and Blue Cross Blue Shield of Missouri.

Utilization management services include:

- Precertifications of medical/surgical, mental health, rehabilitation, skilled nursing, outpatient and home health care
- Concurrent review of medical/surgical, mental health, rehabilitation, skilled nursing, outpatient and home health care
- Retrospective review
- Discharge planning
- Alternative care planning
- Individual case management
- Appeal for denial of payment due to lack of medical necessity
- Medical review

Our contracts with network providers require them to handle all certifications for BlueCHOICE members. You will not have to be concerned about managed care procedures as long as you receive care from network providers.

We offer special programs to help members with health conditions such as asthma, diabetes and high-risk pregnancy. These are voluntary programs to help members manage their particular health condition. These programs are explained in Section 5(g).

Accreditation status: BlueCHOICE is accredited by the National Committee for Quality Assurance (NCQA). The comprehensive review process evaluates how well a plan manages its benefits. The accreditation process evaluates more than 60 standards in the following six categories:

- Quality management and improvement
- Physician qualifications and evaluation
- Members' rights and responsibilities
- Preventive health services
- Utilization management and
- Medical records

Networks, providers and facilities: The BlueCHOICE network includes approximately 1,500 primary physicians, 5,700 specialists and 68 hospitals. Approximately 79 percent of network physicians are Board Certified and 85 percent are accepting new patients. The physician's Board status and whether or not he/she is accepting new patients are included in the BlueCHOICE provider directory.

We have established credentialing policies that require us to select and recredential physicians every three years, based on an evaluation of their experience and training, board certification and staff privileges at network hospitals. Our program goals are to support the development and maintenance of credentialing and recredentialing standards for our participating providers, to review the qualifications of potential participating providers against established standards, and to reassess the qualifications and performance of our network providers.

Our credentialing criteria for network hospitals include accreditation by the Joint Committee on Accreditation of Health Care Organizations (JCAHO), Medicare certification, effective utilization management pricing, geographic location, scope of services and utilization experience.

If you want more information about us, call 1-800-932-4480, visit our Web site at www.bcbsmo.com, or write us at 471 Siemers, Cape Girardeau MO 63701. For the hearing impaired (TDD), call 1-800-822-1215.

Service Area

To enroll in this Plan, you must live in our Service Area. This is where our providers practice. Our service area is:

The St. Louis Area, including the Missouri counties of Crawford, Franklin, Gasconade, Jefferson, Lincoln, Montgomery, Pike, St. Charles, St. Francois, St. Louis (City and County), Ste. Genevieve, Warren and Washington; *the Central Missouri Area* counties of Audrain, Boone, Callaway, Camden, Chariton, Cole, Cooper, Howard, Macon, Maries, Miller, Moniteau, Monroe, Morgan, Osage, Phelps, Pulaski, and Randolph; *the Southwest Missouri Area* counties of Barry, Barton, Cedar, Christian, Dade, Dallas, Douglas, Greene, Hickory, Jasper, Laclede, Lawrence, McDonald, Newton, Ozark, Polk, Stone, Taney, Texas, Webster and Wright.

You may also enroll with us if you live in the Illinois counties of Madison or St. Clair.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office. As a BlueCHOICE member, you may have access to physician care through the BlueCard® Traditional network. This nationwide network is made up of 5,400 hospitals and 711,000 physicians that participate with Blue Cross and Blue Shield Plans across the country. Benefits are easy to use – a “suitcase” logo on members’ ID cards will identify them as BlueCard members. To locate a BlueCard provider outside the BlueCHOICE service area, members simply call the toll-free BlueCard Access number on their ID card (1-800-810-BLUE (2583)) or visit the **BlueCard Hospital and Doctor Finder at www.BCBS.com**. Members should contact their primary care physician just as they would if they were at home. The primary care physician will provide a non-network referral and coordinate care with the out-of-area provider as appropriate.

Section 2. How we change for 2005

Do not rely on these change descriptions; this page 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

- In Section 9, we revised the **Medicare Primary Payer Chart** and updated the language regarding Medicare Advantage plans (formerly called Medicare + Choice plans).
- In Section 12, we revised the language regarding the Federal Flexible Spending Account Program - *FSAFEDS* and the Federal Long Term Care Insurance Program.

Changes to this Plan

- Your share of the non-Postal premium will increase by 20.8% for Self Only or 15.5% for Self and Family.
- Prescription drug benefits: Retail and Mail-Order Prescription Drug categories are currently identified as Generic, Preferred Brand-Name and Non-Preferred Brand-Name. The drug categories are being restructured. Any reference to Generic will now be referred to as Tier 1, Preferred Brand-Name as Tier 2 and Non-Preferred Brand-Name as Tier 3. Copay amounts will remain unchanged. To obtain the most current list of available drugs and to find out which Tier your drug falls under check the BCBSMo Web site at www.bcbsmo.com. (Section 5(f))
- Chiropractic care will no longer have a combined maximum of 20 visits per calendar year with physical therapy. Chiropractic care will have a maximum of 26 visits per calendar year. (Section 5(a))
- Physical, occupational and speech therapies will no longer have separate calendar year maximums of 20 visits each. They will have a combined maximum of 60 visits per calendar year. (Section 5(a))
- Coverage for Replacement CPAP apparatus as listed under the Durable Medical Equipment (DME) will now be listed as: nasal application device (mask) - \$25 copay; nasal pillow or face seal - \$10 copay; headgear - \$10 copay; chinstrap - \$0 copay; tubing - \$10 copay; filter, either disposable or reusable - \$0 copay. (Section 5(a))
- Coverage for a ventilator at \$150 copay per month will be covered as a Durable Medical Equipment (DME) benefit. (Section 5(a))
- Coverage for a pneumatic percusser at \$10 copay will be covered as a Durable Medical Equipment (DME) benefit. (Section 5(a))
- Coverage for an infusion pump (as part of outpatient infusion therapy when not provided by a home infusion therapy provider) at \$50 copay per month will be covered as a Durable Medical Equipment (DME) benefit. (Section 5(a))
- We have added drugs to the GenericSelectSM Drugs list. (Section 5(f))
- We have clarified that a Neuromuscular Electronic Stimulator (NMES) and ABI Vest, used to treat members with cystic fibrosis, listed under the DME list are subject to review by BlueCHOICE. (Section 5(a))
- We have clarified what diabetic supplies are covered under the DME list. (Section 5(a))
- The name RightSteps[®], a special feature that strives to help mothers-to-be avoid potential problems during pregnancy, is changed to BabyConnection. (Section 5(g))

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 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 at 1-800-932-4480. You may also request replacement cards through our Web site at www.bcbsmo.com.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments and you will not have to file claims.

- **Plan providers**

Plan providers are primary care physicians, specialists 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 annually. The BlueCHOICE directory is also on our Web site, www.bcbsmo.com. The online directory is updated daily.

- **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. This decision is important since your primary care physician provides or arranges for most of your health care.

Use the directory or Web site to select a physician convenient to you. Write the physician’s office code number in the space provided on your Provider Selection Card. You’ll find the office code number listed before each primary care physician’s name. See the Selection Card for instructions.

- **Primary care**

Your primary care physician can be a family or general practitioner, internist, pediatrician or geriatrician. 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. We will send you a new ID card with your new doctor’s name and phone number on the front.

- **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 a network OB/GYN for any medically necessary OB/GYN care without a referral. And you may go to a network eye care provider for one routine vision exam each calendar year without a referral.

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 develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, 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; or
 - 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.

If you think you have a mental health or substance abuse problem, we encourage you to see your primary care physician. If you do not wish to go through your primary care physician, you may choose to receive care from another network provider without a referral.

Inpatient, residential treatment and certain outpatient treatment for mental health and substance abuse require precertification. Your network provider is responsible for contacting us to obtain precertification.

- **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 in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-932-4480. If you are new to the FEHB Program, we will arrange for you to receive care.

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; or
- 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.

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.

Services requiring our prior approval

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

We call this review and approval process precertification and recertification. Your physician must obtain precertification before you can receive certain types of care, such as:

- Inpatient hospital care
- Outpatient hospital care
- Care in a freestanding surgery center or skilled nursing facility
- Home health care
- Certain types of outpatient diagnostic services, including MRI (magnetic resonance imaging), MRA (magnetic resonance angiography) and PET (positron emission tomography) procedures.

Your physician must obtain recertification if your care needs to continue longer than originally certified.

Your BlueCHOICE primary care physician or specialist will handle all certification requirements for you. However, if you receive emergency care at a non-network facility, you will need to contact us for approval. Please see Section 5(d) for further information.

Section 4. Your costs for covered services

You must share the costs of some services. You are responsible for:

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

Example: When you see your primary care physician you pay a copayment of \$10 per office visit.

Deductible

We do not have a deductible.

Coinsurance

We do not have coinsurance.

Your catastrophic protection out-of-pocket maximum

After you pay 100% of your annual premium in copayments for one family member (per person), or 100% of your annual premium for two or more family members (self and family), you do not have to make any further payments for certain services for the rest of the year. This is called a catastrophic limit. However, copayments for your prescription drugs and dental services do not count toward these limits and you must continue to make these payments.

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

Section 5. Benefits – OVERVIEW

(See page 9 for how our benefits changed this year and page 68 for a benefits summary.)

Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. 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 our benefits, contact us at 1-800-932-4480 or at our Web site at www.bcbsmo.com.

Section 5(a) Medical services and supplies provided by physicians and other health care professionals.....	16
Diagnostic and treatment services.....	16
Lab, X-ray and other diagnostic tests.....	17
Preventive care, adult.....	17
Preventive care, children.....	18
Maternity care.....	19
Family planning.....	19
Infertility services.....	20
Allergy care.....	20
Treatment therapies.....	21
Physical, occupational and speech therapies.....	22
Hearing services (testing, treatment, and supplies).....	22
Vision services (testing, treatment, and supplies).....	23
Foot care.....	23
Orthopedic and prosthetic devices.....	24
Durable medical equipment (DME).....	24
Home health services.....	27
Chiropractic.....	27
Alternative treatments.....	27
Educational classes and programs.....	27
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	28
Surgical procedures.....	28
Reconstructive surgery.....	29
Oral and maxillofacial surgery.....	30
Organ/tissue transplants.....	31
Anesthesia.....	32
Section 5(c) Services provided by a hospital or other facility, and ambulance services.....	33
Inpatient hospital.....	33
Outpatient hospital or ambulatory surgical center.....	34
Extended care benefits/Skilled nursing care facility benefits.....	34
Hospice care.....	35
Ambulance.....	35
Section 5(d) Emergency services/accidents.....	36
Emergency within our service area.....	37
Emergency outside our service area.....	37
Ambulance.....	38
Section 5(e) Mental health and substance abuse benefits.....	39
Mental health and substance abuse benefits.....	39
Section 5(f) Prescription drug benefits.....	40
Covered medications and supplies.....	41
Section 5(g) Special features.....	44
Flexible Benefits Option.....	44
Services for deaf and hearing impaired.....	44
Away From Home Care®.....	44

Blue Quality	44
BabyConnection.....	44
TakeCharge® Asthma Program.....	45
TakeCharge® Diabetes Program.....	45
TakeCharge® Congestive Heart Failure Program.....	45
Postpartum Depression Screening Program.....	45
Section 5(h) Dental benefits.....	46
Section 5(i) Non-FEHB benefits available to Plan members.....	47
Summary of benefits for the BlueCHOICE - 2005	68
2005 Rate Information for BlueCHOICE	70

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

Here are some important things you should keep in mind about these benefits:

**I
M
P
O
R
T
A
N
T**

- 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.
- 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.

**I
M
P
O
R
T
A
N
T**

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician's office • Office medical consultations • Second surgical opinion 	\$10 per office visit
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility 	Nothing
At home	\$10 per visit
<i>Not covered:</i> <ul style="list-style-type: none"> • Care that is not medically necessary • Care that is investigational • Care from a non-network provider without prior approval from us 	<i>All charges.</i>

Diagnostic and treatment services – continued on next page

Diagnostic and treatment services <i>(continued)</i>	You pay
Lab, X-ray and other diagnostic tests	
<p>Laboratory tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CT Scans/MRI • Ultrasound/Sonogram – one routine ultrasound/sonogram for a normal pregnancy • Electrocardiogram and EEG <p>Note: Preauthorization is needed for certain outpatient diagnostic services such as MRI, MRA and PET (See page 12)</p>	<ul style="list-style-type: none"> • Nothing if services are received during your office visit • \$10 copay applies to services received at freestanding facilities (Refer to Section 5(c))
<p><i>Not Covered:</i></p> <ul style="list-style-type: none"> • <i>Ultrasound/sonogram tests for routine purposes, except one routine ultrasound/sonogram for a normal pregnancy.</i> 	<p><i>All charges.</i></p>
Preventive care, adult	
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total blood cholesterol – once every three years* • Colorectal cancer screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50* <p>And other diagnostic tests as recommended by the American Cancer Society Guidelines</p> <ul style="list-style-type: none"> • Chlamydial infection • Routine Prostate Specific Antigen (PSA) test– one annually for men age 40 and older* • Routine Pap test – annual* • Osteoporosis screening 	<p>\$10 per office visit</p>

* Or more frequently if recommended by your BlueCHOICE physician.

Preventive care, adult – continued on next page

Preventive care, adult <i>(continued)</i>	You pay
Routine mammogram – once per calendar year or more frequently if recommended by a physician	\$10 per visit
Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – ages 19 and over is based on medical necessity • Influenza vaccines • Pneumococcal vaccines 	Nothing (\$10 office visit copay applies to any other covered services)
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i> • <i>Immunizations for travel or occupational reasons.</i> 	<i>All charges.</i>
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing (\$10 office visit copay applies to any other covered services)
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> – Eye exams to determine the need for vision correction – Ear exams to determine the need for hearing correction – Newborn hearing screening, rescreening and initial amplification – Examinations done on the day of immunizations 	\$10 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i> • <i>Immunizations for travel or occupational reasons.</i> 	<i>All charges.</i>

Infertility services	You pay
<p>Diagnosis and treatment of infertility limited to:</p> <ul style="list-style-type: none"> • In vitro fertilization • Gamete intrafallopian tube transfer (GIFT) • Zygote intrafallopian tube transfer <p>However, we will only cover these treatments if you or your spouse:</p> <ol style="list-style-type: none"> 1) Have not been able to become pregnant or sustain a pregnancy through reasonable, less costly and medically appropriate covered infertility treatment; 2) Have not undergone four completed oocyte retrievals (except if a live birth follows a completed oocyte retrieval, then we will cover two more completed oocyte retrievals); and 3) Have the procedures performed at medical facilities that conform to the American College of Obstetrics and Gynecology guidelines or to the American Fertility Society's minimum standards for in vitro fertilization. 	<p>\$10 per office visit</p>
<ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> – Intravaginal insemination (IVI) – Intracervical insemination (ICI) – Intrauterine insemination (IUI) 	<p>Nothing</p>
<ul style="list-style-type: none"> • Oral fertility drugs and injectable fertility drugs <p><i>Note: Preauthorization is required for fertility medication.</i></p>	<p>We cover fertility drugs under the prescription drug benefit. Please refer to Section 5(f).</p>
<p><i>Not covered</i></p> <ul style="list-style-type: none"> • <i>Treatment for infertility following voluntary sterilization</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> • <i>Any treatment not specified above</i> 	<p><i>All charges.</i></p>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injection 	<p>\$10 per office visit</p> <p>\$3 per visit (\$10 office visit copay applies to any other covered services)</p>
<p>Allergy serum</p>	<p>Nothing</p>
<p><i>Not covered: Provocative food testing and sublingual allergy desensitization</i></p>	<p><i>All charges.</i></p>

Treatment therapies	You pay
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 31.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Benefits for medical care <i>associated with</i> phase III or IV clinical trials for cancer treatment. The clinical trial must be underwritten by the National Institutes of Health Cooperative or an equivalent entity. The clinical trial treatment (including drugs, devices and procedures) itself is not covered. To receive benefits, there must not be an identical or superior non-investigational treatment available. Also, to be covered, any drugs or devices used in the clinical trial must have FDA approval for treatment of one or more conditions, but the approval does not have to be for the particular condition involved in the trial. • Growth hormone therapy (GHT) <p>Note: Before administering any GHT treatment, your BlueCHOICE physician needs to obtain authorization by submitting a written request to our Provider Services Unit. Please check with your BlueCHOICE physician before receiving GHT treatment.</p> <p>We will not cover GHT or related services and supplies unless you have received prior authorization.</p> <p>Growth hormone is covered as a medical benefit.</p>	<p>Nothing</p> <p>\$10 per visit outpatient</p> <p>\$10 per visit outpatient</p> <p>Nothing</p> <p>Nothing</p> <p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Therapy that is not listed as covered in this booklet. For example, massage therapy or exercise conditioning.</i> 	<p><i>All charges.</i></p>

Physical, occupational and speech therapies	You pay
<ul style="list-style-type: none"> • Up to a combined maximum of 60 visits per calendar year for physical, occupational and speech therapy. <p>For the services of each of the following:</p> <ul style="list-style-type: none"> – Qualified physical therapists – Occupational therapists and – Speech therapists <p>Note: We only cover physical and occupational therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation following, but not limited to, a heart transplant, bypass surgery or a myocardial infarction, is provided for one consecutive 12-week program per calendar year. • Pulmonary rehabilitation for up to 14 sessions within 12 months and then one session every 3 months thereafter. 	<p>\$10 per office visit/\$10 per outpatient visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs 	<p><i>All charges.</i></p>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Routine hearing exams • Newborn hearing, screening, rescreening and initial amplification 	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Hearing aids, testing and examinations for them 	<p><i>All charges.</i></p>

Vision services (testing, treatment, and supplies)	You pay
<ul style="list-style-type: none"> Routine eye exam (one per calendar year) Eyeglasses and contact lenses are reimbursed up to \$35 per 24-month period when received from a BlueCHOICE vision care provider. In addition, reduced-cost glasses or contact lenses are available from selected providers. 	\$10 per office visit
<ul style="list-style-type: none"> One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts). 	\$10 per office visit
<ul style="list-style-type: none"> Eye exam to determine the need for vision correction for children (see Preventive care, children) Annual eye refractions 	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Eye exercises and orthoptics</i> <i>Radial keratotomy and other refractive surgery, including LASIK procedures</i> 	<i>All charges.</i>
Foot care	
<ul style="list-style-type: none"> Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. <p>See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>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</i> <i>Treatment of 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)</i> 	<i>All charges.</i>

Durable medical equipment (DME) <i>(continued)</i>	You pay
Air flotation mattress and alternating pressure pump	\$ 10
Apnea monitor ⁽¹⁾	\$ 25
Bi-directional Positive Airway Pressure (BIPAP) apparatus ⁽¹⁾	\$ 50
Bili phototherapy system ⁽¹⁾	\$ 25
Blood glucose monitor ⁽¹⁾	\$ 25
Bone growth stimulator (electrical) ⁽²⁾	\$100
Canes	\$ 10
Commode (bedside)	\$ 10
Compression (anti-embolic) stockings (up to 2 pairs per calendar year)	\$ 25 (per pair)
Continuous Passive Motion (CPM) Devices	\$ 25
Continuous Positive Airway Pressure (CPAP) apparatus ⁽¹⁾	\$ 25
Replacement CPAP apparatus, as follows:	
Nasal application device (mask)	\$ 25
Nasal pillow or face seal	\$ 10
Headgear	\$ 10
Chinstrap	\$ 0
Tubing	\$ 10
Filter, either disposable or reusable	\$ 0
Continuous Positive Airway Pressure (CPAP) humidifier	\$ 25
Crutches	\$ 10
Diabetic supplies: lancets, insulin syringes, glucose test strips and urine test strips, and equipment, other than a blood glucose monitor, one month supply	\$ 10
Enteral feeding equipment	\$ 25
Enteral feeding supplies	\$ 10
Hospital bed (electric)	\$ 50
Hospital bed (nonelectric)	\$ 25
Incontinence catheters and irrigation supplies, one month supply per copayment ⁽¹⁾	\$ 10
Infusion pump, per month per copayment (as part of outpatient infusion therapy when not provided by a home infusion therapy provider)	\$ 50
Insulin pump ⁽²⁾	\$100
Insulin pump supplies ⁽²⁾	\$ 25
Intermittent Positive Pressure Breathing Apparatus (IPPB) ⁽¹⁾	\$ 25
Lymphedema pumps/lymphedema sleeves	\$ 50
Mattress overlays	\$ 25
Medical and post-surgical dressings, irrigation supplies, and dressing tape, one month supply per copayment	\$ 10
Nebulizer compressor ⁽¹⁾	\$ 25
Neuromuscular Electronic Stimulator (NMES) ⁽²⁾	\$ 25
Nutritional formula and low-protein modified food products for phenylketonuria (PKU) or other inherited disease of amino and organic acids, covered for members through age 5 only, one month supply per copayment	\$ 15

Durable medical equipment – continued on next page

Durable medical equipment (DME) <i>(continued)</i>	You pay
Ostomy supplies, all types, one month supply per copayment Oxygen, one month supply per copayment Patient lifts Peak flow meters Pneumatic percusser Pulmoaids Spacers for Metered Dose Inhalers (MDI) Sphygmomanometer for gestational hypertension Suction catheters, one month supply per copayment ⁽¹⁾ Suction equipment Transcutaneous Electrical Nerve Stimulator (TENS) Units Traction devices Ventilator, per month per copayment Walkers Wheelchairs (electric) Wheelchairs (non-electric) Wheelchair gel pads	\$ 10 \$ 50 \$ 25 \$ 10 \$ 10 \$ 10 \$ 10 \$ 25 \$ 10 \$ 25 \$ 25 \$ 25 \$ 25 \$ 25 \$ 150 \$ 10 \$ 50 \$ 25 \$ 10
<p>The maximum benefit for a medically necessary nonstandard wheelchair is \$2,000. The regular copay for a manual or electric wheelchair applies. ⁽²⁾</p> <p>ABI Vest, used to treat members with cystic fibrosis, is available for \$200 per month. ⁽²⁾</p> <p>(1) Includes initial provision of nonpharmaceutical medically necessary supplies.</p> <p>(2) Subject to review by BlueCHOICE. To obtain more information, you may contact us at 1-800-932-4480.</p>	\$ 10
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Dialysis equipment (rental or purchase)</i> • <i>Equipment or supplies that are not listed as covered</i> • <i>Nonstandard models of equipment</i> 	<p><i>All charges.</i></p> <p><i>Copay plus any charges above the allowed amount for the basic equipment.</i></p>

Home health services	
<ul style="list-style-type: none"> • 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. Your physician will periodically review the program for appropriateness and need. • Services include oxygen therapy, intravenous therapy and medications. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family.</i> • <i>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<i>All charges.</i>
Chiropractic	You pay
<ul style="list-style-type: none"> • 26 visits per calendar year • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> • <i>Maintenance care</i> • <i>Relaxation therapy</i> 	<i>All charges.</i>
Alternative treatments	
<i>See Non-FEHB benefits, page 47.</i>	
Educational classes and programs	
<ul style="list-style-type: none"> • Smoking Cessation • Asthma and diabetes self-management 	<p>Please refer to Mental health and substance abuse benefits in Section 5(e); for prescription drug benefits, Section 5(f); and for non-FEHB benefits, Section 5(i).</p> <p>Please refer to Special features, Section 5(g).</p>

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

Here are some important things to keep in mind about these benefits:

**I
M
P
O
R
T
A
N
T**

- 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.
- 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 health care 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 OF 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.

**I
M
P
O
R
T
A
N
T**

Benefit Description	You pay
Surgical procedures	
<p>A comprehensive range of services, such as</p> <ul style="list-style-type: none"> • 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 -- a condition in which an individual weighs 100 pounds or 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. 	<p>Nothing, unless services are received during an office visit, then the \$10 copay applies.</p>

Surgical procedures – continued on next page

Surgical procedures <i>(continued)</i>	You pay
<ul style="list-style-type: none"> • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>Nothing, unless services are received during an office visit, then the \$10 copay applies.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care.</i> 	<p><i>All charges.</i></p>
Reconstructive surgery	You pay
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – 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; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – 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. 	<p>Nothing, unless services are received during an office visit, then the \$10 copay applies.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>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</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges.</i></p>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/pancreas • Liver • Lung: single –double • Pancreas • Allogeneic bone marrow transplant, if the treatment is part of a National Cancer Institute (NCI) phase III or IV trial, or the treatment is available elsewhere as part of a NCI phase III or IV trial. Donor screening tests and donor search expenses are also covered for allogeneic bone marrow transplants. • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and single or tandem transplants for testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. • Human Leukocyte Antigen (HLA) testing, where member is recipient. <p>Note: Autologous bone marrow or stem cell transplants after high-dose chemotherapy to treat breast cancer, and related care, must be received at St. Louis University Hospital/SLU Care.</p> <p>National Transplant Program (NTP): We are a member of the Blue Quality Center for Transplants.</p> <p>All care for transplants must be coordinated through BlueCHOICE in writing. The physician should send a letter to the BlueCHOICE Medical Director requesting precertification.</p> <p>If you live outside the St. Louis metropolitan area, we may cover up to \$10,000 in reasonable and necessary expenses for transportation, lodging and meals while you are away from home for the transplant. <i>This must be approved in advance by Case Management.</i></p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>Nothing</p>

Organ / tissue transplants – continued on next page

Organ/tissue transplants <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered • Organ donation expenses unless this program is covering the organ transplantation 	<p><i>All charges</i></p>
Anesthesia	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) <p>General anesthesia for certain dental patients, limited to:</p> <ul style="list-style-type: none"> • Children through age 4 • Severely disabled people; and • People with medical or behavioral conditions that require hospitalization or general anesthesia for dental care. <p>The general anesthesia must be provided in a network hospital, network freestanding surgery center or dentist’s office. A primary care physician referral is required. The dental procedures themselves are not covered.</p>	<p>Nothing</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>Nothing</p> <p>\$10 per office visit</p>

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

Here are some important things to remember about these benefits:

I
M
P
O
R
T
A
N
T

- 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, unless it is an emergency, (see Section 5(d)).
- 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 covered in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

I
M
P
O
R
T
A
N
T

Benefit Description	You pay
<p>Inpatient hospital</p> <p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets <p>NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	<p>Nothing</p>
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • 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 	<p>Nothing</p>

Inpatient hospital – continued on next page

Inpatient hospital (continued)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and guest beds • Private nursing care 	<p><i>All charges.</i></p>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>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.</p>	<p>Nothing</p>
Extended care benefits/Skilled nursing care facility benefits	You pay
<p>Extended care/skilled nursing facility (SNF):</p> <p>We cover treatment in a network skilled nursing facility for a condition that otherwise would require hospital confinement.</p> <p>You may transfer directly from the hospital. If you do not, your primary care physician must obtain advance approval from BlueCHOICE.</p> <p>We will cover the care only as long as it is medically necessary. We will notify you if we determine SNF care is no longer necessary. Then we will not cover any SNF charges after the date in the notice.</p> <p>We cover the following SNF services:</p> <ul style="list-style-type: none"> • Semiprivate room and board (We will cover a private room if BlueCHOICE agrees in advance that it is medically necessary. If not, you are responsible for any difference between the private room and the semiprivate room.) • General nursing care • Drugs, medications, biologicals, supplies, equipment and services ordered by the attending network physician with the primary care physician's prior authorization. 	<p>Nothing</p>
<p><i>Not covered: Custodial care</i></p>	<p><i>All charges.</i></p>

Hospice care	
<p>When a terminally ill member's life expectancy has reached six months or less, the member may benefit from hospice care. This care provides pain control and emotional support.</p> <p>Your primary care physician must obtain advance approval from BlueCHOICE. You must go to a network hospital or receive care from a network home health agency licensed to provide hospice care. The hospice provider will write a treatment plan for your signature. BlueCHOICE and your primary care physician must coordinate your care.</p> <p>We also cover inpatient hospice care for short-term pain control.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Independent nursing</i> • <i>Homemaker services</i> • <i>Bereavement services</i> 	<i>All charges.</i>
Ambulance	
<ul style="list-style-type: none"> • Local professional ambulance service when medically appropriate 	Nothing

Section 5(d). Emergency services/accidents

I
M
P
O
R
T
A
N
T

Here are some important things to 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.
- 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.
- When you need emergency medical care outside of the U.S., go to the nearest hospital. Call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583), or call collect at 1-804-673-1177, if you are admitted.

I
M
P
O
R
T
A
N
T

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:

Emergencies at network hospitals within our service area:

If possible, when an unexpected condition arises, call your primary care physician– unless you believe any delay would be harmful. This applies even if it's after office hours. Your primary care physician will tell you whether to go to the emergency room. Your primary care physician's number is listed on the front of your ID card.

If you need additional care after an emergency condition is stabilized, precertification is required. Your BlueCHOICE physician will handle this for you. We will make a decision about the care within 30 minutes after we receive all the necessary information.

When you need care right away but it is not an emergency, always call your primary care physician. Your primary care physician may have you come into the office for an urgent appointment. An urgent appointment is one scheduled with a physician for the same day or during hours not normally used for appointments.

Emergencies at non-network hospitals (inside or outside our service area):

If possible, when an unexpected condition arises, call your primary care physician unless you believe any delay would be harmful. This applies even if it's after office hours. Your primary care physician will tell you whether to go to the emergency room. Your primary care physician's number is listed on the front of your ID card.

If you receive emergency care before you call your primary care physician, you or a family member should notify your primary care physician as soon as possible. We encourage you to try to call within 24 hours. Your primary care physician's number is listed on the front of your ID card.

If you need additional care after an emergency condition is stabilized, precertification is required. We will make a decision about the care within 30 minutes after we receive all the necessary information.

If you are admitted as an inpatient to a non-network hospital as a result of an emergency, you, your doctor or a family member should call BlueCHOICE as soon as possible for precertification of the case. BlueCHOICE will cover your care until you are stabilized. Then you must transfer to a BlueCHOICE network hospital. The transfer must be coordinated through BlueCHOICE in advance.

BlueCHOICE will not provide benefits for continued care at a non-network hospital after you are stable enough to transfer.

When you need care right away but it is not an emergency, always call your primary care physician. Your primary care physician may have you come into the office for an urgent appointment. An urgent appointment is one scheduled with a physician for the same day or during hours not normally used for appointments.

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services • Hospital observation <p>If you need follow-up care after emergency treatment, call your primary care physician. If your primary care physician cannot provide the care, he or she will give you a written referral to a network specialist.</p> <p>If you are treated in the emergency room and then held for observation, only one copay will be charged.</p> <p><i>If you receive follow-up care without a written referral from your primary care physician, you must pay all charges.</i></p>	<p>\$10 per office visit</p> <p>\$10 per office visit</p> <p>\$50 at emergency room (waived if admitted)</p> <p>\$50 (waived if admitted)</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>
Emergency outside our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services • Hospital observation <p>If you need follow-up care after emergency treatment, call your primary care physician. If your primary care physician cannot provide the care, he or she will give you a written referral to a network specialist.</p> <p>If you are treated in the emergency room and then held for observation, only one copay will be charged.</p> <p>After your condition is stabilized, you, the hospital, a family member or a friend must call us for approval of continued care.</p> <p>Benefits are available only until BlueCHOICE determines that your condition has improved enough for you to travel back to the BlueCHOICE service area.</p> <p><i>If you receive follow-up care without a written referral from your primary care physician, you must pay all charges.</i></p>	<p>\$10 per office visit</p> <p>\$10 per office visit</p> <p>\$50 at emergency room (waived if admitted)</p> <p>\$50 (waived if admitted)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> 	<i>All charges.</i>

Ambulance	
Professional ambulance and air ambulance service when medically appropriate. Transportation by air ambulance must be approved in advance by BlueCHOICE. See Section 5(c) for non-emergency service.	Nothing

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

**I
M
P
O
R
T
A
N
T**

Cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to 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.
- 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.

**I
M
P
O
R
T
A
N
T**

Benefit Description	You pay
Mental health and substance abuse benefits	
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition.</p>	\$10 per office visit
<ul style="list-style-type: none"> • Diagnostic tests 	\$10 per office visit or test
<ul style="list-style-type: none"> • Individual and group therapy for the treatment of smoking cessation 	Nothing
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services that have been preauthorized for alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	Nothing on inpatient basis; \$10 per visit for outpatient

Preauthorization

If you think you have a mental health or substance abuse problem, we encourage you to see your primary care physician. If you do not wish to go through your primary care physician, you may choose to receive care from another network provider without a referral.

Inpatient, intensive outpatient, partial hospitalization, residential treatment and certain outpatient treatment for mental health and substance abuse require precertification. Your network provider is responsible for contacting us to obtain precertification.

Outpatient benefits include up to two visits per calendar year to diagnose or assess a mental health condition, in or out of network, without authorization.

Section 5(f). Prescription drug benefits

I
M
P
O
R
T
A
N
T

Here are some important things to 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.
- Some prescription drugs are covered only if your physician obtains prior authorization from us. In addition, coverage for some drugs is provided in limited quantities.
- 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.

I
M
P
O
R
T
A
N
T

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

- **Who can write your prescription.** A plan physician or plan dentist must write the prescription, unless it is an emergency.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication.
- **Reimbursement for prescriptions purchased out-of-area will be covered up to the allowed amount after a \$25 copayment.**

Most maintenance drugs are available through mail order. To find out if a certain maintenance drug is available by mail order, call 1-800-655-1936.

- **We use an incentive-based three-tier formulary.** A formulary is a list of preferred drugs chosen for use based upon their effectiveness, safety and cost. Drugs are prescribed by Plan doctors and dispensed in accordance with BlueCHOICE's drug formulary. Tier 3 drugs will be covered when prescribed by a Plan doctor. The Plan may require authorization for a Tier 3 drug before it may be dispensed. It is the prescribing doctor's responsibility to obtain the Plan's authorization. You pay a \$7 copay per prescription unit or refill for Tier 1 medications; \$12 for Tier 2 drugs; and \$25 for Tier 3 drugs. When a Tier 1 drug is available but you or your physician request the brand-name drug, you pay the price difference between the Tier 1 drug and brand-name drug as well as the \$7 copay per prescription or refill *unless* your physician has obtained prior authorization for the brand-name drug. When the physician has obtained the prior authorization, you pay only the appropriate brand copay.
 - **These are the dispensing limitations.** Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply for retail or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin); and are available at \$7 for Tier 1; \$12 for Tier 2; and \$25 for Tier 3. Mail order prescription drugs are dispensed for up to a 90-day supply, and are available at \$14 for Tier 1; \$24 for Tier 2; and \$50 for Tier 3. In the event a member is called to active military duty or faces an emergency or other extenuating circumstances, refills may be obtained once 70 percent of an original 30-day supply has been used. In addition, with prior authorization, members may obtain a 3-month supply for the appropriate copay per month.
 - **Why use generic drugs?** Generic drugs normally cost considerably less than brand-name drugs. So, the copayment you pay for generic drugs is also lower. The generic name of a drug is its chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand-name drugs must meet the same standards for safety, purity, strength and effectiveness. They are dispensed in the same dosage and taken in the same way.
 - **GenericSelectSM Program.** Through this program, you can have your first prescription for certain generic prescription drugs filled free at a network pharmacy. See drug list on page 42.
 - **When you have to file a claim.**
Follow the same procedures for filing a prescription drug claim found in Section 7.
-

Benefit Description	You pay
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order and online program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Drugs that under state law are dispensed only with a written prescription from a physician or other lawful provider. • Insulin • Disposable needles and syringes for the administration of covered medications, including insulin • Drugs for sexual dysfunction (See Limited Drug Benefits below) • FDA-approved prescription drugs and devices for birth control • Diabetic test strips, lancets • FDA-approved medications for the treatment of tobacco use <p>Please note:</p> <ul style="list-style-type: none"> • Most prescriptions are limited to a 30-day supply each time the prescription is filled. • Refills your doctor authorizes are covered for up to 12 months from the original prescription date. Then a new prescription is required. • Some prescription drugs are covered only if your physician obtains prior authorization from us. In addition, coverage for some drugs is provided in limited quantities. • Intravenous fluids and medication for home use are provided under home health services at no charge; and some injectable drugs are covered under Medical and Surgical Benefits. <p>Limited Drug Benefits</p> <p>Prescription benefits for the treatment of sexual dysfunction will only be available with prior authorization where sexual dysfunction is secondary to a medical condition and the medical history and work-up is documented. You must receive prior authorization before receiving any prescription for the treatment of sexual dysfunction. If approved, six prescribed treatments per month will be available and subject to the Tier 3 copayment.</p>	<p>Retail (up to a 30-day supply)</p> <p>\$7 Tier 1 \$12 Tier 2 \$25 Tier 3</p> <p>Mail order and online (up to a 90-day supply)</p> <p>\$14 Tier 1 \$24 Tier 2 \$50 Tier 3</p> <p>Tier 1 drugs (lowest copay) – Nearly all Tier 1 drugs are generic drugs, but Tier 1 may include some lower-cost brand-name drugs.</p> <p>Tier 2 drugs (middle level copay) – These are brand-name drugs that are lower cost and/or provide greater therapeutic value than comparable brand-name drugs.</p> <p>Tier 3 drugs (highest copay) – Nearly all Tier 3 drugs are brand-name drugs that cost more and/or have less therapeutic value than comparable medications, but Tier 3 may include some high-cost generic drugs.</p> <p>Note: If you purchase a brand-name drug that has an equivalent Tier 1 drug, you will be responsible for the difference between the program’s allowed charge for the Tier 1 drug and the equivalent brand-name drug, in addition to the copay for the Tier 1 drug, unless your physician has obtained prior authorization for the brand-name drug. This applies wherever the prescription is filled, at a network or non-network pharmacy, out-of-area, through mail order, or online.</p>

Covered medications and supplies – continued on next page

Covered medications and supplies <i>(continued)</i>	You pay
<p>GenericSelectSM Drugs covered are:</p> <ul style="list-style-type: none"> • Fluoxetine* - for the common FDA indications for depression <i>Equivalent Brand Name Drug:</i> Prozac <i>Other Brand Name Drugs with Similar FDA Indications:</i> Zoloft*, Paxil*, Celexa* • Lovastatin* - for the common FDA indications for High Cholesterol <i>Equivalent Brand Name Drug:</i> Mevacor <i>Other Brand Name Drugs with Similar FDA Indications:</i> Lipitor*, Pravachol*, Zocor, Lescol • Ranitidine Tablets* - for the common FDA indications for Acid Reflux <i>Equivalent Brand Name Drug:</i> Zantac Tablets <i>Other Brand Name Drugs with Similar FDA Indications:</i> Prevacid*, AcipHex*, Nexium, Protonix, Prilosec • Lisinopril* - for the common FDA indications for High Blood Pressure <i>Equivalent Brand Name Drug:</i> Zestril / Prinivil <i>Other Brand Name Drugs with Similar FDA Indications:</i> Diovan*, Cozaar*, Avapro, Atacand, Norvasc* • Atenolol* - for the common FDA indications for High Blood Pressure <i>Equivalent Brand Name Drug:</i> Tenormin <i>Other Brand Name Drugs with Similar FDA Indications:</i> Diovan*, Cozaar*, Avapro, Atacand, Norvasc* • Metoprolol* - for the common FDA indications for High Blood Pressure <i>Equivalent Brand Name Drug:</i> Lopressor <i>Other Brand Name Drugs with Similar FDA Indications:</i> Diovan*, Cozaar*, Avapro, Atacand, Norvasc* • Hydrochlorothiazide* - for the common FDA indications for High Blood Pressure <i>Equivalent Brand Name Drug:</i> Hygroton <i>Other Brand Name Drugs with Similar FDA Indications:</i> Diovan*, Cozaar*, Avapro, Atacand, Norvasc* • Chlorthalidone* - for the common FDA indications for High Blood Pressure <i>Equivalent Brand Name Drug:</i> Oretic <i>Other Brand Name Drugs with Similar FDA Indications:</i> Diovan*, Cozaar*, Avapro, Atacand, Norvasc* • Metformin* - for the common FDA indications for Diabetes <i>Equivalent Brand Name Drug:</i> Glucophage <i>Other Brand Name Drugs with Similar FDA Indications:</i> Actos*, Avandia* • Glipizide* - for the common FDA indications for Diabetes <i>Equivalent Brand Name Drug:</i> Glucotrol <i>Other Brand Name Drugs with Similar FDA Indications:</i> Actos*, Avandia* • Glyburide* - for the common FDA indications for Diabetes <i>Equivalent Brand Name Drug:</i> Diabeta/Micronase <i>Other Brand Name Drugs with Similar FDA Indications:</i> Actos*, Avandia* 	<p>The first prescription is filled free at a network pharmacy. Subsequent refills can be obtained at the Tier 1 copay.</p>

Covered medications and supplies – continued on next page

Covered medications and supplies (<i>continued</i>)	You pay
<ul style="list-style-type: none"> • Ibuprofen* - for the common FDA indications for Arthritis Pain <i>Equivalent Brand Name Drug:</i> Motrin <i>Other Brand Name Drugs with Similar FDA Indications:</i> Celebrex*[†], Vioxx*[†], Bextra • Naproxen* - for the common FDA indications for Arthritis Pain <i>Equivalent Brand Name Drug:</i> Naprosyn <i>Other Brand Name Drugs with Similar FDA Indications:</i> Celebrex*[†], Vioxx*[†], Bextra <p>*Formulary (preferred brand) drug † Requires Prior Authorization</p>	
<p>Here are some things to keep in mind about our prescription drug program:</p> <ul style="list-style-type: none"> • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name-brand drug when a Federally approved Tier 1 generic drug is available, <i>whether or not your physician has specified Dispense as Written</i> for the name-brand drug, you have to pay the difference in cost between the name-brand drug and the Tier 1 generic, unless your physician has obtained prior authorization for the brand-name drug. • We have an incentive-based, three-tier formulary. 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 a 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. We update our formulary throughout the year. To obtain the most current list of available drugs and under which Tier it falls check the BCBSMo Web site at www.bcbsmo.com or call Client Services at 1-800-932-4480. 	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs for which there is a nonprescription equivalent available</i> • <i>Drugs obtained at a non-Plan pharmacy (except out-of-area emergencies)</i> • <i>Vitamins and nutritional substances that can be purchased without a prescription</i> • <i>Medical equipment, devices and supplies such as dressings and antiseptics</i> • <i>Drugs for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Test agents and devices</i> • <i>Appetite suppressants and other drugs for weight loss</i> • <i>Nonprescription medicines</i> • <i>Replacement drugs due to loss or theft</i> • <i>Travel (except for emergencies)</i> • <i>Special packaging for drugs in nursing homes</i> 	<p><i>All charges.</i></p>

Section 5(g). Special features

Feature	Description
Flexible Benefits Option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf and hearing impaired	For the hearing impaired (TDD), call 1-800-822-1215.
Away From Home Care[®]	<p>Through our BlueCard[®] program, BlueCHOICE offers its members medical care in emergency and urgent situations when traveling outside the service area.</p> <p>Also, members who are traveling for an extended time or who are on an extended work assignment in another city may be eligible to apply for an <i>Away From Home Care[®]</i> Guest Membership in a local Blue Cross and Blue Shield HMO. The Guest Membership also temporarily covers dependent children who are away at school or living in another city. For more information, see Section 1, page 8, or members can call Customer Service at the number listed on the back of their ID card.</p>
Blue Quality	National Transplant Program (NTP): We are a member of the Blue Quality Centers for Transplants.
BabyConnection	<p>This is a voluntary program that strives to help mothers-to-be avoid potential problems during pregnancy and the first year of the child's life. The program offers expectant mothers educational information about pregnancy, childbirth and infant care. The maternity health coaches are registered obstetric nurses prepared to help members with questions about their pregnancy. We encourage members to call their physicians any time they have medical concerns. All identified pregnant members receive a brochure entitled, "Warning Signs – Is it Preterm Labor?" Pregnant women who choose to participate in the BabyConnection program are asked to complete a telephonic health risk assessment questionnaire to establish their level of risk for preterm labor. Also, members that participate in the program will receive pregnancy related educational material. In addition to receiving educational material, members identified as at-risk for preterm labor will also receive telephone calls from a RN health coach. Another very important component of the BabyConnection program is the behavior health referral process that is available to members who may be experiencing symptoms of depression during their pregnancy and the postpartum depression program after delivery. Mothers-to-be who participate in the program can also receive up to a \$40 reimbursement for the cost of a childbirth, infant safety, infant CPR, parenting or breast-feeding class.</p>

<p>TakeCharge® Asthma Program</p>	<p>Our goal is to help our members who have asthma manage their disease more successfully. We provide case management services to severe asthmatics through frequent phone calls, individual care plans, home health visits (as approved by the patient’s doctor), durable medical equipment benefits and asthma educational material. A team of health coaches routinely follow adults and children at high risk. Upon request, those members who are at low risk can receive asthma educational materials and health coaching.</p>
<p>TakeCharge® Diabetes Program</p>	<p>This comprehensive care and disease management program is designed to support the health care needs of people with diabetes. Diabetes health coaches periodically contact high-risk members with diabetes to discuss their health and ways to manage their diabetes, and to answer any questions. The member’s doctor also receives information about the program.</p>
<p>TakeCharge® Congestive Heart Failure Program</p>	<p>Members with congestive heart failure who enroll in the program will receive information on how to manage their condition. A team of health coaches routinely follow members at high risk. Upon request, those who are at low risk can receive educational materials and health coaching.</p>
<p>Postpartum Depression Screening Program</p>	<p>All female members who receive obstetric services, including those who deliver live infants as well as those who deliver stillborns or miscarry, are eligible for this program. We send each member a postpartum depression brochure after delivery, along with the Edinburgh Depression Scale, a screening tool specific for postpartum depression, and a return envelope.</p>
<p>Note: Special programs such as BabyConnection, TakeCharge® Asthma Program, TakeCharge® Diabetes Program, TakeCharge® Congestive Heart Failure Program, and the Postpartum Depression Screening Program are special programs that are available to members who have primary health coverage through BlueCHOICE.</p>	

Section 5(h). Dental benefits

Dental benefits

No Dental Benefits

Section 5(i). 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 an FEHB disputed claim about them.** Fees you pay for these services do not count toward the FEHB out-of-pocket maximum. Your medical program copay does not apply to these services. You must pay for the services or supplies when you receive them.

Wellness and Education Programs

Eat Smart: Learn to eat right and control your weight. You'll get \$75 if you achieve your weight loss goal through a participating facility.

Breathe Easy: Smoking cessation classes offered in cooperation with local health care providers teach you some helpful tips for kicking the habit. Earn \$50 for regular class attendance and for quitting smoking.

Physical Fitness: If you are 18 or older, we will reimburse you 25 percent (up to \$100) for a single membership and 50 percent of annual dues (up to \$200) for a family membership at the health club of your choice.

Discounted Services

Hearing Aids: Free hearing evaluations and savings on hearing aids are available through Hometown Hearing and Audiology providers (314-962-2100) and Southwestern Hearing Aid Centers' providers (1-800-272-1101).

Vision Care: BlueCHOICE members may receive discounts on eye exams, lenses and frames by showing their ID card at a participating vision center. Members also can receive discounts off the regular retail price for all eye care accessories, including contact lens solutions and non-prescription sunglasses. Members can obtain discounted eye wear and eye care services through Crown Optical (1-800-475-6320) and Unity Health Eye Care network (314-729-4610).

Savings on LASIK surgery are available to members through Crown Optical. For more information, contact Crown at 1-800-232-4526. TruVision also offers savings to members for LASIK surgery. Additional information can be obtained by calling 1-866-487-2020.

Alternative Health Programs through American Specialty Health Networks: BlueCHOICE provides access to an alternative health care discount program through American Specialty Health Networks (ASHN). BlueCHOICE members can pay discounted fees when they see chiropractors, acupuncturists and massage therapists in ASHN's credentialed network. Members receive ASHN's toll-free telephone number to request provider directories and program brochures when they enroll.

In addition, members can access ASHN's national network of fitness clubs at the clubs' lowest membership rates. Additionally, members can try the fitness facilities at no charge for one full week.

Additional discounts are available for everything from educational videos to herbal supplements ordered through the Internet. Just go to www.bcbsmo.com for additional information.

Dental Services

For Missouri Residents Only:

For an additional premium, you may choose dental coverage with one of our *DentaBlue* plans, *DentaBlue Individual*, for individuals and families, or *DentaBlue Senior*, for individuals age 65 and older. *DentaBlue* uses a select network of local dentists and, in addition, provides access to a nationwide network of approximately 33,000 dentists. This means that you will be able to receive the higher network level of benefits should you need dental care when outside the Missouri service area. Members are also free to receive care from non-network dentists. The level of network and non-network benefits depends on the plan you select. As a *DentaBlue* member, you will get the added advantage of the OrthoBlue orthodontic discount program. For more information, call 1-888-800-7830.

Premiums will be billed directly to your home.

Note: We may receive payments from the providers of these discount programs to cover administrative and related costs associated with offering the programs and services to members. We do not select or recommend providers for the discount programs and do not recommend or prescribe the services or treatments provided. We encourage members to consult with their physician about any of these services or products.

Section 6. General exclusions – things we don't cover

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits).
- Services, drugs, or supplies you receive while you are not enrolled in the Plan.
- Services, drugs, or supplies that are not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Investigational or Experimental Care, except reasonable and medically necessary drugs, devices, medical treatments, procedures or other technology included as part of a Phase III or IV clinical trial undertaken to treat cancer. The clinical trial must be underwritten by a National Institute of Health Cooperative or an equivalent entity. Covered items do not include: the investigational item or service itself; items and services used only for data collection, not for clinical management of the patient; or items and services customarily provided by research sponsors at no charge.
- 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 from immediate relatives or household members, such as spouse, parent, child, brother or sister, by blood, marriage or adoption.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

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.

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

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800-932-4480.

How to file a claim:

- You can obtain claim forms by calling Client Services at 1-800-932-4480. The back of the claim form has complete filing instructions.
- You can use the same claim form to file a claim for all your health care benefits, except for prescription drugs.
- You may submit claims for more than one person in the same envelope. *However, you must submit a separate claim form for each person.* Attach each person's bill to the correct form.
- Complete the claim form fully and accurately. You must check "yes" or "no" for each question. If you do not answer a question, we may have to return your claim to you. This is also true if you do not provide additional information required.
- When you write in your identification number on the claim form, be sure to include the first three digits.
- We can only accept itemized bills. Each bill must show: the name of the patient, the name and address of the provider of care, a description of each service and the date provided, a diagnosis and the charge for each service.
- Canceled checks and nonitemized bills that show only "balance due" or "for professional services rendered" are not sufficient.
- Include all bills for covered services not previously submitted.
- If you have paid the provider, mark each bill "paid."
- In some cases, we will pay you directly for covered services. In other cases, we will pay the provider.
- Please keep copies of the completed claim form and itemized bills.
- Send your claims to the address shown below:

BlueChoice
P.O. Box 66834
St. Louis, MO 63166

Prescription drugs

Major chains and independent pharmacies belong to your pharmacy network. At these pharmacies, if you show your BlueCHOICE ID card, you should only be responsible for paying your share of the cost. The pharmacy should file your claim, and we will pay the pharmacy directly.

At a Non-Network Pharmacy: If you go to a non-network pharmacy in an urgent or emergency situation outside the BlueCHOICE service area, you are responsible for paying for your prescription at the time of service and then filing a claim. Your program will not provide benefits if you use a non-network pharmacy within the BlueCHOICE service area.

You can obtain a Prescription Drug Claim Form by calling Client Services at 1-800-932-4480.

You can file up to three prescriptions on each form. *Please do not use a regular health benefits claim form to file your prescription drug claim.* If you do, your claim may be denied.

- Please fill out a separate claim form for each person and pharmacy.
- Be sure to provide all the information requested for each prescription. You may need to have the pharmacy complete the form or get the information from the pharmacy.
- Then you or the pharmacist should fill out the pharmacy's name, address and National Association of Board of Pharmacy (NABP) number.
- On the completed form, *tape* your *original* itemized prescription drug receipt(s). Please do not send cash register receipts, canceled checks, bottle labels, copies of the original prescription drug receipts, or your own itemization of charges.
- The receipt(s) must show: the prescription number, the patient's name, the name of the drug, the quantity and unit dose, and the strength of the drug.
- Sign the claim form. Then mail it and your receipt(s) to the address shown below:

PrecisionRx
P.O. Box 961025
Fort Worth, TX 76161-9863

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.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval:

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: BlueCHOICE Grievance Unit P.O. Box 66828 St. Louis, MO 63166-6828Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial – go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>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.</p> <p>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.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620.</p>

The disputed claims process (*continued*)

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; and
- Your daytime phone number and the best time to call.

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.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5

OPM 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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-932-4480 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call the OPM's Health Insurance Group 2 at 202-606-3818 between 8 a.m. and 5 p.m. Eastern Time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under another group health plan or have 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 payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. All programs together will not pay more than 100% of allowable expenses. The allowable expense is the maximum amount that a plan will pay for covered services. We will not pay more than our allowance.

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 two 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. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE 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.

• 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 to set up an appointment to apply. If you do not apply for one or both 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 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 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. Some things are not covered under Original Medicare, such as most prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

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. *Your care must continue to be authorized by your Plan PCP and you will still be responsible for the Plan's copayments.*

- **Filing a claim**

When this Plan is primary and you have a claim for covered services that you must file yourself, please follow the claim filing instruction in Section 7.

Once you receive an Explanation of Benefits (EOB) from us, then file a claim for your Medicare benefits. *(For information on filing a Medicare claim, contact your Social Security office.)*

When Original Medicare is primary you must submit your claims to Medicare first. The federal government requires most health care providers and suppliers to file your Medicare claims for you. So in most cases, you shouldn't need to file a claim to obtain your Medicare benefits.

In most cases, *you* shouldn't need to file to receive the benefits of *this* program. If the services or supplies are covered by Medicare, the Medicare carrier will usually forward your medical claim to us. Then we will provide the benefits of this program automatically in most cases. However, you should file a claim if you receive services or supplies that are not covered by Medicare but are covered by this program.

You should *not* submit a claim for benefits of this program if your Medicare Summary Notice (MSN) states, in part: "This information is being sent to your private insurer." This note means that the Medicare carrier is submitting your claim to us. Then we can provide the benefits of this program. If this note is on your MSN, please do *not* submit a claim to us. Also, please let your providers of care know that they should *not* submit your claim to us. When we receive duplicate claims, this increases costs. Your MSN may not indicate that your claim has been referred to supplemental claims processing. In that case, you should file your own claim.

We do not waive any costs if the Original Medicare Plan is your primary payer.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer 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.

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee or through your spouse who is also an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is also an annuitant	✓	
3) 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 #1 above	✓	
4) 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		
5) 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 #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	✓*	
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...		✓ for 30-month coordination period
• This Plan was the primary payer before eligibility due to ESRD		
• Medicare was the primary payer before eligibility due to ESRD	✓	
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

• Medicare Advantage

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) in some areas of the country. In most Medicare Advantage plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare Advantage plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare Advantage plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

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 **you will still be responsible for** copayments. 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.

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 the program.

Workers' Compensation

We do not cover services that:

- You 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 medical or hospital care for injuries or illness caused by another person, 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.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

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.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	<p>Services that do not seek to cure, but are provided primarily for the convenience of the patient or his or her family, the maintenance of the patient, or to assist the patient in meeting his or her activities of daily living, rather than primarily for therapeutic value in the treatment of a Condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, eating, preparation of special diets, supervision over self-administration of medications not requiring constant attention of trained medical personnel, or acting as a companion or sitter. Custodial care that lasts 90 days or more is sometimes known as Long term care.</p> <p><i>Note: BlueCHOICE will have the sole discretion to determine whether care is Custodial care. BlueCHOICE may consult with professional peer review committees or other appropriate sources for recommendations.</i></p>
Experimental or investigational services	<p>A drug, device or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.</p> <p>An FDA-approved drug, device or biological product (for use other than its intended purpose and labeled indications), or medical treatment or procedure is experimental or investigational if</p> <ol style="list-style-type: none">1) Reliable evidence shows that it is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, or2) Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis. <p>Reliable evidence shall mean only published reports and articles in the authorized medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.</p> <p>FDA-approved drugs, devices, or biological products used for their intended purpose and labeled indication and those that have received FDA approval subject to postmarketing approval clinical trials, and devices classified by the FDA as “Category B Non-experimental/Investigational Devices” are not considered experimental or investigational.</p>
Group health coverage	A health benefit plan that is offered to employees through their place of employment or to the membership of a sponsoring organization such as a union or association.

Medical necessity

We only cover care that is medically necessary. But we do not cover all medically necessary care. Even if the type of care is covered in general, the care is not covered if we determine it was not medically necessary in a specific case. BlueCHOICE must agree that care was medically necessary.

However, in some cases, you will not have to pay for care that was not medically necessary. In these cases, the provider is responsible. You do not need to pay if *all* of the following are true:

- You obtained the proper referral for the care.
- BlueCHOICE did not notify you in advance that the care was not medically necessary.
- The services would have been covered if they were medically necessary.

To be medically necessary, care must be provided to diagnose or treat a condition. Also, the type and level of care must be necessary and appropriate. We use current standards of medical practice to decide necessity and appropriateness. The type and level of care must not be more than what is necessary.

For example, surgery may not be medically necessary for your condition if your provider has not tried more conservative treatment. Also, inpatient care is not medically necessary if appropriate care is available on an outpatient basis.

Plan allowance

The maximum amount we will pay for covered services.

Us/We

Us and We refer to *BlueCHOICE*

You

You refers to the enrollee and each covered family member.

Section 11. 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.

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about 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;
- When your enrollment ends; and
- 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.

- **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 unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after 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 when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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.

- **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 2005 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 2004 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.

- **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.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Spouse equity coverage**

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. But, you may be eligible for your own FEHB coverage under 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 Employees Health Benefits Plans 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/insure.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for 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 job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal 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 Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual 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 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.

- **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/insure/health; 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 12. Two Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB.

The Federal Flexible Spending Account Program – *FSAFEDS*

• What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%.*

There are two types of FSAs offered by FSAFEDS:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum annual amount that can be allotted for the HCFSA is \$4,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$4,000 each (\$8,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you and your spouse, if married, can work, look for work, or attend school full-time.
- Qualifying dependents for this account include your dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return (and who is mentally or physically incapable of self care).
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive.

• Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2005 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2005. Enrollment is easy!

- **Online:** visit www.FSAFEDS.com and click on **Enroll**.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS, (372-3337), Monday through Friday, from 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB – you can choose to participate in either, or both, of the FSAs. *However, if you enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), you are not eligible to participate in an HCFSA.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called “when actually employed” [WAE]) employees expected to work fewer than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, the advantages of having an FSA are the same regardless of the agency for which you work.

• How much should I contribute to my FSA?

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS places strict guidelines on how the money can be used. Under current IRS tax rules, you are required to forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “use-it-or-lose-it” rule. You will have until April 30, following the end of the plan year to submit claims for your eligible expenses incurred from January 1 through December 31. For example if you enroll in FSAFEDS for the 2005 Plan Year, you will have until April 30, 2006, to submit claims for eligible expenses.

The FSAFEDS Calculator at www.FSAFEDS.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

• What can my HCFSA pay for?

Every FEHB plan includes cost sharing features, such as copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 68 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

Under this plan, typical out-of-pocket expenses include: office-visit copay, emergency room copay and prescription drug copay. In addition, common expenses not covered under this plan include: dental fees, over-the-counter drugs, and hearing aids and hearing aid batteries.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at www.FSAFEDS.com/fsafeds/eligibleexpenses.asp. If you do not see your service or expense listed please call an FSAFEDS Benefits Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

• Tax savings with an FSA

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon the retirement system in which you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424 - a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

- **Health care expenses**

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

- **Dependent care expenses**

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.FSAFEDS.com and download the [Dependent Care Tax Credit Worksheet](#) from the Forms and Literature page to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

No. Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the Plan Year, resulting in the forfeiture of funds remaining in your account (the IRS "use-it-or-lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at www.FSAFEDS.com, or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m., Eastern Time.

- E-mail: FSAFEDS@shps.net
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

The Federal Long Term Care Insurance Program

- **It's important protection** Why should you consider applying for coverage under the Federal Long Term Care Insurance Program (FLTCIP)?
 - **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” 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. The need for long term care can strike anyone at any age and the cost of care can be substantial.
 - **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
 - **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
 - **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
 - **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.
- **To find out more and to request an application** Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Index

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

Allergy tests.....	20	Fecal occult blood test.....	17	Pap test.....	17
Allogeneic bone marrow transplant.....	31	Flexible Spending Account (FSA)	9, 63	Physical examination	17, 18
Alternative treatments.....	27, 47	Fraud	3, 4	Physical therapy	9, 22
Ambulance.....	33, 35, 38	General exclusions	48	Postpartum depression screening	45
Anesthesia	28, 30, 32, 34	H earing services.....	22	Precertification	12, 36, 39
Autologous bone marrow transplant.....	21, 31	Home health services.....	12, 27	Pre-existing condition	60
Away From Home Care.....	8, 44	Hospice care	35	Prescription drugs	9, 40, 41, 42, 43, 50
B abyConnection	44	Hospital	12, 33, 34, 36	Preventive care, adult.....	17, 18
Biopsy.....	28	I mmunizations.....	18	Preventive care, children.....	18
Blood and blood plasma	33	Infertility	20	Primary care physician.....	6, 8, 10, 11
Casts	33	In-hospital physician care.....	16	Prior approval.....	12
Catastrophic protection out-of-pocket maximum	13, 69	Inpatient hospital benefits.....	12, 33, 34	Prostate cancer screening	17
Changes for 2005.....	9	Insulin.....	40, 41	Prosthetic devices.....	24
Chemotherapy	21	Laboratory and pathological services....	17, 34	Psychologist	39
Childbirth	19, 44	Long Term Care Insurance Program ..	9, 66	Radiation therapy	21
Chiropractic	27	Magnetic Resonance Imagings (MRIs) .	12, 17	Renal dialysis	21, 53
Cholesterol tests.....	17	Mail order Prescription Drugs	40, 41, 50	Room and board.....	33, 34
Claims.....	49, 50, 51, 52	Mammograms	17, 18	Second surgical opinion.....	16
Coinsurance.....	13	Maternity benefits	13, 19, 33	Skilled nursing facility care..	12, 16, 32, 34
Colorectal cancer screening	17	Medicaid.....	57	Smoking cessation.....	27, 39, 47
Congenital anomalies	28, 29	Medically necessary	48, 59	Speech therapy	9, 22
Contraceptive drugs and devices	19	Medicare.....	9, 53, 54, 55, 56	Splints	33
Coordination of benefits	53	Mental Health/Substance Abuse Benefits	11, 39	Sterilization procedures.....	19, 20, 29
Covered charges	14	Newborn care	18, 19, 22	Subrogation	57
Covered providers	6, 10, 11, 39	Non-FEHB benefits.....	47	Substance abuse	11, 39
Crutches.....	25	Nurse Licensed Practical Nurse (LPN).....	27	Surgery	28
D eductible	13	Registered Nurse.....	19, 27, 44	Anesthesia.....	28, 32, 33
Definitions.....	58	Nursery charges.....	19, 33	Oral	30
Dental care.....	46, 47	O bstetrical care	11, 19, 33	Outpatient	34
Diagnostic services.....	16, 17, 33, 39	Occupational therapy.....	9, 22	Reconstructive	29
Disputed claims review	51	Ocular injury	23	Syringes	41
Donor expenses	31, 32	Office visits	16	TakeCharge asthma.....	45
Dressings	34	Oral and maxillofacial surgical.....	30	TakeCharge diabetes	45
Durable medical equipment (DME) ..	9, 24, 25, 26, 43	Orthopedic devices.....	24	TakeCharge congestive heart failure	45
Educational classes and programs	47	Ostomy and catheter supplies.....	26	Temporary Continuation of Coverage (TCC).....	61, 62
Effective date of enrollment	10, 60, 61	Out-of-pocket expenses	13	Transplants.....	31, 44
Emergency.....	6, 8, 12, 33, 36, 37, 38	Outpatient facility care	12, 34	Treatment therapies.....	21
Experimental or investigational	48, 58	Oxygen.....	26, 27	Vision services	23
Eyeglasses	23			W heelchairs	26
F amily planning.....	19			W orkers' Compensation	55, 56
				X -rays.....	17, 33

Summary of benefits for BlueCHOICE - 2005

- **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.

Benefits	You pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: \$10	16
Services provided by a hospital: • Inpatient..... • Outpatient	Nothing Nothing	33 34
Emergency benefits • In-area..... • Out-of-area	\$ 50 per emergency room visit \$ 50 per emergency room visit	37 37
Mental health and substance abuse treatment	Regular cost sharing	39
Prescription drugs • Retail	\$ 7 Tier 1 \$12 Tier 2 \$25 Tier 3	40
• Mail Order	\$14 Tier 1 \$24 Tier 2 \$50 Tier 3	
Vision care	Routine eye exam (one per calendar year); \$10 per office visit. Eyeglasses and contact lenses are reimbursed up to \$35 per 24-month period when received from a BlueCHOICE vision care provider. In addition, reduced-cost glasses or contact lenses are available from selected providers.	23
Special features: • Flexible Benefits Option • Services for deaf and hearing impaired • Away From Home Care • Blue Quality • BabyConnection		44

<ul style="list-style-type: none"> • TakeCharge Asthma Program • TakeCharge Diabetes Program • TakeCharge Congestive Heart Failure Program • Postpartum Depression Screening Program 		
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	After you pay 100% of your annual premium in copayments for one family member (per person), or 100% of your annual premium for two or more family members (self and family), you do not have to make any further payments for certain services for the rest of the year. Some costs do not count toward this protection.	13

2005 Rate Information for BlueCHOICE

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	9G1	\$131.08	\$46.42	\$284.01	\$100.57	\$154.74	\$22.76
Self & Family	9G2	\$288.23	\$96.07	\$624.49	\$208.16	\$341.07	\$43.23