

PersonalCare Insurance of Illinois, Inc.

www.PersonalCare.org

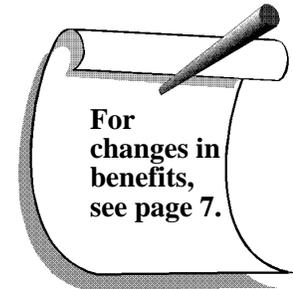


2007

A Health Maintenance Organization

Serving: *Central and Northern Illinois*

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 6 for requirements.



Enrollment code for this Plan:

GE1 Self Only

GE2 Self and Family

Authorized for distribution by the:



**United States
Office of Personnel Management**

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



Important Notice from PersonalCare About

Our Prescription Drug

Coverage and Medicare

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

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

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

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

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

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of PersonalCare Insurance of Illinois, Inc. (PersonalCare) under our contract (CS2042) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for PersonalCare administrative offices is:

PersonalCare
2110 Fox Drive
Champaign, IL 61820

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, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 7. 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.

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:

Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.

Let only the appropriate medical professionals review your medical record or recommend services.

Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

Carefully review explanations of benefits (EOBs) statements 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 PersonalCare at 800/431-1211 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.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

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

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

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

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

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:

Exactly what will you be doing?

About how long will it take?

What will happen after surgery?

How can I expect to feel during recovery?

- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reactions to anesthesia, and any medications you are taking.

Visit these Web sites for more information about patient safety.

- www.ahrq.gov/path/beactive.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/. 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 the Plan for a copy of their most recent provider directory.

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

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

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Your rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. 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.

PersonalCare's HMO is a prepaid health plan (mixed model) that contracts with medical groups and individual doctors in Champaign, Danville, Decatur, Kankakee, Peoria, Rockford, Springfield, and many other Illinois communities. PersonalCare was founded by physicians in 1984 and is now a part of Coventry Health Care, a for-profit company.

You may contact PersonalCare for assistance in choosing the most conveniently located doctors by calling (800) 431-1211.

PersonalCare Insurance of Illinois is a wholly-owned subsidiary of Coventry Health Care, Inc., which is a **for-profit managed health care company**.

If you want more information about us, call (800) 431-1211, or write to us at 2110 Fox Drive, Champaign, IL 61820. You may also contact us by fax at (217) 366-5410 or visit our Web site at www.PersonalCare.org.

Service Area

To enroll in this plan you must live or work in our service area. This is where our providers practice. Our service area in the Illinois counties of Bond, Boone, Calhoun, Carroll, Champaign, Christian, Clinton, Coles, Cumberland, DeWitt, Douglas, DuPage, Effingham, Fayette, Ford, Greene, Henry, Iroquois, Jasper, Jersey, Kane, Kankakee, LaSalle, Lee, Logan, Macon, Macoupin, Madison, Marshall, Mason, Menard, Mercer, Monroe, Montgomery, Morgan, Moultrie, Ogle, Peoria, Piatt, Rock Island, Sangamon, Shelby, Stark, St Clair, Stephenson, Tazewell, Vermilion, Washington, Whiteside, Will, Winnebago and Woodford.

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

Section 2 How we change for 2007

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

Changes to this Plan

- Your share of the non-Postal premium will increase by 12.8% for Self Only or 44.9% for Self and Family.
- We will not require referrals for rehabilitative therapies and chiropractic services.
- We will not require prior approval for chiropractic services.
- We will cover genetic counseling under family planning benefits.
- We will cover the cost of donor sperm and the cost of donor egg under the infertility benefits.
- We will require prior approval for the following:
 - Diagnostic and treatment services (PET scan, MRI/MRA, CT scan, cardiac stress imaging, cardiac nuclear scan, intra-cardiac electrophysiological study, radio frequency ablation, stress echo cardiogram, cardiac catheterization)
 - Durable Medical Equipment over \$100
 - Lesion removal in location other than the office
 - Medical injectable medications
 - Out-patient mental and substance abuse services
 - Orthotic and prosthetic devices over \$250
 - Pain management injection
 - Self-administered injectable medications
 - Sleep studies
 - Surgical procedures at outpatient hospital or ambulatory surgical centers
- We will not cover motorized wheel chairs.
- We will cover air ambulance services when medically necessary.
- We will cover prosthetic replacements every two years instead of every five years.
- We will limit externally worn breast prostheses to one every two years.
- We will limit post-mastectomy surgical bras to three standard models every six months.
- PersonalCare is now available in Boone, Carroll, Cumberland, DuPage Fayette, Henry, Jasper, Kane, Mason, Mercer and Rock Island Counties.

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 letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (800) 431-1211 or write to us at PersonalCare, 2110 Fox Drive, Champaign, IL 61820. You may also request replacement cards and print a temporary card through our Web site at www.PersonalCare.org.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance.

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.

- **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. These doctors are listed in your provider directory, and you may call our Customer Service Department at (800) 431-1211 to tell us what doctor you choose.

- **Primary care**

Your primary care physician can be any type of physician listed under the heading “Primary Care Physician” in your provider directory. 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.

- **Specialty care**

Although your Primary Care Physician should help coordinate your care, you do not need a referral to visit most specialists. However, most substance abuse and mental health specialists do require 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.

- **Hospital care**

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

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (800) 431-1211. If you are new to the FEHB Program, we will arrange for you to receive care and reimburse you for your covered expenses while you are in the hospital beginning on the effective date of your coverage.

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

You are discharged, not merely moved to an alternative care center; 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 cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

How to get approval for...

- **Your hospital stay**

A provider contacts PersonalCare via "Pre Authorization Line" or "fax submission" for a decision on requested service. When a call is made to the Pre Authorization Line, if possible, the Pre Authorization staff person will render an approval at the time of the call. If further review is necessary with the medical director or additional information is requested from the provider a decision will be made and notification provided to the provider rendering the services and member via fax or mail.

Non-urgent pre authorization decisions are made within 15 days upon receipt of necessary information.

Urgent pre authorization decisions are made within 72 hours of receipt of the request.

Urgent concurrent review decisions are made within 24 hours of receipt of the request.

- **How to precertify an admission**

A provider contacts PersonalCare via “Pre Authorization Line” or “fax submission” for a decision on requested service. When a call is made to the Pre Authorization Line, if possible, the Pre Authorization staff person will render an approval at the time of the call. If further review is necessary with the medical director or additional information is requested from the provider a decision will be made and notification provided to the provider rendering the services and member via fax or mail.

Non-urgent pre authorization decisions are made within 15 days upon receipt of necessary information.

Urgent pre authorization decisions are made within 72 hours of receipt of the request.

Urgent concurrent review decisions are made within 24 hours of receipt of the request.

- **Maternity care**

A provider contacts PersonalCare via “Pre Authorization Line” or “fax submission” for a decision on requested service. When a call is made to the Pre Authorization Line, if possible, the Pre Authorization staff person will render an approval at the time of the call. If further review is necessary with the medical director or additional information is requested from the provider a decision will be made and notification provided to the provider rendering the services and member via fax or mail.

Non-urgent pre authorization decisions are made within 15 days upon receipt of necessary information.

Urgent pre authorization decisions are made within 72 hours of receipt of the request.

Urgent concurrent review decisions are made within 24 hours of receipt of the request.

- **What happens when you do not follow the precertification rules**

If no one contacted us, we will decide whether the hospital stay was medically necessary.

If we determine that the stay was medically necessary, we will pay the inpatient charges, less the \$500 penalty.

If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

If we denied the precertification request, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

When we precertified the admission but you remained in the hospital beyond the number of days we approved and did not get the additional days precertified, then:

For the part of the admission that was medically necessary, we will pay inpatient benefits, but

For the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

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 PersonalCare. Before giving approval, PersonalCare considers if the service is covered, medically necessary, and flows generally accepted medical practice.

PersonalCare calls this review and approval process pre-authorization. Your physician must obtain approval for the following services:

Inpatient and observation services:

- All hospital admissions, including observations
- All admissions to Skilled Nursing Facilities or inpatient Specialty care programs such as Rehabilitation; Hospice; Mental Health & Substance Abuse
- Transplants

Outpatient services:

- Ambulance, non-emergency transfers
- Cardiac and Pulmonary Rehabilitation
- Chemotherapy (Off Label Use Only)
- Diagnostics / services:
- PET scans -CT scans
- MRI/MRA -Radio frequency ablation
- All cardiac stress imaging -Stress echocardiogram
- Cardiac nuclear scans -Cardiac catheterizations
- Intracardiac Electrophysiological studies (EPS)
- Durable medical equipment over \$100 and all rental equipment
- Home health care, Home hospice care and Home Infusion Therapy
- Infertility services
- Lesion removal in location other than office (skin tag removal not covered benefit)
- Medical Injectable medications – Contact PersonalCare’s Customer Service Department
- Mental Health and Substance Abuse (call MHNet at 800-423-8070)
- Orthotic and prosthetic devices over \$250 (Over the counter devices such as braces & splints and shoe inserts are not covered benefits)
- Pain management injections including epidural and facet injections
- Prescription drugs, if applicable - Contact PersonalCare’s Customer Service Department
- Self Administered Injectable medications - Contact PersonalCare’s Customer Service Department
- Sleep Studies
- Surgical procedures at outpatient hospital or ambulatory surgical center - Contact PersonalCare’s Customer Service Department

Section 4 Your costs for covered services

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

Copayments

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

Example: When you see your primary care physician you pay a copayment of \$20 per office visit and when you go in the hospital, you pay \$100 per admission.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. We do not have a deductible.

Coinsurance

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

Example: In our Plan, you pay 50% of our allowance for durable medical equipment, prosthetic devices, and orthopedic devices.

Differences between our Plan allowance and the bill

In-network providers agree to limit what they will bill you. Because of that, when you use a network provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example about coinsurance: You see a network physician who charges \$150, but our allowance is \$100. You are only responsible for your coinsurance. That is, you pay just – 10% of our \$100 allowance (\$10). Because of the agreement, your network physician will not bill you for the \$50 difference between our allowance and his bill.

Out-of-network providers, on the other hand, have no agreement to limit what they will bill you. When you use an out-of-network provider, you will pay your deductible and coinsurance - **plus** any difference between our allowance and charges on the bill. Here is an example: You see an out-of-network physician who charges \$150 and our allowance is again \$100. Because you've met your deductible, you are responsible for your coinsurance, so you pay 30% of our \$100 allowance (\$30). Additionally, because there is no agreement between the out-of-network physician and us, he can bill you for the \$50 difference between our allowance and his bill.

Your catastrophic protection out-of-pocket maximum

After your copayments total \$1,500 per person or \$3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription drugs
- Durable medical equipment and prosthetic devices
- Vision screening
- Self administered injectables

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

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

High Option Benefits

See page 7 for how our benefits changed this year. Page 68 is a benefits summary.

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Section 5 High Option Benefits Overview

This Plan offers a High Option which is described in Section 5. Make sure that you review the benefits that are available under this option.

The High Option Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also read the General exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about High Option benefits, contact us at 800-431-1211 or at our Web site at www.PersonalCare.org.

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

Important things you should keep in mind about these benefits:

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

Plan physicians must provide or arrange your care.

A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.

We have no calendar year deductible.

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

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians In physician's office	\$20 per office visit
Professional services of physicians In an urgent care center During a hospital stay In a skilled nursing facility Office medical consultations Second surgical opinion	\$20 per office visit
At home	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel</i> • <i>Blood and blood derivatives not replaced by the member</i> 	<i>All charges.</i>
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap test s • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing

Benefit Description	You pay
Preventive care, adult	
<p>Routine physical every year which includes:</p> <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 three to five years starting at age 50 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 • Pelvic exam and Pap smear – every one to three years, females members age 18 or older 	<p>\$20 per office visit</p> <p>Nothing if you receive these services during your office visit; otherwise \$20 per visit</p>
<p>Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</p>	<p>Nothing if you receive these services during your office visit; otherwise \$20 per visit</p>
<p>Routine Pap test</p> <p>Note: The office visit is covered if pap test is received on the same day; see <i>Diagnostic and treatment services</i>, above.</p>	<p>Nothing if you receive these services during your office visit; otherwise \$20 per visit</p>
<p>Routine mammogram – covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	<p>Nothing if you receive these services during your office visit; otherwise \$20 per visit</p>
<p>Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) limited to:</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 18 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older <ul style="list-style-type: none"> - One dose if susceptible high risk, ages 18-65 - Age 65 and over • Hepatitis B, 3 doses if medical high risk, age 18 or older 	<p>Nothing if you receive these services during your office visit; otherwise \$20 per visit</p>
<p><i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i></p>	<p><i>All charges.</i></p>
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	<p>Nothing if you receive these services during your office visit; otherwise \$20 per visit</p>
<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 through age 17 to determine the need for vision correction 	<p>\$20 per office visit</p>

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	
<ul style="list-style-type: none"> - Hearing exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22) - Routine preventive examinations and care, age 1 and older 	\$20 per office visit
<ul style="list-style-type: none"> • Well-baby examinations and care up to age 1 	Nothing
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 10 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery (you do not need to precertify the normal length of stay). We will extend your inpatient stay for you or your baby if medically necessary. See page 10 for other circumstances. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	Nothing for office visits; \$100 per day up to a 5 day maximum copay for hospital admission
<i>Not covered: Routine sonograms to determine fetal age, size or sex.</i>	<i>All charges.</i>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs and contraceptive devices (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms • Genetic counseling and studies for diagnosis or treatment of genetic abnormalities. <p>Note: We cover injectable fertility drugs under medical benefits. We cover oral fertility drugs and oral contraceptives under the prescription drug benefit.</p>	\$20 per office visit
<i>Not Covered:</i>	<i>All charges.</i>

Family planning - continued on next page

Benefit Description	You pay
Family planning (cont.)	
<i>Reversal of voluntary surgical sterilization</i>	<i>All charges.</i>
Infertility services	
Diagnosis and treatment of infertility such as: <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • Cost of donor sperm • Cost of donor egg 	\$20 per office visit
<ul style="list-style-type: none"> • Fertility drugs • Injectable infertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	50%
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections • Allergy serum 	Nothing
<i>Not covered:</i> <i>Provocative food testing and sublingual allergy desensitization.</i>	<i>All charges.</i>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 27. <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy 	\$20 per office visit
<ul style="list-style-type: none"> • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit as an injectable. Note: We only cover GHT when we preauthorize the treatment. Your primary care physician or referral specialist will arrange for authorization. We must authorize GHT before you begin treatment; we will not cover unauthorized treatments.	50% of charges

Benefit Description	You pay
Physical and occupational therapies	
<p>Up to two consecutive months per condition for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. [Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.]</p>	<p>\$20 per office visit</p> <p>Nothing per visit during covered inpatient admission</p>
<p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to two months per condition if significant improvement can be expected within two months.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long-term rehabilitative therapy</i> • <i>Exercise programs</i> 	<p><i>All charges.</i></p>
Speech therapy	
<p>Up to two consecutive months per condition</p>	<p>\$20 per office visit</p> <p>Nothing per visit during covered inpatient admission.</p>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Hearing screening, one every year • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	<p>\$20 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, testing and examinations for them</i> 	<p><i>All charges.</i></p>
Vision services (testing, treatment, and supplies)	
<p>Eye refractions for all members (to provide a written lens prescription for eyeglasses) may be obtained through Cole Vision’s Vision One Exam Plus ® Program. Cole Vision has a large network of providers in the optical departments of major retailers such as Sears, JC Penney, and participating Pearle Vision Centers. Call (800) 799-0259 to find the provider nearest you. Cole Vision also has a discount program for frames and lenses.</p> <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p>	<p>\$30 per office visit</p>
<p>One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts); we do not cover frames.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses and after age 17, examinations for them</i> 	<p><i>All charges.</i></p>

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

Benefit Description	You pay
Vision services (testing, treatment, and supplies) (cont.)	
<ul style="list-style-type: none"> • Eye exercises and orthoptics • Radial keratotomy and other refractive surgery 	All charges.
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.</p>	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above • Treatment of 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) 	All charges.
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hoses • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. Replacement of each external breast prosthesis is limited to once every two (2) years. Post mastectomy surgical bras are limited to the standard model and limited to three (3) bras every six (6) months. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. <p>Note: Internal prostate devices are paid as hospital benefit; see Section 5(c) for payment information. Insertion of device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device.</p> <ul style="list-style-type: none"> • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	50% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Orthopedic and corrective shoes • Arch supports • Foot orthotics • Heel pads and heel cups • Lumbosacral supports • Corsets, trusses, elastic stockings, support hose, and other supportive devices • Prosthetic replacements provided less than 2 years after the last one we covered 	All charges

Benefit Description	You pay
Durable medical equipment (DME)	
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen; • Dialysis equipment; • Hospital beds; • Basic model wheelchairs; • Crutches; • Walkers; • Blood glucose monitors, LifeScan Blood Glucose Monitoring System (One Touch Ultra or One-Touch Sure Step) only; and • Insulin pumps. <p>Note: Call us at (800) 431-1211 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	50% of charges
<i>Not covered: Motorized wheelchairs and scooters</i>	<i>All charges.</i>
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 Plan physician will periodically review the program for continuing 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>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	
<ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	\$20 per office visit
Alternative treatments	
<p>Acupuncture – by a doctor of medicine or osteopathy for: anesthesia, pain relief</p> <p>Note: You must receive prior approval for these services. See Section 3 for services requiring prior approval.</p>	\$20 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> 	<i>All charges.</i>

Alternative treatments - continued on next page

Benefit Description	You pay
Alternative treatments (cont.)	
<ul style="list-style-type: none"> • <i>Biofeedback</i> 	<i>All charges.</i>
Educational classes and programs	
Coverage is limited to: <ul style="list-style-type: none"> • Smoking cessation – Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. • Diabetes self management training and education 	\$20 per office visit

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

Important things you should keep in mind about these benefits:

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

Plan physicians must provide or arrange your care.

We have no calendar year deductible.

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.

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 <i>Reconstructive surgery</i>) • Surgical treatment of morbid obesity (bariatric surgery) <p>Surgical treatment, vertical-banded gastroplasty (gastric stapling) and roux-en-y gastric bypass (Roux-en-Y), of morbid obesity will be covered by PersonalCare when all of the following criteria are met:</p> <ul style="list-style-type: none"> • The patient is an adult (≥ 18 years of age) with morbid obesity that has persisted for at least 3 years, and for which there is no treatable metabolic cause for the obesity; • There is presence of morbid obesity, defined as a body mass index (BMI) exceeding 40, or greater than 35 with documented co-morbid conditions (cardiopulmonary problems e.g., severe apnea, Pickwickian Syndrome, and obesity-related cardiomyopathy, severe diabetes mellitus, hypertension, or arthritis). (BMI is calculated by dividing a patient's weight (in kilograms) by height (in meters) squared. To convert pounds to kilograms, multiply pounds by 0.45. To convert inches to meters, multiply inches by .0254); 	<p>Nothing</p>

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
<ul style="list-style-type: none"> • The patient has failed to lose weight (approximately 10% from baseline) or has regained weight despite participation in a three month physician-supervised multidisciplinary program within the past six months that included dietary therapy, physical activity and behavior therapy and support; • The patient has been evaluated for restrictive lung disease and received surgical clearance by a pulmonologist, if clinically indicated; has received cardiac clearance by a cardiologist if there is a history of prior phen-fen or redux use, and the patient has agreed, following surgery, to participate in a multidisciplinary program that will provide guidance on diet, physical activity and social support; and, • The patient has completed a psychological evaluation and has been recommended for bariatric surgery by a licensed mental health professional (this must be documented in the patient’s medical record) and the patient’s medical record reflects documentation by the treating psychotherapist that all psychosocial issues have been identified and addressed; and the psychotherapist indicates that the patient is likely to be compliant with the post-operative diet restrictions; • A complete description of our policy, including contraindications, and requirements following the scheduled surgery, is available. • Insertion of internal prosthetic devices. See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information • 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>	Nothing
<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> • <i>Surgery primarily for cosmetic purposes</i> 	<i>All Charges.</i>
Reconstructive surgery	
<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; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: 	Nothing

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	
<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 <i>Prosthetic devices</i>) <p>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
<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> 	<i>All Charges.</i>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • Treatment (non-dental) of temporomandibular joint disorders 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<i>All charges.</i>
Organ/tissue transplants	
<p>Solid organ transplants limited to:</p> <p>Cornea</p> <p>Heart</p> <p>Heart/lung</p> <p>Single, double or lobar lung</p> <p>Kidney</p> <p>Liver</p> <p>Pancreas</p> <p>Kidney/Pancreas</p>	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas 	Nothing
Blood or marrow stem cell transplants limited to the stages of the following diagnoses; medical necessity limitation is considered satisfied for other tissue transplants if the patient meets staging description: <ul style="list-style-type: none"> • Allogeneic (donor) transplants for <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency disease - Severe or very severe aplastic anemia • Autologous transplants for <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Advanced neuroblastoma • Autologous tandem bone marrow transplants for recurrent germ cell tumors (including testicular cancer) 	Nothing
Blood or marrow stem cell transplants for: <ul style="list-style-type: none"> • Allogeneic (donor) transplants for <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced myelodysplastic syndromes (e.g., DeNovo, secondary, high dose) not previously treated - Advanced neuroblastoma - Infantile malignant osteopetrosis - Mucopolipidosis (e.g., adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfillipo’s syndrome, Maroteaux-Lamy syndrome variants) • Autologous transplants for <ul style="list-style-type: none"> - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors - Breast cancer - Multiple myeloma - Epithelial ovarian cancer 	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for</p> <p>Allogeneic transplants for</p> <ul style="list-style-type: none"> - Chronic lymphocytic leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Chronic and juvenile myelomonocytic leukemia <p>Nonmyeloablative allogeneic transplants for</p> <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced forms of myelodysplastic syndromes - Advanced Hodgkins lymphoma - Advanced non-Hodgkins lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders - Non-small cell lung cancer - Ovarian cancer - Prostate cancer - Renal cell carcinoma - Sarcomas 	Nothing
<p>Autologous transplants for</p> <ul style="list-style-type: none"> - Multiple myeloma - Amyloidosis (single) - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Systemic sclerosis <p>National Transplant Program (NTP)</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
<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 • Non-human organs • Hair transplants. 	<p><i>All Charges</i></p>
Anesthesia	
<p>Professional services provided in:</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>Nothing</p>

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

Important things you should keep in mind about these benefits:

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.

We have no calendar year deductible.

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

The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).

YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS. Please refer to Section 3 to be sure which services require precertification.

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>\$100 copay per day up to a maximum of 5 days per inpatient admission</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 • Blood or blood plasma, if not donated or replaced • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen 	<p>Nothing</p>
<ul style="list-style-type: none"> • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Private nursing care</i> 	<p><i>All Charges</i></p>

Benefit Description	You pay
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>	Nothing
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges.</i>
Extended care benefits/Skilled nursing care facility benefits	
<p>Skilled nursing facility (SNF): up to 120 days per calendar year</p> <ul style="list-style-type: none"> • Bed, board, and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor 	Nothing
<i>Not covered: Custodial care</i>	<i>All charges.</i>
Hospice care	
<p>Supportive and palliative care for a terminally ill member in the home or hospice facility provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less. Services include:</p> <ul style="list-style-type: none"> • Inpatient and outpatient care • Family counseling 	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All Charges</i>
Ambulance	
<p>Professional ambulance service when medically appropriate.</p> <p>Air ambulance service when determined medically necessary by PersonalCare.</p>	\$50 per trip

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

We have no calendar year deductible.

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

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

When we decide what conditions are true emergencies, we think about what a person with average knowledge of health and medicine would do. If that person would reasonably believe that the condition is life-threatening or disabling, then we consider it an emergency.

If you have a true emergency, you should immediately go to a hospital emergency department. You should go to a PersonalCare network hospital unless a delay in going to that hospital would endanger your life or health. Tell the hospital staff your PCP's name.

If the symptoms are not immediately threatening to your life or health, you should call your PCP to find out if you should go to the emergency department or to his or her office. PersonalCare will not pay for emergency department visits that are not true emergencies. We also will not pay for emergency department visits related to conditions not covered by your plan.

Emergencies within our service area:

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. You should go to a PersonalCare network hospital, unless a delay in going to that hospital would endanger your life or health. Be sure to tell the emergency room personnel that you are a Plan member and who your PCP is. You or a family member should notify your PCP within 48 hours.

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

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

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

Emergencies outside our service area:

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

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

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

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 	\$20 per office visit
<ul style="list-style-type: none"> Emergency care as an outpatient at a hospital , including doctors’ services <p>Note: We waive the ER copay if you are admitted as an inpatient within 48 hours for the same condition.</p>	\$100 or 50%, whichever is less
<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 	\$20 per office visit
<ul style="list-style-type: none"> Emergency care as an outpatient at a hospital, including doctors’ services <p>Note: We waive the ER copay if you are admitted as an inpatient within 48 hours for the same condition.</p>	\$100 or 50%, whichever is less
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</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>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All Charges.</i>
Ambulance	
<p>Professional ambulance service when medically appropriate.</p> <p>Air ambulance service when determined medically necessary by PersonalCare.</p> <p>Note: See Section 5 (c) for non-emergency services.</p>	\$50 copay per trip

Section 5(e) Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, 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.

Important things you should keep in mind about these benefits:

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.

We have no calendar year deductible.

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

YOU MUST GET PREAUTHORIZATION OF THESE SERVICES. See the instructions after the benefits description below.

Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<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>\$20 per office visit</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>Nothing</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>\$100 per day up to a maximum of 5 days</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services we have not approved.</i> • <i>Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate</i> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All Charges.</i></p>

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

We cover prescribed drugs and medications, as described in the chart beginning on the next page.

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.

We have no calendar year deductible.

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

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at Plan pharmacy.
- **We use a formulary.** PersonalCare's physician committee has developed the preferred drug list. This list includes high-quality drugs to treat medical conditions. A physician committee reviews the list often to make sure that the best drugs are included. Your doctor may prescribe drugs not on the list. You will pay a higher copayment for drugs not on the preferred list. Some drugs will not be on the list because PersonalCare does not cover them or because other drugs work better. A few drugs need approval from PersonalCare before your doctor can prescribe them. Your doctor will take care of this for you. You can get a copy of our preferred drug list by calling PersonalCare Customer Service at (800) 431-1211. You will also find the formulary listing on our Web site at www.PersonalCare.org.
- **These are the dispensing limitations.** For most drugs, you will pay one copayment for each 100 units or 30-day supply, whichever is less. You pay this at the pharmacy when you have the prescription filled. Prepackaged medications (such as inhalers, ophthalmic solutions, topical creams) require one copayment per package. If your doctor prescribes a non-formulary drug, your copayment will be higher for each 30-day supply, or each prepackaged unit. Your pharmacy will give you a generic drug if one is available and if your doctor allows a generic substitution. You pay only a \$10 copayment for these drugs. When there is no generic, you will get the formulary (\$20 copayment) or non-formulary (\$50 copayment) brand name. Important: If a generic drug is available to you, and you or your doctor ask for a name brand drug instead of the generic, you will pay the \$10 generic copayment plus the difference in retail price between the generic drug and the name brand drug. A member who is called to active duty in the United States military should call Customer Service at (800) 431-1211 for instructions on obtaining emergency supplies of medications.
- **A generic equivalent will be dispensed if it is available?** Generic drugs contain the same active ingredients and are equivalent in strength and dosage to the original brand name product. Generic drugs cost you and your Plan less money than a name brand drug.
- **When you do have to file a claim?** PersonalCare has a national network of pharmacies, and you will not have to file a claim if you fill your prescriptions at any of these pharmacies. If you need a prescription filled in an emergency when you are out of the service area, or your regular pharmacy is closed, and you can not locate a network pharmacy, go to the nearest open pharmacy. Please send the cash receipt and the reason that this was an emergency to PersonalCare. We will reimburse you for the prescription, less your copayment, in true emergency situations.

Benefit Description	You pay
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order 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>. • Insulin, with a copay charge applied to each vial • Diabetic supplies including insulin syringes, needles, glucose test tablets and test tape, Benedict’s solution or equivalent and acetone test tablets • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction, with dispensing limitations. (Contact the Plan for details.) • Oral fertility drugs • Contraceptive drugs and devices • Growth hormone (injectable) <p>Note: Intravenous fluids and medication for home use, implantable drugs, and some injectable drugs are covered under Medical and Surgical Benefits.</p>	<p>\$10 copay for generic drugs</p> <p>\$20 copay for name brand formulary drugs</p> <p>\$50 copay for name brand non-formulary drugs</p> <p>20% for name brand formulary self administered injectables</p> <p>40% for name brand non-formulary self administered injectables</p> <p>Note: If there is no generic equivalent available, you will still have to pay the name brand copay.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacies; except for out-of-area emergencies</i> • <i>Vitamins and nutritional substances that can be purchased without a prescription</i> • <i>Nonprescription medicines</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.
Centers of excellence	<p>PersonalCare uses the transplant facilities of the Coventry Transplant Network (CTN). CTN contracts only with major medical centers. These providers are available only with a referral from you primary care physician and authorization from PersonalCare.</p>

Section 5(h) Dental benefits

Important things you should keep in mind about these benefits:

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary

Plan dentists must provide or arrange your care.

We have no calendar year deductible.

We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.

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

Benefit Description	You Pay
Dental benefits	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth due to traumatic injury within thirty (30) days of the injury. The need for these services must result from an accidental injury.	Nothing

Dental benefits

We have no other dental benefits.

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** (see specifics regarding transplants).

We do not cover the following:

Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*);

Services, drugs, or supplies you receive while you are not enrolled in this Plan;

Services, drugs, or supplies not medically necessary;

Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;

- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);

Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;

Services, drugs, or supplies related to sex transformations;

Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or

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, coinsurance, or deductible.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 800-431-1211.

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

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

Submit your claims to: *PersonalCare, P.O. Box 7141, London, KY 40742.*

Prescription drugs

Submit your claims to: *PersonalCare, 2110 Fox Drive, Champaign, IL 61820.*

Other supplies or services

Submit your claims to: *PersonalCare, P.O. Box 7141, London, KY 40742.*

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 benefits for 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 required by Section 3. Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

- 1** Ask us in writing to reconsider our initial decision. You must:
 - a) Write to us within 6 months from the date of our decision; and
 - b) Send your request to us at: 2110 Fox Drive, Champaign, IL 61820; and
 - c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
 - d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

- 2** We have 30 days from the date we receive your request to:
 - a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or
 - b) Write to you and maintain our denial - go to step 4; or
 - c) Ask 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** You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

- 4** If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

 - 90 days after the date of our letter upholding our initial decision; or
 - 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or
 - 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.

Send OPM the following information:

 - A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
 - Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
 - Copies of all letters you sent to us about the claim;
 - Copies of all letters we sent to you about the claim; 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.

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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 800-431-1211 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 OPM's Health Insurance Group 3 at 202/206-0737 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 any other 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. 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; and

People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.

Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.

Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 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 more Parts of Medicare, you can still be covered under the FEHB Program.

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

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

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

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

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

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 800-431-1211 or see our Web site at www.PersonalCare.org.

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) 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 we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

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

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

Medicare always makes the final determination as to whether they are the primary 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 an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is 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 • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• 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.

**TRICARE and
CHAMPVA**

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

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

You 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.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 12.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 12.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Custodial care means the service which do not need the technical skills or professional training of medical and/or nursing personnel in order to be safely and effectively performed. Examples of custodial care are helping with activities of daily living, giving of oral medications, assistance in walking, turning and positioning in bed, and acting as a companion. Custodial care that lasts 90 days or more is sometimes known as Long term care.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.
Experimental or investigational service	A drug or device is considered experimental if it does not have the approval for marketing from the U.S. Food and Drug Administration. A drug, device, treatment or procedure is considered experimental or investigational if published reports or written protocols show that it is undergoing clinical trials or is otherwise under study to determine dosage, toxicity or safety.
Group health coverage	Health coverage purchased by an employer, association, union or other organization for its employees or members and their eligible dependents.
Medical necessity	Medical necessity means the most appropriate level of health care services and supplies needed for your treatment. You should receive the right care for your health problem that is common for physicians to give to patients.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: PersonalCare determines the plan allowance with each participating provider based upon negotiated charges contained within the provider's participation agreement. The negotiated charge represents the amount a participating provider must accept as payment in full for covered services provided to Plan members.
Us/We	Us and We refer to PersonalCare.
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/health for enrollment information as well as:

 - Information on the FEHB Program and plans available to you
 - A health plan comparison tool
 - A list of agencies who participate in Employee Express
 - A link to Employee Express
 - Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal 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 family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorcé, or when your child under age 22 marries.

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 2007 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 2006 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.

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

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

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide To Federal 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**

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.

Section 12 Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

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

Second, the **Federal Flexible Spending Account 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.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis

The Federal Long Term Care Insurance Program – *FLTCIP*

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.** 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. 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 about your health. 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 request an Information Kit and application.** Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

Health Care FSA (HCFSA) – Pays for eligible health care expenses for you and your dependents which are not covered or reimbursed by FEHBP coverage or other insurance.

Limited Expense Health Care FSA (LEX HCFSA) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.

Dependent Care FSA (DCFSA) – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

What expenses can I pay with an FSAFEDS account?

For the HCFSA– Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).

For the LEX HCFSA– Dental and vision care expenses including eligible over-the-counter medicines and products related to dental and vision care (but not insurance premiums).

For the DCFSA – Daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves.

AND MUCH MORE! Visit www.FSAFEDS.com

Who is eligible to enroll?

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern Time. TTY: 1-800-952-0450.

When can I enroll?

If you wish to participate, you must make an election to enroll each year by visiting www.FSAFEDS.com or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.

Who is SHPS?

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is BENEFEDS?

BENEFEDS is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a new program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004.

OPM has contracted with several insurance carriers to make supplemental dental and vision benefits available to eligible Federal and USPS employees, annuitants, and their eligible family members.

Dental Insurance

Dental plans will provide a comprehensive range of services, including the following:

Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.

Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.

Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.

Class D (Orthodontic) services with a 24-month waiting period

Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

Vision Insurance

Vision plans will provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

What plans are available?

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

Premiums

The premiums will vary by plan and by enrollment type (self, self plus one, or self and family). There is no government contribution to the premiums. If you are an active employee, your premiums will be taken from your salary on a pre-tax basis when your salary is sufficient to make the premium withholding. If you are an annuitant, premiums will be withheld from your monthly annuity check when your annuity is sufficient. Pre-tax premiums are not available to annuitants. For information on each plan's specific premiums, visit www.opm.gov/insure/dentalvision.

Who is eligible to enroll?

Federal and Postal Service employees eligible for FEHB coverage (whether or not enrolled) and annuitants (regardless of FEHB status) are eligible to enroll in a dental plan and/or a vision plan.

Enrollment types available

Self-only, which covers only the enrolled employee or annuitant;

Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee; and

Self and family, which covers the enrolled employee or annuitant and all eligible family members.

Which family members are eligible to enroll?

Eligible family members include your spouse, unmarried dependent children under age 22, and unmarried dependent children age 22 or over incapable of self-support because of a mental or physical disability that existed before age 22.

When can I enroll?

Eligible employees and annuitants can enroll in a dental and/or vision plan during this open season -- November 13 to December 11, 2006. You can enroll, disenroll, or change your enrollment during subsequent annual open seasons, or because of a qualified life event. New employees will have 60 days from their first eligibility date to enroll.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. BENEFEDS is a secure enrollment website sponsored by OPM where you enter your name, personal information like address and Social Security Number, the agency you work for (or retirement plan that pays your annuity), and the dental and/or vision plan you select. For those without access to a computer, call 1-877-888- FEDS (TTY number, 1-877-TTY-5680). If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

When will coverage be effective?

The new Program will be effective December 31, 2006. Coverage for those who enroll during this year's open season (November 13 – December 11, 2006) will be effective December 31, 2006. Coverage for any other enrollments will be effective on/or after December 31, 2006.

How does this coverage work with my FEHB plan's dental or vision coverage?

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses.

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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

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Summary of benefits for PersonalCare - 2007

- **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.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	\$20 per office visit	17
Services provided by a hospital:		
• Inpatient	\$100 copay per day up to a maximum of 5 days per admission	30
• Outpatient	Nothing	31
Emergency benefits:		
• In-area or Out-of-area	\$100 or 50%, whichever is less	32
Mental health and substance abuse treatment:	Regular cost sharing	34
Prescription drugs:		36
• Retail pharmacy	\$10 generic, \$20 formulary brand, \$50 non-formulary brand; 20% for name brand formulary self administered injectables; 40% for name brand non-formulary self administered injectables	36
• Mail order	\$10 generic, \$20 formulary brand, \$50 non-formulary brand	36
Dental care:	No benefit.	39
Vision care:	\$30 copay per exam	21
Special features:		38
• Centers of Excellence for transplants		
• Flexible benefit options		
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$1,500/Self Only or \$3,000/Family enrollment per year Some costs do not count toward this protection	12

2007 Rate Information for PersonalCare

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.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	GE1	\$139.45	\$46.48	\$302.14	\$100.71	\$165.01	\$20.92
High Option Self and Family	GE2	\$321.89	\$155.95	\$697.43	\$337.89	\$380.01	\$97.83