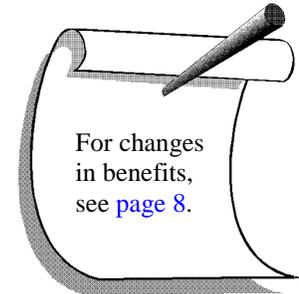


**A Health Maintenance Organization**

**Serving:** Utica/Rome, Watertown and Plattsburgh Metropolitan Areas

**Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See [page 7](#) for requirements.**



This Plan has excellent accreditation from NCQA.

**Enrollment codes for this Plan:**

**AH1 Self Only**  
**AH2 Self and Family**

Authorized for distribution by the:



**United States**  
**Office of Personnel Management**  
Retirement and Insurance Service  
<http://www.opm.gov/insure>





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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at [www.opm.gov/insure](http://www.opm.gov/insure).

Sincerely,

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

Kay Coles James  
Director



## Notice of the Office of Personnel Management's Privacy Practices

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

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

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

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

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

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

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

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

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

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

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

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

For more information on exercising your rights set out in this notice, look at [www.opm.gov/insure](http://www.opm.gov/insure) on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

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

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

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

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

---

## Table of Contents

---

Introduction .....	4
Plain Language.....	4
Stop Health Care Fraud!.....	5
Section 1. Facts about this HMO plan.....	6
How we pay providers.....	6
Who provides my healthcare .....	6
Your Rights .....	6
Service Area .....	7
Section 2. How we change for 2003.....	8
Program-wide changes .....	8
Changes to this Plan .....	8
Section 3. How you get care.....	9
Identification cards .....	9
Where you get covered care .....	9
• Plan providers .....	9
• Plan facilities.....	9
What you must do to get covered care .....	9
• Primary care .....	9
• Specialty care .....	9
• Hospital care .....	10
Circumstances beyond our control .....	11
Services requiring our prior approval.....	11
Section 4. Your costs for covered services.....	12
• Copayments.....	12
• Deductible .....	12
• Coinsurance.....	12
Your catastrophic protection out-of-pocket maximum.....	12
Section 5. Benefits.....	13
Overview .....	13
(a) Medical services and supplies provided by physicians and other health care professionals.....	14
(b) Surgical and anesthesia services provided by physicians and other health care professionals .....	22
(c) Services provided by a hospital or other facility, and ambulance services .....	26
(d) Emergency services/accidents .....	28
(e) Mental health and substance abuse benefits .....	30
(f) Prescription drug benefits .....	32
(g) Special features.....	34
(h) Dental benefits .....	36

Section 6. General exclusions -- things we don't cover.....37

Section 7. Filing a claim for covered services.....38

Section 8. The disputed claims process.....39

Section 9. Coordinating benefits with other coverage.....41

- When you have Other health coverage .....41
- What is Medicare .....41
- Medicare Managed Care Plan .....43
- TRICARE and CHAMPVA.....43
- Workers' Compensation.....43
- Medicaid .....43
- Other Government agencies.....43
- When others are responsible for injuries.....43

Section 10. Definitions of terms we use in this brochure .....44

Section 11. FEHB facts .....45

- Coverage information.....45
  - No pre-existing condition limitation .....45
  - Where you get information about enrolling in the FEHB Program.....45
  - Types of coverage available for you and your family .....45
  - Children’s Equity Act.....45
  - When benefits and premiums start .....46
  - When you retire.....46
- When you lose benefits .....46
  - When FEHB coverage ends .....46
  - Spouse equity coverage.....46
  - Temporary Continuation of Coverage (TCC) .....46
  - Converting to individual coverage .....46
  - Getting a Certificate of Group Health Plan Coverage.....47

Long term care insurance is still available .....48

Index .....49

Summary of benefits .....51

Rates.....Back cover

---

## Introduction

---

This brochure describes the benefits of HMOBlue under our contract (CS2294) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for administrative offices is:

BlueCross BlueShield of Utica-Watertown Inc., d.b.a. HMOBlue  
Utica Business Park, 12 Rhoads Drive  
Utica, NY 13502-6398

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on [page 51](#). Rates are shown at the end of this brochure.

---

## Plain Language

---

Teams of Government and health plans' staff worked on all FEHB brochures 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 BlueCross BlueShield Utica-Watertown.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the 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](http://www.opm.gov/insure) or e-mail OPM at [fehbwebcomments@opm.gov](mailto:fehbwebcomments@opm.gov). You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 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 (FEHB) 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 you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 800/447-6269 and explain the situation.
  - If we do not resolve the issue:

**CALL -- THE HEALTH CARE FRAUD HOTLINE  
202-418-3300**

**OR WRITE TO:**

The United States Office of Personnel Management  
Office of the Inspector General Fraud Hotline  
1900 E Street, NW, Room 6400  
Washington, DC 20415

- 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 or with OPM if you are retired.
- 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.

---

## 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.

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 only pay 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.

### Who Provides My Healthcare

BlueCross BlueShield of Utica-Watertown, d.b.a. HMOBlue, is a division of Excellus Health Care, Inc. HMOBlue is an individual practice association HMO. You, and each member of your family, must select a primary care doctor to coordinate all medical needs. There are over 1200 primary care doctors to choose from, representing family practice, general practice, internal medicine, OB/GYN and pediatrics. The Plan also contracts with an additional 3000 specialists throughout the service area.

Benefits for urgent care rendered outside of this Plan's service area may be covered. This Plan is affiliated with HMO-USA, a network of BlueCross and BlueShield HMOs that can coordinate your medical care. If you need more information, a Plan representative can tell you more about its reciprocity benefits.

### Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB website ([www.opm.gov/insure](http://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:

- BlueCross BlueShield of Utica-Watertown has been serving our community for 64 Years with the finest health care insurance
- HMOBlue is a Non-Profit organization

You can obtain additional information by calling Member Services at 1-800-722-7884. The information available includes:

- Consumer satisfaction, clinical quality and service performance measures
- Whether facility has been excluded from any Federal health programs
- Cancellation, suspension, or exclusion from participation in Federal programs or sanctions.
- Number of primary care and specialty providers
- Methods of compensation, ownership or interest in health care facilities that are associated with the plan

There is some information that we do not track, but you should be able to get the following information from your doctor and/or hospital. If you are not able to get this information, we will assist you in obtaining it.

**Doctor:**

- Language(s) spoken and availability of interpreters, facilities that are accessible to the disabled
- Corporate form of providers
- Names of hospitals where physicians have admitting privileges
- Years in practice as a physician and as a specialist if so identified
- Experience with performing certain medical or surgical procedures

**Hospitals:**

- Corporate form
- Consumer satisfaction, clinical quality and service performance measures
- Whether facility specialty programs meet guidelines established by specialty societies or other bodies
- Complaint procedures
- Volume of certain procedures performed
- Numbers and credentials of providers of direct patient care
- Whether the facility's affiliation with a provider network would make it more likely that a consumer would be referred to health professionals or other organizations in that network.

If you want more information about us, call 800-722-7884, or write to 12 Rhoads Dr., Utica, NY, 13502. You may also contact us by visiting our website at <http://www.bcbsuw.com>.

**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 is: The New York counties of Chenango, Clinton, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Otsego and St. Lawrence.

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. However, you may also contact your primary care physician to get a referral.

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. Guest Membership is available in most parts of the United States from HMO-USA. If you have family members living outside of our service area and want to enroll them as a guest member, you must complete an additional application. Contact HMOBlue for more information regarding Guest Membership. 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 changed for 2003

---

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

### **Program-wide changes**

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

### **Changes to this Plan**

- Your share of the non-Postal premium will increase by 56.2% for Self Only or 62.5% for Self and Family.
- Your office visits copay has changed from \$10 to \$15.
- You will now pay an inpatient copay of \$240 for each admission
- Your prescription drug copay has changed for a 30-day supply of drugs as follows:
  - \$5 to \$10 for generic drugs
  - \$20 to \$25 for brand named drugs
  - \$35 to \$40 for formulary drugs
- Away From Home Care will no longer be provided for 2003
- The Plan no longer requires a 48 hour notification for emergency admissions.
- Away From Home Care with Guest Membership is now BlueCard rather than any care facility.

---

## Section 3. How you get care

---

### Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-722-7884.

### Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, and/or coinsurance. You normally won’t have to submit claims to us unless you receive emergency services from a provider who doesn’t contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

- **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 provider directory is also on our website at <http://www.bcbsuw.com>.

- **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 facilities in the provider directory, which we update periodically. The list is also on our website at <http://www.bcbsuw.com>.

### 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. To determine if a physician is a participating provider and accepting new patients, you can refer to our Provider Directory or contact us at 800-722-7884.

- **Primary care**

Your primary care physician can practice family medicine, internal medicine, pediatrics, and general medicine. 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 at 800-722-7884. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see an optometrist once a year for a routine exam, and a woman may see an OB-GYN twice a year for routine exams without a referral.

Here are 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 or 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 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 in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-722-7884. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

These provisions apply only to the benefits of the hospitalized person.

**Circumstances beyond our control**

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

**Services requiring our prior approval**

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

We call this review and approval process a pre-authorization. Your physician must obtain pre-authorization for the following services:

1. Air Ambulance,
2. All Inpatient Admissions,
3. All Referrals to Non-Participating Providers,
4. Ambulatory Surgery,
5. Chemotherapy & Radiation Treatment,
6. Colonoscopy & Endoscopy Procedures,
7. Diabetic Equipment,
8. Home Health Care,
9. Home Infusion Therapy,
10. Inpatient Physical Rehabilitation,
11. Kidney Dialysis,
12. Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA).
13. Mental Health Services,
14. Nutritional Counseling,
15. Organ & Bone Marrow Transplants,
16. Outpatient Alcohol or Drug Abuse,
17. Pain Management,
18. Short Term Therapy,
19. Skilled Nursing Facility Care, and
20. Sleep Apnea Studies.

---

## Section 4. Your costs for covered services

---

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

- **Copayments**

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

Example: When you see your primary care physician you pay a copayment of \$15 per office visit and when you go in the hospital, **You Pay** \$240 copay.

- **Deductible**

We do not have a deductible.

- **Coinsurance**

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

Example: In our Plan, **You Pay** 50% of our allowance for infertility services and 20% of our allowance for durable medical equipment.

**Your catastrophic protection  
out-of-pocket maximum**

We do not have an out-of-pocket maximum.

---

## Section 5. Benefits -- OVERVIEW

(See [page 8](#) for how our benefits changed this year and [page 51](#) for a benefits summary.)

---

**NOTE:** This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 800-722-7884 or at our website at [www.bcbsuw.com](http://www.bcbsuw.com).

(a) Medical services and supplies provided by physicians and other health care professionals .....	14-21
•Diagnostic and treatment services	
•Lab, X-ray, and other diagnostic tests	
•Preventive care, adult	
•Preventive care, children	
•Maternity care	
•Family planning	
•Infertility services	
•Allergy care	
•Treatment therapies	
•Physical and occupational therapies	
•Speech therapy	
•Hearing services (testing, treatment, and supplies)	
•Vision services (testing, treatment, and supplies)	
•Foot care	
•Orthopedic and prosthetic devices	
•Durable medical equipment (DME)	
•Home health services	
•Chiropractic	
•Alternative treatments	
•Educational classes and programs	
(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	22-25
•Surgical procedures	
•Reconstructive surgery	
•Oral and maxillofacial surgery	
•Organ/tissue transplants	
•Anesthesia	
(c) Services provided by a hospital or other facility, and ambulance services .....	26-27
•Inpatient hospital	
•Outpatient hospital or ambulatory surgical center	
•Skilled nursing care facility benefits	
•Hospice care	
•Ambulance	
(d) Emergency services/accidents.....	28-29
•Medical emergency	
•Ambulance	
(e) Mental health and substance abuse benefits.....	30-31
(f) Prescription drug benefits.....	32-33
(g) Special features .....	34-35
• Flexible benefit option	
• Reciprocity benefit	
• Centers of Excellence for transplants/heart surgery/etc	
(h) Dental benefits .....	36
Summary of benefits .....	51

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

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

Benefit Description	You pay
<b>Diagnostic and treatment services</b>	<b>You pay</b>
Professional services of physicians <ul style="list-style-type: none"> <li>• In physician’s office</li> <li>• In an urgent care center</li> <li>• In a skilled nursing facility</li> <li>• Office medical consultations</li> <li>• Second surgical opinion</li> </ul>	\$15 per office visit
Professional services of physicians <ul style="list-style-type: none"> <li>• During a hospital stay</li> <li>• Initial examination of a newborn child covered under a family enrollment</li> </ul>	\$15 per office visit
At home	\$15 per home visit
<b>Lab, X-ray and other diagnostic tests</b>	<b>You pay</b>
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine Mammograms</li> <li>• Cat Scans/MRI</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	Nothing

Preventive care, adult	You pay
Routine screenings such as: <ul style="list-style-type: none"> <li>• Blood lead level</li> <li>• Total Blood Cholesterol</li> <li>• Colorectal Cancer Screening, including               <ul style="list-style-type: none"> <li>••Fecal occult blood test</li> <li>••Sigmoidoscopy, screening – every five years starting at age 50</li> </ul> </li> </ul>	Nothing
Prostate Specific Antigen (PSA test) <ul style="list-style-type: none"> <li>• One routine annual exam for men age 40 and older</li> </ul>	Nothing
Routine pap test	Nothing
Routine mammogram –covered for all women	Nothing
Routine Immunizations, Inoculations and Boosters for Adults:	Nothing
Annual Physical Exams	Nothing
Routine Gynecological Exams <ul style="list-style-type: none"> <li>• Primary and preventive obstetric and gynecological services including two annual exams.</li> </ul>	Nothing
Allergy Injections	Nothing
Vision Exams <ul style="list-style-type: none"> <li>• The annual exam may include physical exam of the eyes, refraction tests, and assessment of binocular vision.</li> </ul>	\$15 per office visit
Hearing Exams – 1 exam per year	\$15 per office visit
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel The Plan will not pay for inoculations for adults or children that are required for employment.</i>	<i>All charges</i>
Preventive care, children	You pay
<b>Well Child Care/Immunizations.</b> Childhood immunizations and exams for children under age 22 at a frequency recommended by the American Academy of Pediatricians. Such exams may cover: a medical history, complete physical exam, developmental assessment, anticipatory guidance, necessary and appropriate immunizations, and lab tests ordered at the time of the visit.	Nothing
<ul style="list-style-type: none"> <li>• Examinations, such as:               <ul style="list-style-type: none"> <li>•Routine Eye Exams</li> <li>•Routine Hearing Exams</li> </ul> </li> </ul>	\$15 per office visit \$15 per office visit

Maternity care	You pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do need to pre-authorize your normal delivery; see <a href="#">page 11</a> for other circumstances, such as extended stays for you or your baby.</li> <li>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.</li> <li>• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We require pre-authorization. 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.</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).</li> </ul>	<p>\$240 copay</p>
<p><i>Not covered: Routine sonograms to determine sex</i></p>	<p><i>All charges</i></p>
Family planning	You pay
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization</li> <li>• Surgically implanted contraceptives (such as Norplant)</li> <li>• Injectable contraceptive drugs (such as Depo Provera)</li> <li>• Intrauterine devices (IUDs)</li> <li>• Diaphragms</li> <li>• Family Planning Service (such as birth control and genetic counseling and elective termination of pregnancy)</li> </ul> <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>Nothing</p>
<p><i>Not covered: reversal of voluntary surgical sterilization.</i></p>	<p><i>All charges</i></p>

Infertility services	You pay
Diagnosis and treatment of infertility, such as: <ul style="list-style-type: none"> <li>• Artificial insemination:               <ul style="list-style-type: none"> <li>••intravaginal insemination (IVI)</li> <li>••intracervical insemination (ICI)</li> <li>••intrauterine insemination (IUI)</li> </ul> </li> <li>• Fertility drugs</li> </ul>	\$10 per office visit copay
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• Assisted reproductive technology (ART) procedures, such as:               <ul style="list-style-type: none"> <li>••in vitro fertilization</li> <li>••embryo transfer, Zift, and GIFT</li> </ul> </li> <li>• Services and supplies related to excluded ART procedures</li> <li>• Cost of donor sperm</li> </ul>	<i>All charges</i>
Allergy care	You pay
Testing and treatment	\$15 per office visit
Allergy injection	Nothing
Allergy serum	Nothing
<i>Not covered: provocative food testing and sublingual allergy desensitization</i>	<i>All charges</i>
Treatment therapies	You pay
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy           <p>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on <a href="#">page 24</a>.</p> </li> <li>• Dialysis – Hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> <li>• Growth hormone therapy (GHT)</li> <li>• Speech therapy           <p>Note: – We will only cover GHT when we pre-authorize the treatment. Have your physician call for pre-authorization. We will ask you or your physician to submit information that establishes that the GHT is medically necessary. Ask your physician to have us authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you or your physician do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p> </li> </ul>	Nothing

Treatment therapies (Continued)	You pay
Respiratory and inhalation therapy <ul style="list-style-type: none"> <li>Inhalers are covered under pharmacy benefits, see <a href="#">page 32</a>.</li> <li>Inhalation therapy equipment is covered under DME, see <a href="#">page 20</a>.</li> </ul> Note: Medications used with inhalation therapy equipment are covered under pharmacy benefits.	Nothing See Pharmacy  See DME
Physical and occupational therapies	You pay
<ul style="list-style-type: none"> <li>Physical therapy</li> <li>Occupational therapy</li> <li>Pulmonary/cardiac therapy</li> <li>2 consecutive months of short term therapy per acute condition</li> </ul> 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.	\$15 per office visit \$15 per outpatient visit Nothing during covered inpatient admission.
<i>Not covered:</i> <ul style="list-style-type: none"> <li>long-term rehabilitative therapy</li> <li>exercise programs</li> </ul>	<i>All charges</i>
Speech therapy	You pay
<ul style="list-style-type: none"> <li>2 consecutive months per condition which in the judgement of the Plan's Medical director is medically necessary.</li> </ul>	\$15 per office visit \$15 per outpatient visit Nothing during covered inpatient admission.
<i>Not covered:</i> <ul style="list-style-type: none"> <li>long-term rehabilitative therapy</li> <li>exercise programs</li> </ul>	<i>All charges</i>
Hearing services (testing, treatment, and supplies)	You pay
<ul style="list-style-type: none"> <li>First Hearing Aid and testing only when necessitated by accidental injury, disease, or illness</li> <li>Hearing testing</li> </ul>	\$15 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> <li>hearing aids, testing and examinations for them not connected with injury, disease, or illness</li> </ul>	<i>All charges</i>

Vision services (testing, treatment, and supplies)	You pay
Routine annual exam ( <i>See Preventive Care</i> )	\$15 per office visit
Initial prescription lenses and frames after cataract surgery	Nothing
<ul style="list-style-type: none"> <li>• Annual eye refractions</li> </ul>	\$15 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Eyeglasses or contact lenses</li> <li>• Eye exercises and orthoptics</li> <li>• Radial keratotomy and other refractive surgery</li> </ul>	<i>All charges</i>
Foot care	You pay
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	\$15 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• 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</li> <li>• 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)</li> </ul>	<i>All charges</i>
Orthopedic and prosthetic devices	You pay
<ul style="list-style-type: none"> <li>• Artificial limbs and eyes</li> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy</li> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device.</li> <li>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</li> </ul>	20% coinsurance

Orthopedic and prosthetic devices <i>(Continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Orthopedic and corrective shoes</i></li> <li>• <i>Arch supports</i></li> <li>• <i>Foot orthotics</i></li> <li>• <i>Heel pads and heel cups</i></li> <li>• <i>Lumbosacral supports</i></li> <li>• <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i></li> </ul>	<p><i>All charges</i></p>
Durable medical equipment (DME)	You pay
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> <li>• hospital beds;</li> <li>• wheelchairs;</li> <li>• braces and crutches;</li> <li>• walkers;</li> <li>• blood glucose monitors;</li> <li>• insulin pumps;</li> <li>• casts;</li> <li>• trusses; and</li> <li>• apnea monitor.</li> </ul> <p>Note: Call us at 800-722-7884 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>	<p>20% Coinsurance</p>
Home health services	You pay
<ul style="list-style-type: none"> <li>• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Services include: <ul style="list-style-type: none"> <li>• oxygen therapy,</li> <li>• intravenous therapy and medications.</li> </ul> </li> </ul>	<p>\$15 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>nursing care requested by, or for the convenience of, the patient or the patient's family;</i></li> <li>• <i>home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i></li> </ul>	<p><i>All charges</i></p>

<b>Chiropractic</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>• Manipulation of the spine</li> <li>• Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application</li> </ul>	\$15 per office visit
<b>Alternative treatments</b>	<b>You pay</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Naturopathic services</i></li> <li>• <i>Hypnotherapy</i></li> <li>• <i>Biofeedback</i></li> </ul>	<i>All charges</i>
<b>Educational classes and programs</b>	<b>You pay</b>
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> <li>• Smoking Cessation Packets – including committed quitters program and “Clear the Air” smoking cessation resource guide.</li> <li>• Managing Your Diabetes – Includes a comprehensive study guide for patients and their health care professionals; diabetes resource list and standards of care.</li> <li>• Nutritional Counseling – One visit per year</li> <li>• Healthy Choice – Valued added programs offered to HMOBlue members.</li> <li>• Healthy Life Self-Care Guide Series – Healthy life self-care guides gives up to date information on 25 of the most common ailments.</li> <li>• Mind Set – This completely confidential program includes a too-free number and free educational videos on anxiety disordered such as social phobia and obsessive-compulsive behavior.</li> <li>• Asthma Community and Education Resource Guide</li> <li>• Environmental Control: Avoiding Exposure In and Around Your Home</li> <li>• Wealth of Health Community Wellness Calendar – Free or low cost HMOBlue sponsored events where you live or work.</li> <li>• Connection Book Series – This informative 3-book series explains the communication process of people who suffer from depression and provides insights into how significant these relationships are affected.</li> </ul>	Nothing





Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Kidney/Pancreas</li> <li>• Liver</li> <li>• Lung: Single –Double</li> <li>• Pancreas</li> <li>• Allogeneic (donor) bone marrow transplants</li> <li>• Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors</li> <li>• Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach and pancreas</li> <li>• National Transplant Program (NTP)</li> </ul> <p>Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.</p> <p>The Plan will cover transportation costs for the recipient and one other individual to and from the site of a covered human organ or bone marrow transplant surgery. If the recipient is a minor, The Plan will cover transportation costs for two individuals to accompany the recipient. Transportation costs include all reasonable and necessary lodging and meal expenses incurred, up to a daily maximum of \$150. Transportation costs are limited to \$10,000 for each covered transplant procedure.</p> <p>The Plan will only pay benefits that are unavailable or not provided to the donor from any other source.</p> <p>The Plan will pay for covered Hospital and surgical services, storage, and transportation costs incurred by the donor that are directly related to the donation of a human organ or bone marrow used in a covered transplant procedure. Donor transportation costs include all reasonable and necessary lodging and meal expenses incurred by the donor, up to a daily maximum of \$150. Our Payments for all donor benefits are limited to \$25,000 for each covered transplant procedure.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>Nothing</p>

<b>Organ/tissue transplants (Continued)</b>	<b>You pay</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i></li> <li>• <i>Implants of artificial organs</i></li> <li>• <i>Transplants not listed as covered</i></li> <li>• <i>The Plan does not provide benefits for the Member to be a human organ or bone marrow donor.</i></li> <li>• <i>The Plan will not pay benefits for any human organ or bone marrow donation or related costs that are covered for the donor under another health benefits plan.</i></li> <li>• <i>The Plan will not pay for services that would be covered for a human organ donor, if those services are provided more than 5 days before a covered human organ transplant.</i></li> <li>• <i>The Plan will not pay for services that would be covered for a bone marrow donor, if those services are provided more than 30 days before a covered bone marrow transplant.</i></li> </ul>	<p><i>All charges</i></p>
<b>Anesthesia</b>	<b>You pay</b>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> </ul>	<p>Nothing</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Hospital outpatient department</li> <li>• Skilled nursing facility</li> <li>• Ambulatory surgical center</li> <li>• Office</li> </ul>	<p>Nothing</p>



<b>Outpatient hospital or ambulatory surgical center</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma, if not donated or replaced</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> </ul> <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>	\$100 copay Nothing
<b>Inpatient Rehabilitation</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>• Inpatient physical rehabilitation. Covered service when performed in a plan approved, free-standing or hospital-based physical rehabilitation treatment center. Limited to 60 days.</li> </ul>	\$240 per admission
<b>Skilled nursing care facility benefits</b>	<b>You pay</b>
<p>Skilled nursing facility (SNF): The Plan provides a comprehensive range of benefits for 45 days per calendar year when medically necessary when in a Skilled Nursing Facility (SNF) and are subject to the following terms:</p> <ul style="list-style-type: none"> <li>• Services are furnished by a facility as defined under Section 2801 of the Public Health Law, or which qualifies as an Extended Care Facility under Medicare which provides therapeutic services to patients needing skilled nursing care. The term “Skilled Nursing Facility” does not include a convalescent nursing home, rest facility or facility for the aged.</li> <li>• Coverage is limited to services provided by a Participating Provider.</li> <li>• A Skilled Nursing Facility which is licensed by the State to provide inpatient medical and nursing care, is recognized as such by Medicare, and which has an agreement with Blue Cross and Blue Shield to provide such services.</li> <li>• Care in a Skilled Nursing Facility is provided only if hospitalization would otherwise be required as determined by The Plan’s Medical Director and the Member’s PCP.</li> </ul>	Nothing
<p><i>Not covered: custodial care</i></p>	<p><i>All charges</i></p>
<b>Hospice care</b>	<b>You pay</b>
<p>Supportive and palliative care for a terminally ill member is covered in the home or hospice facility for up to 210 days. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stage of illness.</p>	Nothing
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<p><i>All charges</i></p>
<b>Ambulance</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>• Local professional ambulance service when medically appropriate</li> </ul>	Nothing

---

## Section 5 (d). Emergency services/accidents

---

I  
M  
P  
O  
R  
T  
A  
N  
T

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

I  
M  
P  
O  
R  
T  
A  
N  
T

---

### What is a medical emergency?

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

---

### What to do in case of emergency:

**Emergencies 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. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been timely notified.

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

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.

If the emergency results in admission to a hospital, the emergency care copay is waived.

**Emergencies outside our service area:** Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

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.

If the emergency results in admission to a hospital, the emergency care copay is waived.

---

Benefit Description	You pay
<b>Emergency within our service area</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office other than the primary care physician</li> <li>Emergency care at an urgent care center</li> </ul>	\$15 per visit
Emergency care as an outpatient or inpatient at a hospital, including doctors' services	\$50 per visit
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>
<b>Emergency outside our service area</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office</li> <li>Emergency care at an urgent care center</li> </ul>	\$15 per visit
Emergency care as an outpatient or inpatient at a hospital, including doctors' services	\$50 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Elective care or non-emergency care</i></li> <li><i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> </ul>	<i>All charges</i>
<b>Ambulance</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>Professional ambulance service when medically appropriate.</li> <li>Air Ambulance</li> </ul> <p>See 5(c) for non-emergency service.</p>	Nothing

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

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

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.

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- 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.

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

Benefit Description	You pay
<b>Mental health and substance abuse benefits</b>	<b>You pay</b>
<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>	Your cost sharing responsibilities are no greater than for other illness or conditions.
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>• Medication management</li> </ul>	\$15 copay per office visit
<ul style="list-style-type: none"> <li>• Diagnostic tests</li> </ul>	Nothing
<ul style="list-style-type: none"> <li>• Services provided by a hospital or other facility</li> <li>• Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full day hospitalization, facility based intensive outpatient treatment.</li> </ul>	\$240 copay
<p><i>Not covered: Services we have not approved.</i></p> <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><b>MENTAL HEALTH</b></p> <ul style="list-style-type: none"> <li>• 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</li> </ul> <p><b>SUBSTANCE ABUSE</b></p> <p>Treatment that is not authorized by a Plan doctor.</p> <ul style="list-style-type: none"> <li>• Benefits for days of care that consist primarily of participation in programs of a social, recreational, or companionship nature.</li> </ul>	<i>All charges.</i>

---

**Preauthorization**

To be eligible to receive these enhanced mental health and substance abuse benefits you obtain a treatment plan and follow all of the following authorization processes:

- The Pre-authorization process must be followed regardless of whether the member is within The Plan's service area or outside the service area. In making the determination to issue pre-authorization approval, the Plan will examine the circumstances surrounding the member's condition and care provided; including reasons for providing or prescribing the care; and any unusual circumstances. Please note the fact that the member's physician prescribed the care does not automatically mean that the care qualifies for plan payments under this contract. The provider, prior to recommending or ordering any pre-authorized services, must call the Medical Management Department at (800) 926-2357. Pre-authorization need not be obtained for Emergency care. For obtaining provider directories, call Member Service Department at (315) 798-4384 or (800) 722-7884.
-

---

## Section 5 (f). Prescription drug benefits

---

I  
M  
P  
O  
R  
T  
A  
N  
T

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

I  
M  
P  
O  
R  
T  
A  
N  
T

---

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

- **Who can write your prescription.** A licensed physician must write the prescription – or – A plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy or by mail. *We only* pay a benefit when you use a network pharmacy.
- **We use a formulary.** A formulary is a list of the most commonly prescribed generic and brand name drugs. If a provider prescribes a name brand drug that is not on our formulary *as a tier one or tier two drug*, you will pay the \$40 tier three drug copay.

To order a prescription brochure call 1-800-722-7884.

- **These are the dispensing limitations.** You will be charged 1 copay for each 30 day supply, retail or mail order. If there is no generic equivalent, you will pay the brand for the two and three tier copay.
- **When you have to file a claim.** If you do not use Plan pharmacies, you will receive no benefits.

**When you fill a first time prescription through mail order.** The first fill of a prescription is limited to a maximum of a (30) day supply.

---

Benefit Description	You pay
<p><b>Covered medications and supplies</b></p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except as excluded below.</li> <li>• Oral and injectable drugs</li> <li>• Implanted, time release contraceptive medications, such as Norplant</li> <li>• Smoking cessation drugs and medication including nicotine patches</li> <li>• Enteral formulas for home use when prescribed in writing by a Plan doctor for poor nourishment or a disorder which would cause chronic physical disability, mental retardation, or death</li> <li>• Medically necessary modified solid food products with low or modified protein for treatment of inherited diseases of amino acids and organic acid metabolism</li> <li>• Drugs for sexual dysfunction (see Prior authorization on <a href="#">page 11</a>)</li> <li>• Contraceptive drugs and devices</li> <li>• Fertility drugs</li> <li>• Growth hormone drugs</li> </ul> <p>Insulin, diabetic supplies and disposable needles and syringes needed to inject covered prescribed medication are available through the Plan’s medical and surgical benefits and are subject to the doctor’s office visit copayment</p>	<p><b>You pay</b></p> <p>\$10 copay per prescription unit or refill for Tier 1 drugs per each 30 day supply</p> <p>\$25 copay per prescription unit or refill for Tier two drugs per each 30 day supply</p> <p>\$40 copay per prescription unit or refill for Tier 3 drugs per each 30 day supply</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p> <p><b>Mail Order</b></p> <p>\$30 copay per prescription unit or refill for Tier 1 drugs per 90 day supply</p> <p>\$75 copay per prescription unit or refill for Tier two drugs per 90 day supply.</p> <p>\$120 copay per prescription unit or refill for Tier 3 drugs per 90 day supply.</p>
<p><i>Not covered</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs available without a prescription or for which there is a nonprescription equivalent available</i></li> <li>• <i>Vitamins and nutritional substances that can be purchased without a prescription</i></li> <li>• <i>Medical supplies such as dressings and antiseptics</i></li> <li>• <i>Drugs for Cosmetic purposes</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Implanted time-release medications other than Norplant</i></li> <li>• <i>Drugs in connection with transsexual surgery</i></li> <li>• <i>Drugs prescribed for experiential or investigational use</i></li> <li>• <i>Replacement for lost or stolen drugs.</i></li> </ul>	<p><i>All charges</i></p>

---

## Section 5 (g). Special features

Feature	Description
<b>Flexible benefits option</b>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"><li>• Healthy Choices is a value-added program, a package of health-related savings. Through a variety of special discounts, Healthy Choice encourages you to take advantage of resources dedicated to promoting a healthy life-style. All products, services, and wellness programs offer substantial savings.</li><li>• Fitness Clubs</li><li>• Golf Passes</li><li>• Fitness Clothing and Equipment</li><li>• Weight Loss Programs</li><li>• Wellness Programs</li><li>• Therapeutic Massage</li><li>• Smoking Cessation Programs</li><li>• Health &amp; Beauty</li><li>• Wellness Books and Audio</li><li>• Health &amp; Safety</li><li>• Vision &amp; Eye Care</li><li>• Discount Coupons</li></ul>

Feature (Continued)	Description
<p><b>Reciprocity benefit</b></p>	<p style="text-align: center;"><b>HMOBlue USA</b>  <b>Away from Home Care with Guest Membership</b>  <b>From BlueCross BlueShield of Utica-Watertown</b></p> <p><b>Enjoy the comforts of your HMO wherever you go.</b>  Now the benefits you enjoy from your HMO at home, are with you where ever you happen to be. <i>Away From Home Care</i> coverage puts you in touch with HMO health care from qualified physicians in nearly every state across the country, wherever you need it. You'll receive the same health care coverage you enjoy at home, through the country's largest HMO network, HMO Blue USA. The benefits of <i>Away From Home Care</i> coverage are yours automatically – and at no extra cost – when you join our HMO.</p> <p><b>The HMO that stays with you whenever you're away from home.</b>  Should you ever come down with an unexpected illness or injury while traveling, which can't wait to be treated at home, you can rest assured knowing that you have a place to turn. We call it BlueCard, because it delivers just that: the help you need, whenever you need it.</p> <p><b>No paperwork whatsoever.</b>  You're not feeling well to begin with. The last thing you need is a big expense to make things worse. With <i>Away From Home Care</i>, you can take comfort knowing you'll have no claims to file, no paperwork and no payment at the time of service.</p> <p><b>Far-reaching comforts no other HMO provides.</b>  HMOBlue USA offers health care coverage in more than 200 major cities across the country. It's also reassuring to know HMOBlue USA's <i>Away From Home Care</i> program is sponsored by the BlueCross and BlueShield Association.</p> <p>You know how important the right HMO coverage is when you're at home. Choose HMOBlue from BlueCross and BlueShield of Utica-Watertown and keep the benefits of your local coverage wherever you go.</p> <p><b>Even your follow-ups follow you.</b>  Should your travel schedule require that you miss a scheduled follow-up appointment at home, our BlueCard lets you conveniently schedule an appointment for ongoing care near your travel destination. Like every <i>Away From Home Care</i> service, you'll receive the same quality you enjoy at home.</p>
<p><b>Centers of Excellence for transplants/heart surgery/etc</b></p>	<p>BlueCross BlueShield Utica-Watertown works with other BlueCross plans to identify centers of excellence which offer quality care in specialized areas. When necessary the plan's Medical Director will recommend, members with diseases and conditions that can not be handled by our providers, to be sent to centers of excellence.</p>

## Section 5 (h). Dental benefits

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; 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.

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

### **Accidental injury benefit**

### **You pay**

These services are limited to those required for injury to sound natural teeth as a result of an accident. Inpatient or outpatient hospital services and physician services related to dental treatment not associated with an accidental injury will not be covered.

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, treat your illness, disease, injury or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- 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; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

---

## Section 7. Filing a claim for covered services

---

When you receive services from Plan physicians, 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. In some cases, these providers may bill us directly. Check with the provider. If you need to file the claim, here is the process:

### **Medical, Hospital, Drug and Other Supplies or Services Benefits**

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 800-722-7884.

When you must file a claim -- such as for out-of-area care -- 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: 12 Rhoads Drive  
Utica Business Park  
Utica, NY 13502**

### **Deadline for filing your claim**

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

### **When we need more information**

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

---

## Section 8. The disputed claims process

---

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

Step	Description
------	-------------

- |   |  |
|---|--|
| 1 | <p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none"><li>(a) Write to us within 6 months from the date of our decision; and</li><li>(b) Send your request to us at: 12 Rhoads Drive, Utica Business Park, Utica, NY 13502; and</li><li>(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li><li>(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li></ul>  |
| 2 | <p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"><li>(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</li><li>(b) Write to you and maintain our denial -- go to step 4; or</li><li>(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.</li></ul>  |
| 3 | <p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>  |
| 4 | <p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"><li>• 90 days after the date of our letter upholding our initial decision; or</li><li>• 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or</li><li>• 120 days after we asked for additional information.</li></ul> <p>Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street NW, Washington, D.C. 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"><li>• A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;</li><li>• Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;</li><li>• Copies of all letters you sent to us about the claim;</li><li>• Copies of all letters we sent to you about the claim; and</li><li>• Your daytime phone number and the best time to call.</li></ul> <p>Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.</p> |

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

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

- 5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.
- 6 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 preauthorization. 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 800-722-7884 and we will expedite our review; or
- (b) We denied your initial request for care or pre-authorization/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 can call OPM's Health Benefits Contracts Division 3 at 202/606-0755 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 are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

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

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

### •What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare managed care plan is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

### • The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

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.

**(Primary payer chart begins on next page.)**

The following chart illustrates whether the Original Medicare Plan 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.

<b>Primary Payer Chart</b>		
<b>A. When either you – or your covered spouse -- are age 65 or over and ...</b>	<b>Then the primary payer is...</b>	
	<b>Original Medicare</b>	<b>This Plan</b>
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when... a) The position is excluded from FEHB, or b) The position is not excluded from FEHB (Ask your employing office which of these applies to you.)	✓	
		✓
4) 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),	1. ✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) 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,	✓ (except for claims related to Workers' Compensation.)	
<b>B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and...</b>		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
<b>C. When you or a covered family member have FEHB and...</b>		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or b) Are an active employee, or c) Are a former spouse of an annuitant, or d) Are a former spouse of an active employee	✓	
		✓
	✓	
		✓

• **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+ Choice Plan --a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that the Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at [www.medicare.gov](http://www.medicare.gov). If you enroll in a Medicare managed care plan, the following options are available to you:

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

**Suspended FEHB coverage to enroll in a Medicare managed care plan:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan is primary, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care 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 managed care plan's service area.

• **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

**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 a one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the program.

**Workers' Compensation**

We do not cover services that:

- You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

**Medicaid**

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

**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

---

<b>Calendar year</b>	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.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	Custodial Care includes any service that can be provided by an average individual who has little or no medical training. Examples of Custodial Care include: (a) assistance in meeting activities of daily living such as feeding, dressing, and personal hygiene, (b) administration of oral medications, routine changing of dressings or preparation of special diets, (c) assistance in walking or getting out of bed, (d) care when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training.
<b>Experimental or investigational services</b>	<p>Experimental/investigational procedures are defined as any procedure, treatment, drug, biological product or device (hereinafter referred to as technology) that, in the sole discretion of the Plan, are determined to be experimental or investigational in nature.</p> <p>Experimental or investigational means that the technology is determined not to:</p> <ul style="list-style-type: none"><li>• have final approval from the appropriate government regulatory body;</li><li>• be proven benefit for the particular diagnosis or treatment of the member's condition;</li><li>• be recognized by the medical community, as reflected in the published peer-reviewed literature, as effective or appropriate for the particular diagnosis or treatment of the member's condition; or</li><li>• be as beneficial as any established alternative.</li></ul> <p>Your primary care physician will work with our medical director and medical staff to determine if a service is experimental or investigational.</p>
<b>Medical necessity</b>	Medically Necessary Care is care which, according to The Plan's criteria is: (a) Consistent with the symptoms or diagnosis and treatment of the Member's condition, disease, ailment or injury, (b) in accordance with standards of acceptable medical practice, (c) not solely for the Member's convenience, or that of the Member's Doctor or other Provider, (d) the most appropriate supply, place of service, or level of service which can safely be provided to the Member, (e) provided for the diagnosis or the direct care and treatment of the Member's condition, illness, disease or injury, and (f) when applied to hospitalization, the Member requires acute care as a bed patient due to the nature of the services rendered, or the Member's condition, and the Member could not have received safe or adequate care in any other setting (e.g. as an outpatient).
<b>Plan allowance</b>	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. We use many different forms of Plan Allowance. Our contract with your providers allows us to change Plan Allowance with a 60 day notice. We believe that listing our Plan Allowances would jeopardize our contracting ability with our providers.
<b>Us/We</b>	Us and we refer to HMOBlue
<b>You</b>	You refers to the enrollee and each covered family member.

---

## Section 11. FEHB facts

---

### No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that 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](http://www.opm.gov/insure). Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

- 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.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22; benefits will not be available to your spouse until you marry.

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 Federal Employees Health Benefits (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 Base Option.

**When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage begins January 1. Annuitants' premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

**When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

**When you lose benefits**

**•When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

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

**• Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get 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.

**•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 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](http://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 be entitled to continued coverage through the Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA is a federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan.

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

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site ([www.opm.gov/insure/health](http://www.opm.gov/insure/health)) refer to the “TCC and HIPAA” frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

---

## Long Term Care Insurance Is Still Available!

---

### Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

### FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

### You Can Also Apply Later, But...

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

### You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

**Find Out More** – Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337)** (TDD for the hearing impaired: **1-800-843-3557**) or visiting [www.ltcfeds.com](http://www.ltcfeds.com) to get more information and to request an application.

---

## Index

---

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

Accidental injury .....	36	Home health services .....	20	Physician.....	22
Allergy tests .....	17	Hospice care .....	27	Pre-admission testing.....	11
Alternative treatment.....	21	Home nursing care .....	20	Preventive care, adult.....	15
Ambulance .....	27	Hospital.....	26	Preventive care, children .....	15
Anesthesia.....	25	Immunizations.....	15	Prescription drugs .....	32
Autologous bone marrow transplant.....	24	Infertility .....	17	Preventive services.....	15
Blood and blood plasma .....	26	In-hospital physician care .....	26	Prior approval .....	11
Breast cancer screening.....	15	Inpatient Hospital Benefits .....	26	Prostate cancer screening.....	15
Casts .....	20	Insulin .....	33	Prosthetic devices.....	19
Catastrophic protection .....	12	Laboratory and pathological services .....	27	Psychologist.....	30
Changes for 2003 .....	8	Machine diagnostic tests.....	14	Radiation therapy.....	17
Chemotherapy .....	17	Magnetic Resonance Imagings (MRIs) .....	26	Rehabilitation therapies .....	27
Childbirth.....	16	Mail Order Prescription Drugs .....	33	Renal dialysis .....	17
Cholesterol tests .....	15	Mammograms .....	15	Room and board.....	26
Claims .....	38	Maternity Benefits.....	16	Second surgical opinion.....	14
Coinsurance .....	12	Medicaid .....	43	Skilled nursing facility care.....	27
Colorectal cancer screening.....	15	Medically necessary.....	44	Smoking cessation .....	21
Congenital anomalies.....	22	Medicare .....	41	Speech therapy .....	18
Contraceptive devices and drugs.....	16	Members .....	6	Splints .....	26
Coordination of benefits .....	42	Mental Conditions/Substance Abuse		Sterilization procedures .....	16
Covered providers .....	9	Benefits .....	30	Subrogation .....	43
Crutches .....	20	Newborn care .....	16	Substance abuse .....	30
Definitions .....	44	Nurse		Surgery	
Dental care .....	36	Licensed Practical Nurse .....	20	• Anesthesia.....	25
Diagnostic services.....	14	Registered Nurse .....	20	• Oral.....	23
Disputed claims review.....	34	Nursery charges.....	16	• Outpatient .....	27
Donor expenses (transplants).....	24	Obstetrical care.....	16	• Reconstructive.....	23
Dressings.....	26	Occupational therapy .....	18	Syringes .....	33
Durable medical equipment (DME) .....	20	Ocular injury.....	15	Temporary continuation of coverage .....	46
Educational classes and programs.....	21	Office visits.....	6	Transplants .....	24
Effective date of enrollment .....	9	Oral and maxillofacial surgery .....	23	Treatment therapies.....	17
Emergency .....	28	Orthopedic devices.....	19	Vision services .....	19
Experimental or investigational.....	44	Out-of-pocket expenses .....	12	Well child care .....	15
Eyeglasses.....	19	Outpatient facility care.....	27	Wheelchairs .....	20
Family planning .....	16	Oxygen.....	20	Worker's compensation.....	43
Fecal occult blood test.....	15	Pap test.....	15	X-rays.....	14
General Exclusions .....	37	Physical examination .....	15		
Hearing services .....	15	Physical therapy .....	18		

**NOTES:**

## Summary of benefits for HMOBlue – 2003

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office .....	Office visit copay: \$15 primary care; \$15 specialist	14
Services provided by a hospital: • Inpatient..... • Outpatient .....	\$240 copay \$100 copay	26 27
Emergency benefits: • In-area..... • Out-of-area .....	\$50 per emergency room visit \$50 per emergency room visit	29 29
Mental health and substance abuse treatment .....	Regular cost sharing.	30
Prescription drugs .....	Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. <b>You pay</b> a \$10 copay for Tier 1, a \$25 copay for Tier 2, a \$40 copay for Tier 3 drugs per prescription unit or refill. Mail order maintenance drugs. <b>You pay</b> a \$30 copay for Tier 1, a \$75 copay for Tier 2 or a \$120 copay for Tier 3 drugs per prescription unit or refill.	32
Dental Care .....	Accidental injury benefit; you pay nothing.	36
Vision Care .....	One refraction annually. You pay a \$15 copay per visit.	19
Protection against catastrophic costs (your out-of-pocket maximum).....	No Maximum	12

## 2003 Rate Information for HMO Blue

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

**Postal rates** apply to 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 special FEHB guides are published for Postal Service Nurses, RI 70-2B; and 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. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	AH1	\$109.30	\$48.33	\$236.82	\$104.71	\$129.03	\$28.60
Self and Family	AH2	\$249.62	\$152.02	\$540.84	\$329.38	\$294.70	\$106.94