

# HealthSpring

[www.myhealthspring.com/feds](http://www.myhealthspring.com/feds)



## 2003

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### A Health Maintenance Organization

**Serving:** Metropolitan Nashville and 27 counties of Middle Tennessee.



**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 URAC accreditation from the American Accreditation Healthcare Commission/URAC. See the 2003 Guide for more information on accreditation.**

#### Enrollment codes for this Plan:

##### HIGH OPTION

6K1 Self Only

6K2 Self and Family

##### STANDARD OPTION

6K4 Self Only

6K5 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.

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## Introduction

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This brochure describes the benefits of HealthSpring under our contract (CS 2865) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for HealthSpring's administrative offices is:

HealthSpring, Inc.  
44 Vantage Way, Suite 300  
Nashville, TN 37228

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 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 8. Rates are shown at the end of this brochure.

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## Plain Language

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

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means HealthSpring.
- 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.

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## Stop Health Care Fraud!

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

OPM's Office of 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 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 any 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 (615) 291-5030 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.

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## Section 1. Facts about this HMO plan

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

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductible 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, deductibles or coinsurance.

### Your Rights

OPM requires that all FEHB Plans to 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.

As a member of HealthSpring, you have rights:

- Confidentiality – Your medical information is confidential. HealthSpring is subject to applicable state and federal laws governing the release of your medical information.
- Consent – Your consent is required for treatment, unless you have an emergency, your life and health are in serious danger or you are unable to provide affirmative verbal or written consent. If your written consent is required for special procedures such as surgery, be sure you understand the procedure and why it is advised. Should you decide you do not want a particular treatment, discuss your concerns with your Primary Care Physician.
- Medical Records – You have the right to access your personal medical records maintained at your physician's office as provided by state and federal laws.
- Advance Directives – Legal provisions allow your wishes to be carried out when you are incapable of making health care decisions. Your health care professional or legal advisor can assist you with making a living will, a durable power of attorney for health care, or a mental health advance declaration a part of your medical records.
- Voice Grievances – You have the right to voice grievances about HealthSpring or the medical care you receive.
- Information – You have the right to be provided with information about HealthSpring, their participating providers, and your rights and responsibilities.
- Years in existence – We have been in business since 1984.
- Profit status – HealthSpring is a for profit company.
- Compliance and Licensing requirements – HealthSpring is licensed in the State of Tennessee as a Health Maintenance Organization. Licensing requires specified cash reserve levels, compliance with all state regulations governing the license, mandated benefits and compliance with federal statutes.

If you want more information about us, call (615) 291-5030 in Nashville or 1-800-917-3888 from outside Nashville, or write us at P.O. Box 20000, Nashville, TN 37202-9613. You may also contact us by visiting our website at [www.myhealthspring.com/feds](http://www.myhealthspring.com/feds).

### **Service Area**

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is the following Middle Tennessee counties:

#### MIDDLE TENNESSEE:

Bedford	Humphreys	Rutherford
Cannon	Lawrence	Smith
Cheatham	Lewis	Stewart
Coffee	Macon	Sumner
Davidson	Marshall	Trousdale
DeKalb	Maury	Warren
Dickson	Montgomery	Wayne
Franklin	Moore	Williamson
Hickman	Robertson	Wilson

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

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

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## Section 2. How we change for 2003

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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

**HIGH OPTION** - Your share of the non-postal premium will increase by 34% for Self Only coverage and 62.2% for Self and Family coverage.

**STANDARD OPTION** – 2003 is the first year we will have a Standard Option. Therefore, premium increase information does not apply to this option.

We now have a High and Standard Option discussed below. Our 2002 option became the High Option with the changes shown below.

### HIGH OPTION

- A primary care physician's office visit copayment is now \$15 per visit; previously you paid \$10 per visit. A specialist's office visit copayment is now \$25 per visit; previously you paid \$10 per visit. The copayment changes apply to all office visits for all covered services except for the following:
  - Maternity care* - the initial office visit copayment is now \$25 per visit. You pay nothing for additional visits.
  - Physical and Occupational therapies* - the office visit copayment is now \$25 per visit.
  - Speech therapy* - the office visit copayment is now \$25 per visit.
  - Vision services* - the office visit copayment is now \$15 per visit.
  - Chiropractic services* - the copayment is now \$25 per visit.
- The home health care visit copayment is now \$15 for primary care doctors, nurses or home health aides' visits and \$25 for a specialist. Previously, you paid \$10 per visit.
- The inpatient hospital admission copayment is now \$250 per admission. Previously, you paid nothing.
- The outpatient hospital or ambulatory surgical center copayment is now \$250 per procedure. Previously, you paid nothing.
- The hospital emergency room copayment is now \$100 per visit. Previously, you paid \$50 per visit.
- The urgent care center copayment is now \$50 per visit. Previously, you paid \$25 per visit.
- Mail Order maintenance drugs now require 3 copayments for a 90-day supply. Previously, you paid 2 copayments for a 90-day supply.
- The out-of-pocket maximums are \$2,000 for Self Only and \$4,000 for Self and Family.

### High Option Clarification:

- We show coverage for cataract supplies (hardware and supplies).

## **STANDARD OPTION**

- A \$500 calendar year deductible applies to most benefits. The deductible does not apply to routine immunizations, reconstructive surgery, organ/tissue transplants benefits.
- Coinsurance at 20% applies to most covered benefits. Coinsurance does not apply to routine immunizations, organ/tissue transplants, inpatient hospital benefits and extended care/skilled nursing facility benefits.
- The out-of-pocket maximums are \$3,000 for Self Only and \$6,000 for Self and Family.
- The primary care physician and specialist office visit copay of \$20 per visit is not subject to the calendar year deductible or the 20% coinsurance.
- The calendar year deductible and the 20% coinsurance apply to the following covered services:
  - Lab, x-ray and other tests
  - Family planning
  - Infertility services
  - Allergy care
  - Treatment therapies
  - Physical and occupational therapies
  - Speech therapy
  - Hearing services
  - Orthopedic and prosthetic devices - \$1,500 maximum Plan benefit. Member must satisfy calendar year deductible and pay 20% of covered charges.
  - Durable medical equipment - \$1,500 maximum Plan benefit. Member must satisfy calendar year deductible and pay 20% of covered charges.
  - Home health services
  - Reconstructive surgery
  - Surgical procedures
  - Oral and maxillofacial surgery
  - Anesthesia
  - Outpatient hospital and ambulatory surgery
  - Accidental dental
- The following covered services are not subject to calendar year deductible or 20% coinsurance. You pay only the amount shown for the service which we cover up to benefit allowance shown below:
  - Cataract Supplies (Hardware and lenses) - \$100 Maximum Plan Allowance
  - Hospice Care - No member copayment
  - Hospital Emergency Room Visit - \$100 copayment per admission
  - Emergency Doctor's Office Visit - \$20 copayment per visit
  - Urgent Care Center Visit - \$50 copayment per visit
  - Ambulance - No member copayment
  - Prescription Drugs Copayment \$10 Generic, \$20 Preferred Brand Name, 50% coinsurance non-preferred brand name
  - Mail Order Prescription Drugs - 90 day supply for 3 copays
  - Inpatient hospital copayment - \$250 per admission
  - Outpatient hospital or ambulatory surgical center copay - \$250 per procedure

## **High Option and Standard Option Benefit Change**

- We now cover a more comprehensive list of dental benefits. [See Section 5\(h\)](#) for details.

## **High Option and Standard Option Clarification**

- We show coverage for smoking cessation.

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## Section 3. How you get care

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### 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 (615) 291-5030 in Nashville or from outside Nashville at 1-800-917-3888. You may also request replacement cards through our website at [www.myhealthspring.com/feds](http://www.myhealthspring.com/feds).

### Where you get covered care

You get care from “Plan Providers” and “Plan Facilities.” You pay only copayments, deductibles and coinsurance. You will not have to file claims.

- **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. Our staff of medical professionals continually credentials and monitors participating doctors and hospitals to assure the network meets strict industry standards of care.

Some Primary Care Physicians belong to independent physician associations (IPAs). IPAs are groups of physicians who contract with managed care organizations to provide health care services. IPA networks may include general physicians or specialists like cardiologists and orthopedists. **Note: Physicians in an IPA may refer only to other physicians and hospitals affiliated with the same IPA. Members should look in their HealthSpring Provider Directory or call HealthSpring’s Customer Service line, (615) 291-5030 to find if a PCP has an IPA relationship.**

We list Plan providers in the Provider Directory, which we update periodically. The provider list is also on our website. The directory lists IPA primary care and specialty providers and independently contracted primary care providers and specialists. The provider list includes physician office addresses and phone numbers.

- **Plan facilities**

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

### 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 (PCP). This decision is important since your Primary Care Physician provides or arranges most of your health care. Selection must be made from the HealthSpring network of Primary Care Physicians. Some Primary Care Physicians belong to IPAs that refer patients only to other Providers in the same IPA. **Members should look to their HealthSpring Provider Directory or call HealthSpring’s Customer Service line, (615) 291-5030 to find if a PCP has an IPA relationship.** Once a PCP has been selected, you should schedule an initial appointment with him/her to establish a physician/patient relationship.

- **Primary care**

Your Primary Care Physician can be a family practitioner, general practitioner, internist, or pediatrician. Your Primary Care Physician cannot be an OB/GYN. Your Primary Care Physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change Primary Care Physicians or if your Primary Care Physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

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 consultation, unless your Primary Care Physician authorized a certain number of visits without additional referrals. The Primary Care Physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your Primary Care Physician gives you a referral. However, you may see a network gynecologist for a routine examination once each calendar year.

**Remember: Some physician groups in the directory refer to a limited number of OB/GYNs. If your Primary Care Physician belongs to an IPA, you must choose an obstetrician/gynecologist who belongs to the same IPA.**

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 work with the specialists and the Plan to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your Primary Care Physician will use our criteria when creating your treatment plan (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 before seeing your specialist. 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 (615) 291-5030 in Nashville or 1-800-917-3888. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

### **Circumstances beyond our control**

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

### **Services requiring our prior approval**

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

We call this review and approval process precertification. There are two review processes associated with review and approval of services. Precertification involves review of elective services 5-7 days before the service occurs. Authorization involves urgent/emergent services and usually occurs within one business day of the service. This review may be before or after the service occurs. Your Plan physician is responsible for obtaining approval for services. Below are some of the services requiring prior approval.

- All inpatient hospital care
- Extended care/skilled nursing facilities
- Mental Health or substance abuse services (through Magellan)
- Inpatient rehab services
- Cardiac and Pulmonary Rehab
- Organ and tissue transplants
- Infertility procedures
- Specialty referrals
- Home Health Care
- Durable Medical Equipment
- Orthopedic and prosthetic devices
- Growth Hormone Therapy
- Certain outpatient oral or injectable drugs
- Hospice
- Outpatient surgery
- Surgical treatment of morbid obesity
- Any request for non-par provider

**Your Primary Care Physician must obtain a referral for specialty care physician services. If you receive services without obtaining a referral you may be obligated to pay for unauthorized services.**

Your Primary Care Physician or Specialty Care Physician is responsible for calling the Health Services Department to obtain precertification or authorization. Failure to obtain

authorization or precertification may result in payment denial. You, or a provider on your behalf, may appeal any decision as outlined in the appeal and grievance process.

If your coverage is terminated prior to the date of service, the service will not be covered, regardless of a precertification or authorization given by us or your Primary or Specialty Care Physician.

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## Section 4. Your costs for covered services

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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: Under the High Option Plan, you pay a \$15 copayment for a Primary Care Physician office visit and a \$25 copayment for a Specialist office visit. Under both options, when you are admitted to the hospital, you pay a \$250 copayment per admission.

- **Deductible**

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

**High Option Plan:** We do not have any deductibles in the High Option Plan.

**Standard Option Plan:** The calendar year deductible is \$500 per person or \$1,000 per family enrollment.

Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

And, if you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

- **Coinsurance**

Coinsurance is the percentage of our negotiated fee that you must pay for your care. Coinsurance does not begin until you meet your deductible.

Example: In our Standard Option Plan, you pay 20% of our allowable charges for the treatment of infertility after you satisfy the calendar year deductible.

### **Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance and copayments**

**High Option -** The out-of-pocket maximum is \$2,000 per person or \$4,000 per family. You pay no more copayments once the out-of-pocket maximum is met.

**Standard Option -** The out-of-pocket maximum is \$3,000 per person or \$6,000 per family. Office visit copayments and calendar deductible do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services. Coinsurance amounts do apply to the out-of-pocket maximum.

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

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## Section 5. Benefits – OVERVIEW

(See 62 for a benefits summary.)

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**NOTE:** This benefits section is divided into subsections. Please read the important things at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claim filing advice, or more information about your benefits, contact us at (615) 291-5030 in Nashville or 1-800-917-3888 from outside Nashville or at our website at [www.myhealthspring.com/feds](http://www.myhealthspring.com/feds).

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

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**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.
- Calendar year deductible:  
**High Option** - We have no calendar year deductible.  
**Standard Option** - The calendar year deductible is \$500 per person or \$1,000 per family and applies to most benefits in this section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about *coordinating benefits* with other coverage, including with Medicare.

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Benefit Description	You Pay - High Option	You Pay - Standard Option
		<p align="center"><b>NOTE: The calendar year deductible applies to most benefits in this section for Standard Option. We show “(No deductible)” when it does not apply.</b></p>
<b>Diagnostic and treatment services</b>		
Professional services of physicians <ul style="list-style-type: none"> <li>• In a physician’s office</li> <li>• During a hospital stay</li> <li>• In a skilled nursing facility</li> <li>• Office medical consultations</li> <li>• Second surgical opinion</li> </ul>	\$15 per primary care physician visit; \$25 per specialist visit  Nothing  Nothing  Nothing  \$15 per primary care physician visit; \$25 per specialist visit	\$20 per primary care physician visit or specialist visit (No deductible)  Nothing  Nothing  Nothing  \$20 per primary care physician visit or specialist visit (No deductible)

Diagnostic and treatment services - *continued on next page*

<b>Diagnostic and treatment services</b> <i>(continued)</i>	<b>You pay - High Option</b>	<b>You pay - Standard Option</b>
At home	\$15 per primary care physician visit; \$25 per specialist visit	20% of charges after satisfying calendar year deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Services, drugs, or supplies you receive while you are not enrolled in this Plan</i></li> <li>• <i>Services or supplies related to self-treatment; or services or supplies provided by any person related to you by blood or marriage or any person who resides in your immediate household</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Lab, X-ray and other diagnostic tests</b>		
<p>Tests, such as:</p> <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	20% of charges after satisfying calendar year deductible
<b>Preventive care, adult</b>		
<p>Routine screening, such as:</p> <ul style="list-style-type: none"> <li>• Total Blood Cholesterol – once every three years</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> <p>Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</p>	\$15 per primary care physician visit; \$25 per specialist visit	\$20 per primary care physician visit or specialist visit (No deductible)

Preventive Care, adult - *continued on next page*

Preventive care, adult <i>(continued)</i>	You pay - High Option	You pay - Standard Option
Routine pap test <b>Note:</b> The office visit is covered if pap test is received on the same day; <i>see Diagnostic and Treatment</i> , above.	\$15 per primary care physician visit; \$25 per specialist visit	\$20 per primary care physician visit or specialist visit (No deductible)
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> <li>• From age 35 through 39, one during this five year period</li> <li>• Over age 40, one every calendar year</li> </ul>	\$15 per primary care physician visit; \$25 per specialist visit	\$20 per primary care physician visit or specialist visit (No deductible)
<i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges</i>	<i>All charges</i>
Routine immunizations, limited to: <ul style="list-style-type: none"> <li>• Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under childhood immunizations)</li> <li>• Influenza vaccine annually</li> <li>• Pneumococcal vaccine, age 65 and over</li> </ul>	\$15 per primary care physician visit; \$25 per specialist visit	\$20 per primary care physician visit or specialist visit (No deductible)
Preventive care, children		
<ul style="list-style-type: none"> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> </ul>	\$15 per primary care physician visit; \$25 per specialist visit	\$20 per primary care physician visit or specialist visit (No deductible)
<ul style="list-style-type: none"> <li>• Well-child care charges for routine examinations, immunizations and care (through age 22)</li> <li>• Examinations, such as:               <ul style="list-style-type: none"> <li>— Eye exams through age 17 to determine the need for vision correction.</li> <li>— Ear exams through age 17 to determine the need for hearing correction.</li> <li>— Examinations done on the day of immunizations (through age 22)</li> </ul> </li> </ul>	\$15 per primary care physician visit; \$25 per specialist visit	\$20 per primary care physician visit or specialist visit (No deductible)

Maternity care	You pay - High Option	You pay - Standard Option
<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><b>Note:</b> Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need to pre-certify your normal delivery. <a href="#">See page 12</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 will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Circumcision is covered under the maternity benefit.</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. <a href="#">See Hospital benefits (Section 5c)</a> and <a href="#">Surgery benefits (Section 5b)</a>.</li> </ul>	<p>\$25 for the initial office visit to confirm pregnancy; no copay for all prenatal and postnatal visits thereafter</p>	<p>\$20 for the initial office visit to confirm pregnancy; no copay for all prenatal and postnatal visits thereafter (No deductible)</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Family planning		
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (e.g. Tubal ligation, Vasectomy)</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> </ul> <p>Note: We cover oral contraceptives under the Prescription Drug benefit.</p>	<p>\$15 per primary care physician visit; \$25 per specialist visit</p> <p>20% coinsurance</p> <p>\$35 copay</p> <p>\$35 copay</p> <p>\$20 copay</p>	<p>20% of charges after satisfying calendar year deductible</p>

Family planning - continued on next page

<b>Family planning (<i>continued</i>)</b>	<b>You pay - High Option</b>	<b>You pay - Standard Option</b>
<i>Not covered: Reversal of voluntary surgical sterilization; genetic counseling</i>	<i>All charges</i>	<i>All charges</i>
<b>Infertility services</b>		
Diagnosis and treatment of infertility, such as: <ul style="list-style-type: none"> <li>• Artificial insemination               <ul style="list-style-type: none"> <li>— <i>Intravaginal insemination (IVI)</i></li> <li>— <i>Intracervical insemination (ICI)</i></li> <li>— <i>Intrauterine insemination (IUI)</i></li> </ul> </li> </ul>	\$15 per primary care physician visit; \$25 per specialist visit  20% coinsurance for treatment	20% of charges after satisfying calendar year deductible
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> <li>— <i>in vitro fertilization</i></li> <li>— <i>embryo transfer, gamete GIFT and zygote ZIFT</i></li> <li>— <i>Zygote transfer</i></li> </ul> </li> <li>• Services and supplies related to excluded ART procedure</li> <li>• Cost of donor sperm</li> <li>• Cost of donor egg</li> <li>• Fertility drugs</li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Allergy care</b>		
Testing and treatment Allergy injections	\$15 per primary care physician visit; \$25 per specialist visit	20% of charges after satisfying calendar year deductible
Allergy serum	Nothing	Nothing
<i>Not covered: provocative food testing and sublingual allergy desensitization.</i>	<i>All charges</i>	<i>All charges</i>

Treatment therapies	You pay - High Option	You pay - Standard Option
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on 31.</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</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> </ul> <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: We will only cover GHT when we preauthorize the treatment. Your physician will be given a prior authorization form and asked to submit information that establishes that GHT is medically necessary. This process must occur before you begin treatment or this treatment may not be covered. If you do not obtain precertification or if we determine that GHT is not medically necessary, we will not cover the GHT. <a href="#">See Services requiring our prior approval in Section 3.</a></p>	<p>\$15 per primary care physician visit; \$25 per specialist visit</p>	<p>20% of charges after satisfying calendar year deductible</p>
<p><i>Not covered: Non-medical ancillary services, testing and treatment which include, but are not limited to, such services as: vocational rehabilitation, cognitive behavioral training/therapy, sleep therapy, recreational therapy, employment counseling, educational testing or therapy for learning disabilities or mental retardation, hypnotherapy, assertiveness training, stress management, biofeedback and marital sex or family therapy.</i></p>	<p><i>All charges</i></p>	<p><i>All charges</i></p>



Vision services (testing, treatment, and supplies)	You pay - High Option	You pay - Standard Option
<ul style="list-style-type: none"> <li>Eye exam, including refraction, by a participating provider, once every 12 months</li> </ul>	\$15 per office visit	\$20 per office visit
<p>We limit coverage to \$100 per member per calendar year.</p> <ul style="list-style-type: none"> <li>One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as cataracts)</li> </ul> <p>Note: <a href="#">See Preventive care, children</a> for eye exams for children.</p>	Nothing up to our \$100 benefit allowance per calendar year and all charges that exceed our maximum allowance	Nothing up to our \$100 benefit allowance per calendar year and all charges that exceed our maximum allowance (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Eyeglasses (lenses and frames, contact lenses);</i></li> <li><i>Eye exercises and orthoptics</i></li> <li><i>Radial keratotomy and other refractive surgery</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
Foot care		
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p><a href="#">See orthopedic and prosthetic devices</a> for information on podiatric shoe inserts.</p>	\$15 per primary care physician visit; \$25 per specialist visit	\$20 per primary care physician visit or specialist visit (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Routine foot care or the treatment of flat feet, corns, calluses, toe nails, fallen arches, weak feet, chronic foot strain, or symptomatic complaints relating to the feet, unless determined by our Medical Director to be medically necessary in the preventive treatment of Diabetics;</i></li> <li><i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i></li> <li><i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by surgery).</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

Orthopedic and prosthetic devices	You pay - High Option	You pay - Standard Option
<p>Our maximum allowance for external orthopedic and prosthetic devices and DME is limited to a combined benefit of \$1,500.</p> <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>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome;</li> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, surgically implanted breast implants following mastectomy. Note: <a href="#">See 5 (b)</a> for coverage of the surgery to insert the device.</li> </ul> <p><b>Note:</b> We pay for internal prosthetic devices as hospital benefits; see <a href="#">Section 5(c)</a> for payment information. <a href="#">See 5(b)</a> for coverage of the surgery to insert the device.</p>	<p>Nothing up to our maximum allowance and all charges that exceed our maximum allowance</p>	<p>20% of charges after satisfying calendar year deductible up to our maximum allowance and all charges that exceed our maximum allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Orthopedic and corrective shoes;</i></li> <li>• <i>Lumbosacral supports;</i></li> <li>• <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices;</i></li> <li>• <i>Penile prostheses or erection devices whether implantable or external;</i></li> <li>• <i>Replacement of external prosthetics or orthotics due to wear and tear, loss, theft, destruction or improved available technology of the device. Repair of external prosthetics or orthotics or payment of warranties related to the prosthetic or orthotic device. Replacement of prosthetics and orthotics is covered only when due to the member's physical development or growth; or</i></li> <li>• <i>Supportive devices, including repairs (example: arch supports), orthotics for the feet or orthopedic shoes, except when necessary as a component of an authorized brace.</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Durable medical equipment (DME)	You pay - High Option	You pay - Standard Option
<p>Our maximum allowance for external orthopedic and prosthetic devices and DME is limited to a combined benefit of \$1,500.</p> <p><b>We cover, at our option,</b> rental or purchase, 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>• oxygen delivery systems;</li> <li>• nebulizers;</li> <li>• hospital beds;</li> <li>• wheelchairs;</li> <li>• crutches;</li> <li>• walkers;</li> <li>• blood glucose monitors; and</li> <li>• insulin pumps (with approval of Medical Director)</li> </ul>	<p>Nothing up to our maximum allowance and all charges that exceed our maximum allowance</p>	<p>20% of charges after satisfying calendar year deductible up to our maximum allowance and all charges that exceed our maximum allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Rentals of equipment that extend beyond the original prescription and authorization if recertification has not been obtained;</i></li> <li>• <i>Braces and splints that are used primarily to assist a member during athletic activities;</i></li> <li>• <i>Repairs of DME except for repairs necessary due to reasonable wear and tear. Replacement of DME equipment is covered only if due to the member's physical development or growth;</i></li> <li>• <i>Air conditioners, air filters, heaters, humidifiers, and other equipment that adjusts or regulates the interior environment, even if ordered by a participating provider;</i></li> <li>• <i>Physical fitness equipment, saunas, whirlpools, water purifiers, swimming pools, tanning beds or recreational equipment even if ordered by a participating provider; or</i></li> <li>• <i>Self-help or hygienic products including, but not limited to, bathtub and shower chairs, safety-grab bars, stair gliders or elevators, over-the-bed tables, or motorized vehicles.</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Home health services	You pay - High Option	You pay - Standard Option
<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.</li> </ul> <p>Services include oxygen therapy, intravenous therapy and medications.</p> <p><b>Note:</b> Oxygen covered as a DME benefit (see <a href="#">Durable Medical Equipment</a>).</p>	\$15 per visit	20% of charges after satisfying calendar year deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Nursing care requested by, or for the convenience of, the patient or the patient's family;</li> <li>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative; or</li> <li>Rest, custodial, domiciliary, convalescent care; personal comfort or convenience items, sitter services, private duty nursing, homemaker services, (including home-delivered meals) or transportation services.</li> </ul>	<i>All charges</i>	<i>All charges</i>
Chiropractic		
<p>Limited to members 18 years of age and older. Maximum of 20 visits per calendar year per member.</p> <ul style="list-style-type: none"> <li>Manipulation of the spine and extremities</li> <li>Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application</li> </ul> <p><b>Note:</b> All diagnostic and lab procedures must be coordinated by your Primary Care Physician. We will not cover these services if not arranged by your PCP.</p> <p><b>Note:</b> We cover benefits only when we determine care is clinically appropriate to treat your condition and is arranged by us.</p>	\$25 per office visit	\$20 per primary care physician visit or specialist visit (No deductible)
<p><i>Not covered: Services or supplies related to the use of acupuncture or acupressure.</i></p>	<i>All charges</i>	<i>All charges</i>
Alternative treatments		
<i>No benefit</i>	<i>All charges</i>	<i>All charges</i>

<b>Educational classes and programs</b>	<b>You pay - High Option</b>	<b>You pay - Standard Option</b>
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> <li>• Diabetes self-management</li>   <li>• Smoking cessation - Our maximum lifetime benefit is \$100</li> </ul>	<p>\$15 per primary care physician visit; \$25 per specialist visit</p> <p>Nothing up to our maximum lifetime benefit and all charges that exceed our maximum allowance.</p>	<p>\$20 per primary care physician visit or specialist visit (No deductible)</p> <p>Nothing up to our maximum lifetime benefit and all charges that exceed our maximum allowance. (No deductible)</p>

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

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**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.
- Calendar year deductible:
  - High Option** - We have no calendar year deductible.
  - Standard Option** - The calendar year deductible is \$500 per person or \$1,000 per family and applies to most benefits in this section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about *coordinating benefits* with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for *charges associated with the facility* (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

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Benefit Description	You pay - High Option	You pay - Standard Option
		<b>NOTE: The calendar year deductible applies to almost all benefits in this section for the Standard Option. We show “(No deductible)” when it does not apply.</b>
<b>Surgical procedures</b>		
A comprehensive range of services, such as: <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> </ul>	\$15 per primary care physician visit; \$25 per specialist visit	20% of charges after satisfying calendar year deductible

Surgical procedures ( <i>continued</i> )	You pay - High Option	You pay - Standard Option
<ul style="list-style-type: none"> <li>• Correction of congenital anomalies (<a href="#">see Reconstructive surgery</a>)</li> <li>• Surgical treatment of morbid obesity – is covered when the following criteria are met:               <ul style="list-style-type: none"> <li>– Eligible members must be 18 years or older, AND</li> <li>– Documented history of repeated failure of physicians supervised medical dietary therapies, AND</li> </ul> </li> <li>• A body mass index (BMI) exceeding 40 or greater than 35 in conjunction with severe co-morbidity such as cardiopulmonary complications or severe diabetes.</li> </ul>	\$15 per primary care physician visit; \$25 per specialist visit	20% of charges after satisfying calendar year deductible
<ul style="list-style-type: none"> <li>• Voluntary sterilization (e.g. Tubal ligation, Vasectomy)</li> <li>• Treatment of burns</li> </ul> <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	\$15 per primary care physician visit; \$25 per specialist visit	20% of charges after satisfying calendar year deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot; <a href="#">see Foot care</a></i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Reconstructive surgery</b>		
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if:               <ul style="list-style-type: none"> <li>– the condition produced a major effect on the member’s appearance and</li> <li>– the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.</li> </ul>	\$15 per primary care physician visit; \$25 per specialist visit	20% of charges (No deductible)

Reconstructive surgery - *continued on next page*

<b>Reconstructive surgery</b> <i>(continued)</i>	<b>You pay - High Option</b>	<b>You pay - Standard Option</b>
<ul style="list-style-type: none"> <li>• All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> <li>– surgery to produce a symmetrical appearance on the other breast;</li> <li>– treatment of any physical complications, such as lymphedemas;</li> <li>– breast prostheses and surgical bras and replacements (see <a href="#">Prosthetic devices</a>)</li> </ul> </li> </ul> <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	\$15 per primary care physician visit; \$25 per specialist visit	20% of charges after satisfying calendar year deductible
<b>Oral and maxillofacial surgery</b>		
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Treatment for TMJ;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures; and</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures.</li> </ul>	\$15 per primary care physician visit; \$25 per specialist visit	20% of charges after satisfying calendar year deductible
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival, and alveolar bone)</i></li> </ul>	<i>All charges</i>	<i>All charges</i>

Organ/tissue transplants	You pay - High Option	You pay - Standard Option
<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>• Small Bowel</li> <li>• Small Bowel/Liver</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> </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>Note: We cover related medical and hospital expenses of the donor when we cover the recipient. Covered services are limited to those services and supplies directly related to the transplant procedure itself.</p>	Nothing	20% of charges after satisfying calendar year deductible
<p>Transportation services, lodging and meals for the member, and one companion.</p> <p>Our maximum Plan allowance for this benefit is \$5,000 per person, with prior approval and coordination by HealthSpring Case Management Department.</p>	Nothing up to our maximum allowance of \$5,000 per person.	Nothing up to our maximum allowance of \$5,000 per person.

Organ/tissue transplants - continued on next page

<b>Organ/tissue transplants (<i>continued</i>)</b>	<b>You pay - High Option</b>	<b>You pay - Standard Option</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>Artificial, mechanical or animal heart, or any other artificial organ or associated expenses</i></li> <li>• <i>Furnishing an organ or tissue</i></li> <li>• <i>Transplants not listed as covered</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Anesthesia</b>		
Professional services provided in – <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> </ul>	Nothing	20% of charges after satisfying calendar year deductible
Professional services provided in – <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>	Nothing	20% of charges after satisfying calendar year deductible



<b>Inpatient hospital</b> <i>(continued)</i>	<b>You pay - High Option</b>	<b>You pay - Standard Option</b>
<ul style="list-style-type: none"> <li>• Dressings, splints, casts, and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> <li>• Take-home items</li> <li>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home</li> </ul>	Nothing – covered in \$250 per admission copay	Nothing – covered in \$250 per admission copay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Custodial care</li> <li>• Non-covered facilities, such as nursing homes</li> <li>• Personal comfort items, such as telephone, television, barber services, guest meals and beds</li> <li>• Private nursing care</li> <li>• Storage of autologous blood</li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Outpatient hospital or ambulatory surgical center</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 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 non-dental procedures by a non-dental physical impairment. We do not cover the dental procedure.</p>	\$250 per procedure	\$250 per procedure (No deductible)
<i>Not covered: blood and blood derivatives not replaced by the member</i>	<i>All charges</i>	<i>All charges</i>

<b>Extended care benefits/skilled nursing care facility benefits</b>	<b>You pay - High Option</b>	<b>You pay - Standard Option</b>
Skilled nursing facility (SNF): Limited to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.	Nothing	Nothing
<i>Not covered: custodial care</i>	<i>All charges</i>	<i>All charges</i>
<b>Hospice care</b>		
Hospice Services <ul style="list-style-type: none"> <li data-bbox="142 674 699 737">• We cover a maximum plan benefit of \$10,000 per calendar year</li> </ul>	Nothing up to our maximum Plan benefit and all charges that exceed our maximum	Nothing up to our maximum Plan benefit and all charges that exceed our maximum
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>	<i>All charges</i>
<b>Ambulance</b>		
<ul style="list-style-type: none"> <li data-bbox="142 936 732 999">• Non-emergency local professional ambulance service when medically appropriate</li> </ul>	Nothing	Nothing

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

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### 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.
- Calendar year deductible:
  - High Option** - We have no calendar year deductible.
  - Standard Option** - The calendar year deductible is \$500 per person or \$1,000 per family and applies to most benefits in this section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about [coordinating benefits](#) with other coverage, including Medicare.

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### 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 medical 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.

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### What to do in case of emergency:

**Emergencies within our service area:** In an emergency, go to the nearest medical facility for treatment. Notify your Primary Care Physician and HealthSpring within 24 hours of receiving emergency services unless it is not reasonably possible to do so. Your Primary Care Physician must coordinate all follow-up care including suture removal. Emergency treatment does not require a written referral. You will have coverage for emergency room charges only when the presenting symptoms to the emergency room meet the definition of an emergency. Emergency service copayment will be waived if admitted to the hospital from the emergency room.

**Emergencies outside our service area:** If an emergency occurs outside the service area, and you could not reasonably return to the service area, you should contact your Primary Care Physician the next business day after receiving treatment to coordinate follow-up care or arrange for a transfer back into the service area. Emergency Service copayment will be waived if admitted as an inpatient from the emergency room.

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Benefit Description	You pay - High Option	You pay - Standard Option
<b>Emergency within our service area</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> <li>Emergency care as an outpatient or inpatient at a hospital, including doctors' services</li> </ul> <p><b>Note:</b> Hospital emergency room copayment is waived if member is admitted to the hospital.</p>	<p>\$15 per primary care physician visit; \$25 per specialist visit</p> <p>\$50 per visit</p> <p>\$100 per visit</p>	<p>\$20 per primary care physician visit or specialist visit</p> <p>\$50 per visit</p> <p>\$100 per visit</p>
<i>Not covered: Elective care or non-emergency care.</i>	<i>All charges</i>	<i>All charges</i>
<b>Emergency outside our service area</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> <li>Emergency care as an outpatient or inpatient at a hospital, including doctors' services</li> </ul> <p><b>Note:</b> Hospital emergency room copayment is waived if member is admitted to hospital.</p>	<p>\$15 per primary care physician visit; \$25 per specialist visit</p> <p>\$50 per visit</p> <p>\$100 per visit</p>	<p>\$20 per primary care physician visit or specialist visit</p> <p>\$50 per visit</p> <p>\$100 per visit</p>
<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> <li><i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> </ul>	<i>All charges</i>	<i>All charges</i>
<b>Ambulance</b>		
<ul style="list-style-type: none"> <li>Professional ambulance service when medically appropriate.</li> </ul> <p><a href="#">See 5(c)</a> for non-emergency service.</p> <ul style="list-style-type: none"> <li>Air ambulance service when medically appropriate and pre-approved by Plan.</li> </ul>	Nothing	Nothing

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

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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:**

- Please remember all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Calendar year deductible:
  - High Option** - We have no calendar year deductible.
  - Standard Option** - The calendar year deductible is \$500 per person or \$1,000 per family and applies to most benefits in this section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about *coordinating benefits* with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

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Benefit Description	You pay - High Option	You pay - Standard Option
<b>Mental health and substance abuse benefits</b>		
<ul style="list-style-type: none"> <li>• All diagnostic and treatment services must be recommended by a Plan provider and contained in a treatment plan we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</li> </ul> <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.	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>	\$25 per visit	\$20 per visit (No deductible)
<ul style="list-style-type: none"> <li>• Diagnostic tests</li> </ul>	Nothing	20% of charges after satisfying calendar year deductible

Mental health and substance abuse - *continued on next page*

<b>Mental health and substance abuse benefits (continued)</b>	<b>You pay - High Option</b>	<b>You pay - Standard Option</b>
<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>	\$250 per admission copay	\$250 per admission 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>	<i>All charges</i>	<i>All charges</i>

**Preauthorization**

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following authorization processes:

To obtain Mental Health or Substance Abuse benefits, call 1-800-500-4638 to receive a referral for any inpatient or outpatient behavioral health services.

All mental health and substance abuse care must be coordinated by a Participating Provider and prior authorization received from the Mental Health Organization contracted by HealthSpring. Your Participating provider is responsible for obtaining prior approval for services. Before giving approval, we consider benefit design, medical necessity, and generally accepted practices. Member must call 1-800-500-4638 to receive a referral for any inpatient or outpatient behavioral health services.

**Limitation**

We may limit your benefits if you do not obtain a treatment plan.

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## Section 5 (f). Prescription drug benefits

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**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.
- We have no calendar year deductible for the prescription drug benefit under either our High Option or Standard Option.
- 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.

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

- **Who can write your prescription?** A plan physician or referral physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a participating pharmacy or by mail for maintenance medications. You must use a network pharmacy. Walgreen's is not a participating pharmacy. For a complete list of participating pharmacies, please check our web page at [www.myhealthspring.com/feds](http://www.myhealthspring.com/feds).
- **We use a formulary.** The formulary is a list of prescription drugs that physicians use in prescribing medications. A Pharmacy and Therapeutics Committee evaluates prescription drugs for safety, effectiveness, quality, and overall value and schedules the medications as preferred or non preferred brand after they have been on the market for at least 6 months. The formulary is subject to change. For a current list of covered medications included in the formulary, as well as their classifications as generic, preferred brand, or non preferred brand, please check our web page at [www.myhealthspring.com/feds](http://www.myhealthspring.com/feds) or you may request a list of covered products by calling Customer Service at (615) 291-5030 in Nashville or 1-800-917-3888. All therapeutic classes are covered. Your physician may request a non-formulary drug by submitting to us medical record information regarding treatment failure with formulary alternatives, but such requests may require up to 5 working days for approval. All injectable medication with a cost of \$500 per course of treatment requires prior approval. Your physician must send a request, with medical records, to our Medical Management/Pharmacy authorization desk at:

*HealthSpring*

*Medical Management / Pharmacy Authorization*

*Phone: 615-291-7024*

*Fax: 615-291-7025*

and such drugs are listed on the web site [www.myhealthspring.com/feds](http://www.myhealthspring.com/feds).

- **These are the dispensing limitations.** When the prescription is filled at participating pharmacy, the pharmacy may dispense up to a 90-day supply for each oral drug or refill. One vial of insulin per one copayment, or one commercially prepared unit (one inhaler, one bottle of ophthalmic medication, one tube of topical ointment, etc.) A prescription may not be refilled before 75% of it has been used.
- **Mail Order.** Maintenance medication prescribed by participating doctors for long term use may be obtained through our mail order program for up to a 90-day supply for three copays. Certain classes of drugs are not available for mail order. For the list, please check the web site. Mail order forms are available from Customer Service at (615) 291-5030 in Nashville or 1-800-917-3888.

- Certain limitations apply:
  - Covered drugs are limited to the formulary;
  - In no event will the copayment exceed the cost of the drug;
  - Certain injectables require prior authorization (when course of treatment exceeds \$500);
  - Viagra, or similar drugs for sexual dysfunction, is limited to 8 tablets per month;
  - Some medications have quantity dispensing limits per month, in accordance with FDA guidelines and to promote patient safety. (See our web site, [www.myhealthspring.com/feds](http://www.myhealthspring.com/feds), for monthly quantity limits).

- Why use generic drugs? Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

You can save money by using generic drugs, which have the lowest copayment. However, you and your physician have the option to request a name-brand drug. When a FDA approved generic is available and you or your physician requests the brand name drug, you must pay the difference in cost between the generic and the brand name drug, plus the brand copayment. Certain drugs are exempt from the mandatory generic program and such drugs are listed on the web site [www.myhealthspring.com/feds](http://www.myhealthspring.com/feds).

- When you have to file a claim. In most cases, you do not have to file a claim when purchasing drugs at a participating pharmacy. However you must pay for the drug when dispensed, and file a claim for reimbursement when the following occurs:
- Your plan ID is not available, eligibility cannot be determined, or when the prescription is filled for a medical emergency outside the service area.

For assistance in filing a claim for direct member reimbursement, call Customer Service at (615) 291-5030 in Nashville or 1-800-917-3888.

Benefit Description	You pay - High Option	You pay - Standard Option
<b>Covered medications and supplies</b>		
<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 listed as <i>Not covered</i>.</li> <li>• Insulin</li> <li>• Drugs for sexual dysfunction (<a href="#">see limitations above</a>)</li> <li>• Oral contraceptive drugs</li> <li>• Diabetic supplies and meters (preferred product only)</li> </ul>	<p><b><u>Retail Pharmacy – up to a 30 day supply</u></b></p> <p>\$10 per generic</p> <p>\$20 per brand name – preferred</p> <p>\$35 per brand name – non-preferred</p>	<p><b><u>Retail Pharmacy – up to a 30 day supply</u></b></p> <p>\$10 per generic</p> <p>\$20 per brand name – preferred</p> <p>50% of covered charges for brand name – non-preferred</p>

Covered medications and supplies - *continued on next page*

<b>Covered medications and supplies</b> <i>(continued)</i>	<b>You Pay - High Option</b>	<b>You pay - Standard Option</b>
<ul style="list-style-type: none"> <li>• Disposable needles and syringes for to inject the administration of covered medications</li> <li>• Drugs for sexual dysfunction (<a href="#">see limitations on page 41</a>)</li> <li>• Self administered injectables, subject to prior approval</li> <li>• Intravenous and provider administered medications are covered under medical, surgical, or home health benefits <a href="#">see section 5(a)</a>.</li> <li>• Growth hormone</li> </ul>	<p><b><u>Mail Order (Maintenance medications only) – up to a 90 day supply</u></b></p> <p>\$30 per generic</p> <p>\$60 per brand name – preferred</p> <p>\$105 per brand name – non preferred</p>	<p><b><u>Mail Order (Maintenance medications only) – up to a 90 day supply</u></b></p> <p>\$30 per generic</p> <p>\$60 per brand name – referred</p> <p>50% of covered charges for brand name – non preferred</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs and supplies for cosmetic purposes</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Fertility drugs</i></li> <li>• <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i></li> <li>• <i>Drugs used for purpose of weight reduction or appetite suppression (unless approved as part of a treatment plan for morbid obesity);</i></li> <li>• <i>Medical supplies such as dressings and antiseptic</i></li> <li>• <i>Drugs for orthodontic care, dental implants, and periodontal disease</i></li> <li>• <i>Replacement of drugs due to loss, theft, or destruction</i></li> <li>• <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i></li> <li>• <i>Nonprescription medicines or over the counter medications</i></li> </ul>	<p><i>All charges</i></p>	<p><i>All charges</i></p>

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## Section 5 (g). Special features

Feature	Description
<b>HealthSpring Disease Management Program</b>	Disease Management Programs are designed to assist you and your family in managing chronic disease states. This management is done through educational assistance, dedicated telephonic nurse coordinator, integrated member care and case management.
<b>Quarterly Newsletters</b>	You receive Healthful News, a quarterly newsletter. The newsletter provides updates, changes and/or important news about your Health Plan and promotes health and wellness.
<b>Centers of Excellence</b>	Patients requiring transplant services have access to nationally recognized transplant centers. HealthSpring has dedicated Case Managers who follow the transplant candidate from initial referral, facility selection, initial evaluation, pre-transplant services, transplant and post-transplant care.
<b>Hospitalist Program</b>	Hospitalists are highly skilled hospital-based physicians who work with your Primary Care Physician in coordinating and managing your overall medical care during inpatient admissions. The hospitalists are readily available to monitor your daily progress and improve the physician/patient communication.

## Section 5 (h). Dental benefits

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**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 dentists must provide or arrange your care.
- Dental Benefits are the same for both the High Option and the Standard Option Benefit Plans.
- The calendar year deductible is: \$25 per person and \$75 per family. The calendar year deductible applies to all Preventive and Diagnostic Services.
- We cover hospitalization for dental procedures only when physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. [See section 5\(c\)](#) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about [coordinating benefits](#) with other coverage, including with Medicare.
- **HOW TO ACCESS OUR DENTAL BENEFITS:** The plan offers access to a network of dentists who have agreed to provide services at a discounted rate. To locate a network dentist in your area, visit our website [www.myhealthspring.com/feds](http://www.myhealthspring.com/feds). For questions about the benefits, call dental Customer Service at 1-800-511-6940. After taking your deductible, a network dentist will submit your claim for preventive services to the dental claim processor for payment. If you receive preventive services from an out-of-network provider, you or the provider must submit your claim to the address on your dental ID card for payment. When receiving covered services you must submit payment to the in-network provider based on the contracted, discounted fee.

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Dental Benefits – High and Standard Options	In Network	Out-of-Network
<b>Accidental injury benefit</b>	<b>You pay</b>	<b>You pay</b>
We cover treatment of accidental injury to sound natural teeth to relieve pain and stop bleeding when service occurs within 24-hours of the injury. The need for these services must result from an accidental injury.	\$15 primary care physician; \$25 per specialist visit	20% of charges after satisfying calendar year deductible
Covered Dental Services - High and Standard Options	In-Network You pay	Out-of-Network You pay
<b>Annual Maximum Benefit – (combined for both In-Network and Out-of-Network services)</b>	<b>\$500 per person per calendar year</b>	<b>\$500 per person per calendar year</b>
Individual Deductible	\$25 per calendar year	\$25 per calendar year
Family Deductible	\$75 per calendar year	\$75 per calendar year
Annual deductible applies to preventive and diagnostic services	Yes	Yes
For new enrollees, a 12-month waiting period applies to major services & orthodontics	No	No

Dental benefits -- *continued on next page*

<b>Dental Benefits – High and Standard Options</b> <i>(continued)</i>	<b>In Network</b>	<b>Out-of-Network</b>
<b>Preventive and Diagnostic Dental Services – High and Standard Options</b>	<b>You Pay</b>	<b>You Pay</b>
<ul style="list-style-type: none"> <li>• Periodic Oral Examinations – Up to 2 per year</li> <li>• Bitewing X-Rays – one series of films per year</li> <li>• Complete Series or Panorex X-rays – one time per 36 months</li> <li>• Dental Prophylaxis (Cleanings) – Up to 2 per year</li> <li>• Fluoride Treatments – for covered persons under the age of 16 years, up to 2 per year</li> <li>• Sealants – For covered persons under the age of 14 years, once per first or second permanent molar every 5 years</li> </ul>	After deductible – nothing	After deductible – 20%
<b>Basic Dental Services</b>	<b>In-Network You pay</b>	<b>Out-of-Network You pay</b>
<ul style="list-style-type: none"> <li>• Amalgam restorations (Fillings)</li> <li>• Resin one surface, Posterior permanent (Fillings)</li> <li>• Space maintainers</li> <li>• Root canal, Molar, Excl. final restoration</li> <li>• Single tooth extraction</li> <li>• Periodontal surgery</li> <li>• Removal of impacted tooth-soft tissue</li> <li>• Palliative treatment</li> <li>• General anesthesia, 1st 30 minutes</li> <li>• Frenectomy</li> </ul>	Discount applies	All Charges
<b>Major Dental Services</b>	<b>In-Network You pay</b>	<b>Out-of-Network You pay</b>
<ul style="list-style-type: none"> <li>• Onlay-procelain/Ceramic, 3 surface</li> <li>• Crown, porcelain fused to Hi Noble</li> <li>• Complete denture – upper</li> <li>• Lower partial denture – metal base</li> <li>• Adjustment of complete dentures – upper</li> <li>• Pontic-procelain fused to HI Noble metal</li> </ul>	Discount applies	All Charges
<b>Orthodontic Services</b>	<b>In-Network You pay</b>	<b>Out-of-Network You pay</b>
<ul style="list-style-type: none"> <li>• Diagnose or correct misalignment of the teeth or bite including Phase I &amp; II, child only to age 19</li> </ul>	Preauthorization required – then discount applies	All Charges

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

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The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is Medically Necessary to prevent, diagnose, or treat your illness, disease, injury, or condition, and we agree, as discussed under *What Services Require Our Prior Approval* on page 12.**

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;
- 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.

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## Section 7. Filing a claim for covered services

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When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan participating pharmacies, you will not have to file claims. Present your identification card and pay your copayment or coinsurance.

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

### Medical, hospital and drug 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 (615) 291-5030 in Nashville or 1-800-917-3888 from outside Nashville.

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

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

**Submit your claims to: HealthSpring  
P. O. Box 20000  
Nashville, TN 37202-9613**

### 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.

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## Section 8. The disputed claims process

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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: HealthSpring, P. O. Box 20000, Nashville, TN 37202-9613; 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, DC 20415-3630.</p>

### **The Disputed Claims process (*continued*)**

Send OPM the following information:

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

NOTE: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

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

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

**5** OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

**NOTE: If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- (a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (615) 291-5030 and we will expedite our review; or
- (b) We denied your initial request for care or preauthorization/prior approval, then:
  - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
  - You may call OPM's Health Benefits Contracts Division 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

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## Section 9. Coordinating benefits with other coverage

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### When you have other health coverage

You must tell us if you or a covered family member have coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

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

When we are the primary payer, we will pay the benefits described in this brochure. When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. 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 + Choice 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. Your care must be coordinated by your Primary Care Physician (PCP) and provided by participating plan providers unless approved in advance by the Plan, except in

an emergency. We will not waive any of our copayment or coinsurance.

Please note: If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at (615) 291-5030 or contact us through our web site at [www.myhealthspring.com/feds](http://www.myhealthspring.com/feds).

**We do not waive any out-of-pocket costs when you have the Original Medicare Plan.**

**(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),	✓	
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 a Medicare managed care plan. These are health 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 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 our Medicare managed care plan:** You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments or coinsurance for your FEHB coverage.

**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 or 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, 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 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 preceding 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.

**Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance:** If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

## **When other Government agencies are responsible for your care**

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

## **When others are responsible for your injuries**

When you receive money to compensate you for for injuries 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.

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

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<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>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care. <a href="#">See page 14.</a>
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. <a href="#">See page 14.</a>
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	Care that is provided primarily for maintenance of your condition. Custodial care is designed to assist in activities of daily living (walking, bathing, dressing, feeding, housekeeping) and includes self-administration of medications not requiring constant attention of medical personnel. Custodial care that lasts 90 days or more is sometimes known as Long term care.
<b>Deductible</b>	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. <a href="#">See page 14.</a>
<b>Experimental or investigational services</b>	Service not already in general use or not recognized by the United States Pharmacopeial Convention, the American Medical Association, or the American society of Pharmacists Compendia.
<b>Medical necessity</b>	Treatment that is non-experimental or investigational, consistent with the symptoms or diagnosis of the condition, appropriate in regards to standards of good medical practice, not primarily for the convenience of the patient, physician, hospital or other provider, and the most appropriate supply or level of service which can safely be provided.
<b>Us/We</b>	Us and we refer to HealthSpring.
<b>You</b>	You refers to the enrollee and each covered family member.

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## Section 11. FEHB facts

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### **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 take an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

### **Types of coverage available for you and your family**

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

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employment 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.

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 option of 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 lower option of the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

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

## **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

## **When you retire**

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

## **When you lose benefits**

### **• When FEHB coverage ends**

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

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.
- You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

### **• Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to supply health

coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's website [www.opm.gov/insure](http://www.opm.gov/insure).

- **Temporary continuation of coverage (TCC)**

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

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

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site ([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.

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## Long Term Care Insurance Is Still Available!

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### 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 call "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 annuitant 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.

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

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## Summary of benefits for HealthSpring - 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 - High Option	You Pay – Standard Option	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office.....	Office visit copay: \$15 primary care; \$25 specialist	Office visit copay: \$20 primary care; \$20 specialist	16
Services provided by a hospital: • Inpatient..... • Outpatient.....	\$250 per admission \$250 copayment	\$250 per admission \$250 copayment	33 34
Emergency benefits: • In-area..... • Out-of-area.....	\$50 per urgent care center visit; \$100 per emergency care visit	\$50 per urgent care center visit; \$100 per emergency care visit	36
Mental health and substance abuse treatment .....	Regular cost sharing.	Regular cost sharing.	38
Prescription drugs .....	<b>Retail Pharmacy:</b> \$10 generic; \$20 brand preferred; \$35 brand non-preferred  <b>Mail Order Maintenance Drugs:</b> \$30 generic; \$60 brand preferred; \$105 brand non-preferred	<b>Retail Pharmacy:</b> \$10 generic; \$20 brand preferred; 50% brand non-preferred  <b>Mail Order Maintenance Drugs:</b> \$30 generic; \$60 brand preferred; 50% brand non-preferred	40
Comprehensive Dental Benefit.....	See section 5(h) for details	See section 5(h) for details	44
Vision Care (Eye exam, including annual refraction).....	\$15 office visit copay	\$20 office visit copay	23
Special features: HealthSpring Disease Management Program; Quarterly Newsletters, Centers of Excellence, Hospitalist Program			43
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum) .....	\$2,000 per individual/\$4,000 per family	\$3,000 per individual/\$6,000 per family	14

## 2003 Rate Information for HealthSpring

**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 a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

### Nashville-Middle Tennessee Areas

Self Only - High Option	6K1	\$109.30	\$38.99	\$236.82	\$84.48	\$129.03	\$19.26
Self and Family High Option	6K2	\$249.62	\$163.63	\$540.84	\$354.54	\$294.70	\$118.55
Self Only – Standard Option	6K4	\$92.84	\$30.95	\$201.16	\$67.05	\$109.86	\$13.93
Self and Family Standard Option	6K5	\$249.62	\$95.34	\$540.84	\$206.57	\$294.70	\$50.26