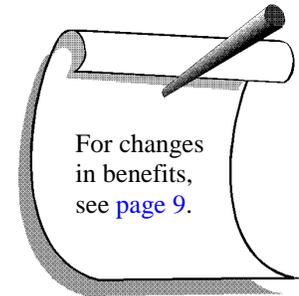




A Health Maintenance Organization

Serving: Utica/Rome and Oneonta Metropolitan Areas

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See [page 8](#) for requirements.



This Plan has excellent accreditation from NCQA.

Enrollment codes for this Plan:

AH1 Self Only
AH2 Self and Family

Authorized for distribution by the:



**United States
Office of Personnel Management**

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





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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this 2004 Federal Employees Health Benefits (FEHB) Program plan brochure. The brochure describes the benefits this plan offers you for 2004. Because benefits vary from year to year, you should review your plan's brochure every Open Season – especially Section 2, which explains how the plan changed.

It takes a lot of information to help a consumer make wise health care decisions. The information in this brochure, our FEHB Guide, and our web-based resources, make it easier than ever to get information about plans, to compare benefits and to read customer service satisfaction ratings for the national and local plans that may be of interest. Just click on www.opm.gov/insure!

The FEHB Program continues to be an enviable national model that offers exceptional choice, and uses private-sector competition to keep costs reasonable, ensure high-quality care, and spur innovation. The Program, which began in 1960, is sound and has stood the test of time. It enjoys one of the highest levels of customer satisfaction of any health care program in the country.

I continue to take aggressive steps to keep the FEHB Program on the cutting edge of employer-sponsored health benefits. We demand cost-effective quality care from our FEHB carriers and we have encouraged Federal agencies and departments to pay the full FEHB health benefit premium for their employees called to active duty in the Reserve and National Guard so they can continue FEHB coverage for themselves and their families. Our carriers have also responded to my request to help our members to be prepared by making additional supplies of medications available for emergencies as well as call-up situations and you can help by getting an Emergency Preparedness Guide at www.opm.gov. OPM's *HealthierFeds* campaign is another way the carriers are working with us to ensure Federal employees and retirees are informed on healthy living and best-treatment strategies. You can help to contain health care costs and keep premiums down by living a healthy life style.

Open Season is your opportunity to review your choices and to become an educated consumer to meet your health care needs. Use this brochure, the FEHB Guide, and the web resources to make your choice an informed one. Finally, if you know someone interested in Federal employment, refer them to www.usajobs.opm.gov

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

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

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

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

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

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

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

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

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

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

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

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 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
United States Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

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

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

Table of Contents

Introduction.....	4
Plain Language	4
Stop Health Care Fraud!	4
Preventing medical mistakes.....	5
Section 1. Facts about this HMO plan	7
How we pay providers	7
Who provides my health care.....	7
Your Rights.....	7
Service Area.....	8
Section 2. How we change for 2004.	9
Program-wide changes.....	9
Changes to this Plan.....	9
Section 3. How you get care	10
Identification cards	10
Where you get covered care.....	10
• Plan providers.....	10
• Plan facilities	10
What you must do to get covered care.....	10
• Primary care	10
• Specialty care	10
• Hospital care.....	11
Circumstances beyond our control.....	12
Services requiring our prior approval	12
Section 4. Your costs for covered services	13
• Copayments	13
• Deductible	13
• Coinsurance	13
Your catastrophic protection out-of-pocket maximum	13
Section 5. Benefits	14
Overview.....	14
(a) Medical services and supplies provided by physicians and other health care professionals	15
(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	23
(c) Services provided by a hospital or other facility, and ambulance services.....	27
(d) Emergency services/accidents	29
(e) Mental health and substance abuse benefits	31
(f) Prescription drug benefits.....	33
(g) Special features	35
• Flexible benefits option	35

(h) Dental benefits.....	37
Section 6. General exclusions -- things we don't cover.....	38
Section 7. Filing a claim for covered services	39
Section 8. The disputed claims process.....	40
Section 9. Coordinating benefits with other coverage	42
When you have Other health coverage	42
• What is Medicare.....	42
• Should I enroll in Medicare?	42
• Medicare + Choice	45
• TRICARE and CHAMPVA	45
• Workers' Compensation.....	45
• Medicaid.....	45
• Other Government agencies	45
• When others are responsible for injuries	45
Section 10. Definitions of terms we use in this brochure.....	46
Section 11. FEHB facts.....	47
Coverage information	47
• No pre-existing condition limitation.....	47
• Where you can get information about enrolling in the FEHB Program	47
• Types of coverage available for you and your family	47
• Children's Equity Act.....	47
• When benefits and premiums start	48
• When you retire	48
When you lose benefits	48
• When FEHB coverage ends.....	48
• Spouse equity coverage	48
• Temporary Continuation of Coverage (TCC).....	48
• Converting to individual coverage	49
• Getting a Certificate of Group Health Plan Coverage	49
Two new Federal Programs complement FEHB benefits	50
The Federal Flexible Spending Account Program – <i>FSAFEDS</i>	50
The Federal Long Term Care Insurance Program.....	53
Index	54
Summary of benefits.....	55
Rates	Back cover

Introduction

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

Excellus BlueCross BlueShield, d.b.a. HMO Blue
Utica Business Park, 12 Rhoads Drive
Utica, NY 13502-6398

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

If you enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2004, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2004, and changes are summarized on [page 9](#). Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

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

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

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 800/447-6269 and explain the situation.
 - If we do not resolve the issue:

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

OR WRITE TO:

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

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing Medical Mistakes

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

- 1. Ask questions if you have doubts or concerns.**
 - Ask questions and make sure you understand the answers.
 - Choose a doctor with whom you feel comfortable talking.
 - Take a relative or friend with you to help you ask questions and understand answers.
- 2. Keep and bring a list of all the medicines you take.**
 - Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
 - Tell them about any drug allergies you have.
 - Ask about side effects and what to avoid while taking the medicine.
 - Read the label when you get your medicine, including all warnings.
 - Make sure your medicine is what the doctor ordered and know how to use it.
 - Ask the pharmacist about your medicine if it looks different than you expected.
- 3. Get the results of any test or procedure.**
 - Ask when and how you will get the results of test or procedures.
 - Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
 - Call your doctor and ask for your results.
 - Ask what the results mean for your care.
- 4. Talk to your doctor about which hospital is best for your health needs.**
 - Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
 - Be sure you understand the instructions you get about follow-up care when you leave the hospital.

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

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

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.htm. The Agency for Health care Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation’s health care delivery system.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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

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

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

How we pay providers

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

Who Provides My Health care

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

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

Your Rights

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

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

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

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

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

Doctor:

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

Hospitals:

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

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

Service Area

To enroll in this Plan, you must live or work in our service area. This is where our providers practice. Our service area is: The New York counties of Chenango, Clinton, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Otsego and St. Lawrence.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care. However, you may also contact your primary care physician to get a referral.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. Guest Membership is available in most parts of the United States from HMO-USA. If you have family members living outside of our service area and want to enroll them as a guest member, you must complete an additional application. Contact HMOBlue for more information regarding Guest Membership. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we changed for 2004

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

- We added information regarding two new Federal Programs that complement FEHB benefits, the Federal Flexible Spending Account Program - *FSAFEDS* and the Federal Long Term Care Insurance Program. See [page 50](#).
- We added information regarding Preventing medical mistakes. See [page 5](#).
- We added information regarding enrolling in Medicare. See [page 42](#).
- We revised the Medicare Primary Payer Chart. See [page 44](#).

Changes to this Plan

- Your share of the non-Postal premium will increase by 85.5% for Self Only or 72.2% for Self and Family.

Section 3. How you get care

Identification cards

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

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

Where you get covered care

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

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The provider directory is also on our website at <http://www.excellusbcb.com>

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these facilities in the provider directory, which we update periodically. The list is also on our website at <http://www.excellusbcb.com>

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. To determine if a physician is a participating provider and accepting new patients, you can refer to our Provider Directory or contact us at 800-722-7884.

- **Primary care**

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

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us at 800-722-7884. We will help you select a new one.

- **Specialty care**

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

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan. The physician may have to get an authorization, or approval, beforehand.
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause; or
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
 - reduce our service area and you enroll in another FEHB Plan, you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

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

• **Hospital care**

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

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

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

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

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

Circumstances beyond our control

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

Services requiring our prior approval

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

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

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

Section 4. Your costs for covered services

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

- **Copayments**

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

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

- **Deductible**

We do not have a deductible.

- **Coinsurance**

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

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

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

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

Section 5. Benefits -- OVERVIEW

(See [page 9](#) for how our benefits changed this year and [page 55](#) for a benefits summary.)

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

(a) Medical services and supplies provided by physicians and other health care professionals.....	15-22
•Diagnostic and treatment services	
•Lab, X-ray, and other diagnostic tests	
•Preventive care, adult	
•Preventive care, children	
•Maternity care	
•Family planning	
•Infertility services	
•Allergy care	
•Treatment therapies	
•Physical and occupational therapies	
•Speech therapy	
•Hearing services (testing, treatment, and supplies)	
•Vision services (testing, treatment, and supplies)	
•Foot care	
•Orthopedic and prosthetic devices	
•Durable medical equipment (DME)	
•Home health services	
•Chiropractic	
•Alternative treatments	
•Educational classes and programs	
(b) Surgical and anesthesia services provided by physicians and other health care professionals	23-26
•Surgical procedures	
•Reconstructive surgery	
•Oral and maxillofacial surgery	
•Organ/tissue transplants	
•Anesthesia	
(c) Services provided by a hospital or other facility, and ambulance services	27-28
•Inpatient hospital	
•Outpatient hospital or ambulatory surgical center	
•Skilled nursing care facility benefits	
•Hospice care	
•Ambulance	
(d) Emergency services/accidents	29-30
•Medical emergency	
•Ambulance	
(e) Mental health and substance abuse benefits	31-32
(f) Prescription drug benefits	33-34
(g) Special features.....	35-36
• Flexible benefit option	
• Reciprocity benefit	
• Centers of Excellence for transplants/heart surgery/etc	
(h) Dental benefits	37
Summary of benefits	55

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 5 (d). Emergency services/accidents

I
M
P
O
R
T
A
N
T

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

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

I
M
P
O
R
T
A
N
T

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been timely notified.

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

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

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

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

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

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

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

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

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

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

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

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

Benefit Description	You pay
Mental health and substance abuse benefits	You pay
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	Your cost sharing responsibilities are no greater than for other illness or conditions.
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	\$15 copay per office visit
<ul style="list-style-type: none"> • Diagnostic tests 	Nothing
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full day hospitalization, facility based intensive outpatient treatment. 	\$240 copay
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p> <p>MENTAL HEALTH</p> <ul style="list-style-type: none"> • Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate <p>SUBSTANCE ABUSE</p> <p>Treatment that is not authorized by a Plan doctor.</p> <ul style="list-style-type: none"> • Benefits for days of care that consist primarily of participation in programs of a social, recreational, or companionship nature. 	<i>All charges.</i>

Preauthorization

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

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

Section 5 (f). Prescription drug benefits

I
M
P
O
R
T
A
N
T

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

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

I
M
P
O
R
T
A
N
T

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

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

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

- **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 the drugs meet the same standards of quality and strength as brand name drugs.

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

When generic substitution is permissible, (i.e., a generic is available and the prescribing doctor does not require the use of a brand name drug), but you request the name brand drug, you pay the \$10 copay for prescription drugs plus the difference between generic and the name brand drug.

- **These are the dispensing limitations.** You will be charged 1 copay for each 30 day supply, retail or mail order. If there is no generic equivalent, you will pay the brand for the two and three tier copay. If you are in the military and called to active duty, please contact us if you need assistance in filling a prescription before your departure.
- **When you have to file a claim.** If you do not use Plan pharmacies, you will receive no benefits.

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

Benefit Description	You pay
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except as excluded below. • Oral and injectable drugs • Implanted, time release contraceptive medications, such as Norplant • Smoking cessation drugs and medication including nicotine patches • Enteral formulas for home use when prescribed in writing by a Plan doctor for poor nourishment or a disorder which would cause chronic physical disability, mental retardation, or death • Medically necessary modified solid food products with low or modified protein for treatment of inherited diseases of amino acids and organic acid metabolism • Drugs for sexual dysfunction (see Prior authorization on page 12) • Contraceptive drugs and devices • Fertility drugs • Growth hormone drugs <p>Insulin, diabetic supplies and disposable needles and syringes needed to inject covered prescribed medication are available through the Plan’s medical and surgical benefits and are subject to the doctor’s office visit copayment</p>	<p>You pay</p> <p>\$10 copay per prescription unit or refill for Tier 1 drugs per each 30 day supply</p> <p>\$25 copay per prescription unit or refill for Tier two drugs per each 30 day supply</p> <p>\$40 copay per prescription unit or refill for Tier 3 drugs per each 30 day supply</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p> <p>Mail Order</p> <p>\$30 copay per prescription unit or refill for Tier 1 drugs per 90 day supply</p> <p>\$75 copay per prescription unit or refill for Tier two drugs per 90 day supply.</p> <p>\$120 copay per prescription unit or refill for Tier 3 drugs per 90 day supply.</p>
<p><i>Not covered</i></p> <ul style="list-style-type: none"> • <i>Drugs available without a prescription or for which there is a nonprescription equivalent available</i> • <i>Vitamins and nutritional substances that can be purchased without a prescription</i> • <i>Medical supplies such as dressings and antiseptics</i> • <i>Drugs for Cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Implanted time-release medications other than Norplant</i> • <i>Drugs in connection with transsexual surgery</i> • <i>Drugs prescribed for experiential or investigational use</i> • <i>Replacement for lost or stolen drugs.</i> 	<p><i>All charges</i></p>

Section 5 (g). Special features

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

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

Section 5 (h). Dental benefits

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

Accidental injury benefit

You pay

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

Nothing

Dental benefits

We have no other dental benefits.

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

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

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

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

Medical, Hospital, Drug and Other Supplies or Services Benefits

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

When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

**Submit your claims to: 12 Rhoads Drive
Utica Business Park
Utica, NY 13502**

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

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

- | | |
|---|--|
| 1 | Ask us in writing to reconsider our initial decision. You must: <ul style="list-style-type: none">(a) Write to us within 6 months from the date of our decision; and(b) Send your request to us at: 12 Rhoads Drive, Utica Business Park, Utica, NY 13502; and(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. |
| 2 | We have 30 days from the date we receive your request to: <ul style="list-style-type: none">(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or(b) Write to you and maintain our denial -- go to step 4; or(c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3. |

- | | |
|---|--|
| 3 | You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

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

We will write to you with our decision. |
|---|--|

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

You must write to OPM within: <ul style="list-style-type: none">• 90 days after the date of our letter upholding our initial decision; or• 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or• 120 days after we asked for additional information. |
|---|--|

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

Send OPM the following information:

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

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

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

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

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

- (a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800-722-7884 and we will expedite our review; or
- (b) We denied your initial request for care or pre-authorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You can call OPM's Health Benefits Contracts Division 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

•What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

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

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

• Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or both Parts of Medicare, you can still be covered under the FEHB Program.

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

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

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + 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.

(Primary payer chart begins on next page.)

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

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

* Unless you have FEHB coverage through your spouse who is an active employee

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

• **Medicare + Choice**

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

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

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

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

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

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Custodial Care includes any service that can be provided by an average individual who has little or no medical training. Examples of Custodial Care include: (a) assistance in meeting activities of daily living such as feeding, dressing, and personal hygiene, (b) administration of oral medications, routine changing of dressings or preparation of special diets, (c) assistance in walking or getting out of bed, (d) care when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training.
Experimental or investigational services	<p>Experimental/investigational procedures are defined as any procedure, treatment, drug, biological product or device (hereinafter referred to as technology) that, in the sole discretion of the Plan, are determined to be experimental or investigational in nature.</p> <p>Experimental or investigational means that the technology is determined not to:</p> <ul style="list-style-type: none">• have final approval from the appropriate government regulatory body;• be proven benefit for the particular diagnosis or treatment of the member's condition;• be recognized by the medical community, as reflected in the published peer-reviewed literature, as effective or appropriate for the particular diagnosis or treatment of the member's condition; or• be as beneficial as any established alternative. <p>Your primary care physician will work with our medical director and medical staff to determine if a service is experimental or investigational.</p>
Medical necessity	Medically Necessary Care is care which, according to The Plan's criteria is: (a) Consistent with the symptoms or diagnosis and treatment of the Member's condition, disease, ailment or injury, (b) in accordance with standards of acceptable medical practice, (c) not solely for the Member's convenience, or that of the Member's Doctor or other Provider, (d) the most appropriate supply, place of service, or level of service which can safely be provided to the Member, (e) provided for the diagnosis or the direct care and treatment of the Member's condition, illness, disease or injury, and (f) when applied to hospitalization, the Member requires acute care as a bed patient due to the nature of the services rendered, or the Member's condition, and the Member could not have received safe or adequate care in any other setting (e.g. as an outpatient).
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. We use many different forms of Plan Allowance. Our contract with your providers allows us to change Plan Allowance with a 60 day notice. We believe that listing our Plan Allowances would jeopardize our contracting ability with our providers.
Us/We	Us and we refer to HMOBlue
You	You refers to the enrollee and each covered family member.

Section 11. FEHB facts

Coverage information

No pre-existing condition limitation

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

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

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

Types of coverage available for you and your family

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

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form.

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

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

Children's Equity Act

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan: or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Base Option.

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

When benefits and premiums start

The benefits in this brochure are effective 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. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2004 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2003 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

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

When you lose benefits

•When FEHB coverage ends

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

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

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

• Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees, or other information about your coverage choices.

•Temporary continuation of coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

•Converting to individual coverage

You may convert to an non FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert;
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

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

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

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health) 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.

Two new Federal Programs complement FEHB benefits

Important information

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

The Federal Flexible Spending Account Program - *FSAFEDS*

- **What is an FSA?**

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

There are two types of FSAs offered by the FSAFEDS Program:

- **Health Care Flexible Spending Account (HCFSA)**

es not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your

- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal income tax return, even if you don't have self and family health benefits coverage. **Note:** The IRS has a broader definition than that of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum amount that can be allotted for the HCFSA is \$3,000 annually. The minimum amount is \$250 annually.

- **Dependent Care Flexible Spending Account (DCFSA)**

- Covers eligible dependent care expenses incurred so you can work, or if you are married, so you and your spouse can work, or your spouse can look for work or attend school full-time.
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified IRS dependent and/or with whom you jointly file your Federal income tax return.
- The maximum that can be allotted for the DCFSA is \$5,000 annually. The minimum amount is \$250 annually. **Note:** The IRS limits contributions to a Dependent Care FSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive

- **Enroll during Open Season**

You **must make an election** to enroll in an FSA during the FEHB Open Season. Even if you enrolled during the initial Open Season for 2003, you must make a new election to continue participating in 2004. Enrollment is easy!

- Enroll online anytime during Open Season (November 10 through December 8, 2003) at www.fsafeds.com.
- Call the toll-free number 1-877-FSAFEDS (372-3337) Monday through Friday, from 9 a.m. until 9 p.m. eastern time and a FSAFEDS Benefit Counselor will help you enroll.

What is SHPS?

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

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB– you can choose to participate in either, or both, of the flexible spending accounts. If you are not eligible for FEHB, you are not eligible to enroll for a Health Care FSA. However, almost all Federal employees are eligible to enroll for the Dependent Care FSA. The only exception is intermittent (also called when actually employed [WAE]) employees expected to work less than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers signed on. Under IRS law, FSAs are not available to annuitants. In addition, the U.S. Postal Service and the Judicial Branch, among others, are Federal agencies that have their own plans with slightly different rules, but the advantages of having an FSA are the same no matter what agency you work for.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits of an FSA, the IRS places strict guidelines on them. You need to estimate how much you want to allocate to an FSA because current IRS regulations require you forfeit any funds remaining in your account(s) at the end of the FSA plan year. This is referred to as the “use-it-or-lose-it” rule. You will have until April 29, 2004 to submit claims for your eligible expenses incurred during 2003 if you enrolled in FSAFEDS when it was initially offered. You will have until April 30, 2005 to submit claims for your eligible expenses incurred from January 1 through December 31, 2004 if you elect FSAFEDS during this Open Season.

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

- **What can my HCFSA pay for?**

Every FEHB health plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on [page 55](#) and detailed throughout this brochure. Your HCFSA will reimburse you for such costs when they are for tax deductible medical care for you and your dependents that is NOT covered by this FEHB Plan or any other coverage that you have.

Under HMOBlue, typical out of pocket expenses include: office visit copayments, prescription drug copayments, and emergency room copayments. Two common but significant expenses, not covered by the plan would be dental services not related to an accidental injury and prescription eyewear.

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

- **Tax savings with an FSA**

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

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

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

- **Tax credits and deductions**

Health care expenses

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

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

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal income tax return. Using the example listed in the above chart, only health care expenses exceeding \$3,700 (7.5% of \$50,000) would be eligible to be deducted on your Federal income tax return. In addition, money set aside through a HCFSA is also exempt from FICA taxes. This exception is not available on your Federal income tax return.

Dependent care expenses

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

Visit www.fsafeds.com and download the Dependent Care Tax Credit Worksheet from the Quick Links box to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

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

Probably not. While there is an administrative fee of \$4.00 per month for an HCFSA and 1.5% of the annual election for a DCFSA, most agencies have elected to pay these fees out of their share of employment tax savings. To be sure, check the FSAFEDS.com web site or call 1-877-FSAFEDS (372-3337). Also, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the plan year and wind up forfeiting your end of year account balance, per the IRS "use-it-or-lose-it" rule.

- **Contact us**

To find out more or to enroll, please visit the **FSAFEDS Web site** at www.fsafeds.com, or contact SHPS by email or by phone. SHPS Benefit Counselors are available from 9:00 a.m. until 9:00 p.m. eastern time, Monday through Friday.

- E-mail: fsafeds@shps.net
- Telephone: 1-877-FSAFEDS (372-3337)
- TTY: 1-800-952-0450 (for hearing impaired individuals that would like to utilize a text messaging service)

The Federal Long Term Care Insurance Program

It's important protection

Here's why you should consider enrolling in the Federal Long Term Care Insurance Program:

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive when you need assistance performing activities of daily living – such as bathing or dressing yourself. This need can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you control over the type of care you receive and where you receive it. It can also help you remain independent, so you won't have to worry about being a burden to your loved ones.
- **It's to your advantage to apply sooner rather than later.** Long term care insurance is something you must apply for, and pass a medical screening (called underwriting) in order to be enrolled. Certain medical conditions will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a change in health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. If you marry, your new spouse will also have a limited opportunity to apply using abbreviated underwriting. Qualified relatives are also eligible to apply with full underwriting.

To find out more and to request an application

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Index

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

Accidental injury.....	37	Home health services.....	21	Physician	23
Allergy tests.....	18	Hospice care.....	28	Pre-admission testing	12
Alternative treatment	22	Home nursing care.....	21	Preventive care, adult	16
Ambulance	28	Hospital	27	Preventive care, children.....	16
Anesthesia	26	Immunizations	16	Prescription drugs.....	33
Autologous bone marrow transplant	25	Infertility.....	18	Preventive services	16
Blood and blood plasma	27	In-hospital physician care.....	27	Prior approval	12
Breast cancer screening	16	Inpatient Hospital Benefits.....	27	Prostate cancer screening	16
Casts.....	21	Insulin	34	Prosthetic devices	20
Catastrophic protection.....	55	Laboratory and pathological services.....	28	Psychologist.....	31
Changes for 2004.....	9	Machine diagnostic tests	15	Radiation therapy	18
Chemotherapy.....	18	Magnetic Resonance Imagings (MRIs)	28	Rehabilitation therapies.....	28
Childbirth.....	17	Mail Order Prescription Drugs	34	Renal dialysis.....	19
Cholesterol tests	16	Mammograms.....	16	Room and board	27
Claims.....	39	Maternity Benefits	17	Second surgical opinion	15
Coinsurance.....	13	Medicaid.....	45	Skilled nursing facility care	28
Colorectal cancer screening	16	Medically necessary	47	Smoking cessation	22
Congenital anomalies	23	Medicare.....	42	Speech therapy.....	19
Contraceptive devices and drugs	17	Members.....	7	Splints.....	27
Coordination of benefits.....	42	Mental Conditions/Substance Abuse		Sterilization procedures.....	17
Covered providers.....	10	Benefits.....	31	Subrogation.....	45
Crutches.....	21	Newborn care.....	17	Substance abuse.....	31
Definitions.....	46	Nurse		Surgery	
Dental care.....	37	Licensed Practical Nurse	21	• Anesthesia	26
Diagnostic services	15	Registered Nurse.....	21	• Oral	24
Disputed claims review	35	Nursery charges	17	• Outpatient.....	28
Donor expenses (transplants).....	25	Obstetrical care	17	• Reconstructive	24
Dressings	27	Occupational therapy.....	19	Syringes.....	34
Durable medical equipment (DME).....	21	Ocular injury	15	Temporary continuation of coverage	48
Educational classes and programs	22	Office visits	15	Transplants.....	25
Effective date of enrollment.....	10	Oral and maxillofacial surgery	24	Treatment therapies	18
Emergency.....	29	Orthopedic devices	20	Vision services.....	20
Experimental or investigational	46	Out-of-pocket expenses.....	13	Well child care.....	16
Eyeglasses	20	Outpatient facility care	28	Wheelchairs	21
Family planning.....	17	Oxygen	21	Worker's compensation	45
Fecal occult blood test	16	Pap test	16	X-rays.....	15
General Exclusions.....	38	Physical examination.....	16		
Hearing services.....	16	Physical therapy.....	19		

Summary of benefits for HMOBlue – 2004

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office.....	Office visit copay: \$15 primary care; \$15 specialist	15
Services provided by a hospital: • Inpatient	<i>\$240 copay</i>	27
• Outpatient.....	<i>\$100 copay</i>	28
Emergency benefits: • In-area	\$50 per emergency room visit	30
• Out-of-area	\$50 per emergency room visit	30
Mental health and substance abuse treatment.....	Regular cost sharing.	31
Prescription drugs	Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. You pay a \$10 copay for Tier 1, a \$25 copay for Tier 2, a \$40 copay for Tier 3 drugs per prescription unit or refill. Mail order maintenance drugs. You pay a \$30 copay for Tier 1, a \$75 copay for Tier 2 or a \$120 copay for Tier 3 drugs per prescription unit or refill.	33
Dental Care.....	Accidental injury benefit; you pay nothing.	37
Vision Care.....	One refraction annually. You pay a \$15 copay per visit.	20
Protection against catastrophic costs (your out-of-pocket maximum)	No Maximum	13

2004 Rate Information for HMO Blue

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

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

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

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
Self Only	AH1	\$121.40	\$89.63	\$263.03	\$194.20	\$143.32	\$67.71
Self and Family	AH2	\$277.09	\$261.79	\$600.36	\$567.21	\$327.12	\$211.76