

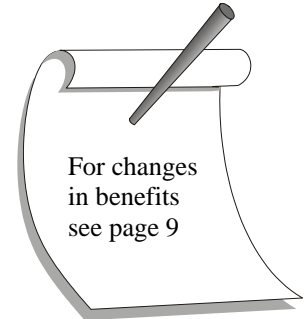


BlueCHOICE®

<http://www.bcbsmo.com>

2005

**A Health Maintenance Organization**



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

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



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

**Enrollment code for this Plan:**

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



Federal Employees  
Health Benefits Program

Authorized for distribution by the:



**United States  
Office of Personnel Management**

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



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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

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

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

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

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

Sincerely,

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

Kay Coles James

Director



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

# Table of Contents

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

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

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

---

## Introduction

---

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

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

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2005, unless those benefits are also shown in this brochure.

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

---

## Plain Language

---

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

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

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

---

## Stop Health Care Fraud!

---

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

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

**Protect Yourself From Fraud** – Here are some things that you can do to prevent fraud:

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

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 1-800-932-4480 and explain the situation.

If we do not resolve the issue:

**CALL — THE HEALTH CARE FRAUD HOTLINE**

**202-418-3300**

**OR WRITE TO:**

**United States Office of Personnel Management**

**Office of the Inspector General Fraud Hotline**

**1900 E Street NW Room 6400**

**Washington, DC 20415-1100**

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

---

## **Preventing medical mistakes**

---

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

1. **Ask questions if you have doubts or concerns.**
  - Ask questions and make sure you understand the answers.
  - Choose a doctor with whom you feel comfortable talking.
  - Take a relative or friend with you to help you ask questions and understand answers.

2. **Keep and bring a list of all the medicines you take.**

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

3. **Get the results of any test or procedure.**

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

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

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

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

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

Want more information on patient safety?

- [www.ahrq.gov/consumer/pathqpack.htm](http://www.ahrq.gov/consumer/pathqpack.htm). The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- [www.npsf.org](http://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](http://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](http://www.leapfroggroup.org). The Leapfrog Group is active in promoting safe practices in hospital care.
- [www.ahqa.org](http://www.ahqa.org). The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- [www.quic.gov/report](http://www.quic.gov/report). Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

---

## Section 1. Facts about this HMO plan

---

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

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

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

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

### How we pay providers

We contract with individual physicians, medical groups, hospitals and other types of providers to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments. We reimburse primary care physicians through capitation, which includes the majority of services the primary care physician renders. We compensate certain services, such as immunizations or cardiac diagnostic testing in the office as fee for service.

### Who provides my health care?

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

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

### Your Rights

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

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

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

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

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

Utilization management services include:

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

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

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

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

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

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

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

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

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

## Service Area

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

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

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

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

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

---

## Section 2. How we change for 2005

---

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

### Program-wide changes

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

### Changes to this Plan

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

---

## Section 3. How you get care

---

### Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-932-4480. You may also request replacement cards through our Web site at [www.bcbsmo.com](http://www.bcbsmo.com).

### Where you get covered care

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

- **Plan providers**

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

We list Plan providers in the provider directory, which we update annually. The BlueCHOICE directory is also on our Web site, [www.bcbsmo.com](http://www.bcbsmo.com). The online directory is updated daily.

- **Plan facilities**

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

### What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

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

- **Primary care**

Your primary care physician can be a family or general practitioner, internist, pediatrician or geriatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one. We will send you a new ID card with your new doctor’s name and phone number on the front.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see a network OB/GYN for any medically necessary OB/GYN care without a referral. And you may go to a network eye care provider for one routine vision exam each calendar year without a referral.

Here are some other things you should know about specialty care:

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

You may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.

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

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

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

- **Hospital care**

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

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

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

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

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

**Circumstances beyond our control**

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

**Services requiring our prior approval**

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

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

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

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

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

---

## Section 4. Your costs for covered services

---

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

### **Copayments**

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

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

### **Deductible**

We do not have a deductible.

### **Coinsurance**

We do not have coinsurance.

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

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

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

---

## Section 5. Benefits – OVERVIEW

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

---

Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 1-800-932-4480 or at our Web site at [www.bcbsmo.com](http://www.bcbsmo.com).

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

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

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

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

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

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

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

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

*Diagnostic and treatment services – continued on next page*

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


\* Or more frequently if recommended by your BlueCHOICE physician.

*Preventive care, adult – continued on next page*

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



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

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

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

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





























































































