

Capital Health Plan

<http://www.capitalhealth.com>

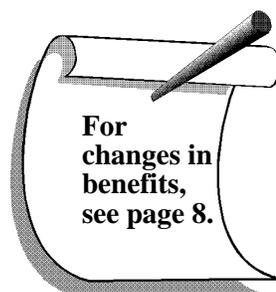


2007

A Health Maintenance Organization

Serving: Tallahassee, Florida, area

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.



*March 6, 2006 – March 6, 2009
This Plan has “Excellent”
accreditation from NCQA. See
the 2005 Guide for more information
on NCQA.*

Enrollment code for this Plan:

EA1 Self Only

EA2 Self and Family



Authorized for distribution by the:



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

Important Notice from Capital Health Plan About Our Prescription Drug Coverage and Medicare

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

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

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

Please be advised

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

Medicare's Low Income Benefits

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

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

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

Table of Contents

Table of Contents	1
Introduction	3
Plain Language.....	3
Stop Health Care Fraud!	3
Preventing medical mistakes.....	4
Section 1 Facts about this HMO plan	6
Section 2 How we change for 2007	8
Section 3. How you get care	9
Identification cards	9
Where you get covered care	9
• Plan providers	9
• Plan facilities.....	9
What you must do to get covered care	9
• Primary care	9
• Specialty care	9
If you are referred to a specialist	10
• Hospital care If you are hospitalized when your enrollment begins.....	11
How to get approval for.....	11
• Your hospital stay	11
• Maternity care	11
What happens when you do not follow the precertification rules when using non-network facilities	11
Circumstances beyond our control.....	11
Services requiring our prior approval.....	11
Section 4 Your costs for covered services	13
Copayments.....	13
Deductible	13
Coinsurance.....	13
Your catastrophic protection out-of-pocket maximum	13
Waivers.....	13
Benefits	14
Section 5 Benefits Overview.....	16
Section 5(a) Medical services and supplies provided by physicians and other health care professionals.....	17
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	25
Section 5(c) Services provided by a hospital or other facility, and ambulance services	30
Section 5(d) Emergency services/accidents	33
Section 5(e) Mental health and substance abuse benefits	35
Section 5(f) Prescription drug benefits	37
Section 5(g) Special features.....	39
Section 5(h) Dental benefits.....	40
Section 6 General exclusions – things we don't cover	41
Section 7 Filing a claim for covered services	42
Section 8 The disputed claims process	43
Section 9 Coordinating benefits with other coverage	45
When you have other health coverage	45
What is Medicare?.....	45
Should I enroll in Medicare?.....	45

The Original Medicare Plan (Part A or Part B).....	46
Medicare Advantage (Part C).....	46
Medicare prescription drug coverage (Part D).....	47
TRICARE and CHAMVA	47
Workers' Compensation	47
Medicaid.....	47
When other Government agencies are responsible for your care.....	47
When others are responsible for injuries	47
Section 10 Definitions of terms we use in this brochure	49
Section 11 FEHB Facts	50
No pre-existing condition limitation	50
Where you can get information about enrolling in the FEHB Program.....	50
Types of coverage available for you and your family.....	50
Children's Equity Act.....	50
When benefits and premiums start	51
When you retire	51
When FEHB coverage ends	52
Upon divorce	52
Temporary Continuation of Coverage (TCC)	53
Converting to individual coverage	53
Getting a Certificate of Group Health Plan Coverage.....	53
Section 12 Three Federal Programs complement FEHB benefits	53
Important information	53
It's important protection.....	53
What is an FSA?.....	53
What expenses can I pay with an FSAFEDS account?	54
Who is eligible to enroll?	54
When can I enroll?	54
Who is SHPS?	54
Who is BENEFEDS?	54
Important Information	55
Dental Insurance.....	55
Vision Insurance.....	56
What plans are available?.....	56
Premiums.....	56
Who is eligible to enroll?	56
Enrollment types available	56
Which family members are eligible to enroll?	56
When can I enroll	56
How do I enroll?.....	56
When will coverage be effective?	56
How does this coverage work with my FEHB plan's dental or vision coverage?	57
Summary of benefits for Capital Health Plan - 2007.....	57
2007 Rate Information for Capital Health Plan	58

Introduction

This brochure describes the benefits of Capital Health Plan under our contract (CS 2034) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Capital Health Plan's Administrative office is:

Capital Health Plan, Inc.

2140 Centerville Place

Tallahassee, Fl. 32308

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

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 8. 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 Capital Health Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

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

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 850/383-3311 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, DC20415-1100

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

Preventing medical mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

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

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

3. Get the results of any test or procedure.

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

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

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

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

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

Visit these Web sites for more information about patient safety.

Ø www.ahrq.gov/path/beactive.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.

Ø www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

Ø www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

Ø www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.

Ø www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Ø www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1 Facts about this HMO plan

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

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments 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 employ physicians and 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 when you follow Plan procedures for accessing care.

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 our facilities. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- **We operate under a State of Florida Certificate of Authority and are federally qualified under Title XIII, PHSA.**
- **We have been in existence for 24 years.**
- **We are a Not-for-Profit Corporation.**

If you want more information about us, call 850-383-3311, or write to Capital Health Plan, 2140 Centerville Place, Tallahassee, FL 32308. You may also contact us by fax at 850-383-3590 or visit our Web site at www.capitalhealth.com.

Capital Health Plan member's Rights and Responsibilities

Capital Health Plan (CHP) is committed to provide and/or arrange for the provision of quality health care in a cost-effective manner. Consistent with our commitment, the following statement of Member's Rights and Responsibilities has been adopted. For a complete, definitive description of your rights and responsibilities as a member of CHP, please refer to your Member Handbook or the master policy or contract provided to your employer.

You Have a Right To:

- Receive information about CHP, the services, benefits, member rights and responsibilities, and participating practitioners who provide care.
- Receive medical care and treatment from practitioners and providers who have met the credentialing standards of CHP.
- Expect CHP participating practitioners to permit you to participate in decision-making about your health care consistent with legal, ethical, and relevant patient-practitioner relationship requirements. If you are unable to fully participate in treatment decisions you have a right to be represented by your parents, guardians, family members, health care surrogates or other conservators to the extent permitted by applicable laws.
- Expect health care practitioners who participate with CHP to provide treatment with courtesy, respect, and with recognition of your dignity and right to privacy.
- Communicate complaints or appeals about CHP or the care provided through the established appeal or grievance procedures found in your Member Handbook and the master policy or contract provided to your employer.

- Have candid discussion with practitioners about the best treatment options for you no matter what the cost of the treatment or your benefit coverage.
- Refuse treatment if you are willing to accept the responsibility and consequences of that decision.
- Have access to your medical records, request amendments to your records, and have confidentiality of these records and member information protected and maintained in accordance with State and Federal law and CHP policies.
- Make recommendations regarding CHP's member rights and responsibility policies.
- Call or write us anytime with helpful comments, questions and observations, whether concerning something you like about our plan, or something you feel is a problem area.

You Have a Responsibility To:

- Seek all non-emergency care through your primary care physician (PCP), obtain a referral from your PCP for medical services by a specialist, and cooperate with those providing care and treatment.
- Be courteous; respect the rights, needs and privacy of other patients, office staff and providers of care.
- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care for you.
- Understand your health problems and participate in developing mutually agreed upon treatment goals to the degree possible.
- Follow the plans and instructions for care that you have agreed to with your practitioners.
- Ask questions and seek clarification to enable you to participate fully in your care.
- Pay copayments and provide current information concerning your CHP membership status to any CHP participating practitioner or provider.
- Follow established procedures for filing a complaint, appeal or grievance concerning medical or administrative decisions that you feel are in error.
- Review and understand the benefit structure, both covered benefits and exclusions, as outlined in the Member Handbook. Cooperate and provide information that may be required to administer benefits.
- Seek access to medical and member information through your Primary Care Physician, CHP Connect or through CHP Member Services.
- Follow the coverage access rules in your Member Handbook.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is: Gadsden, Jefferson, Leon, and Wakulla counties.

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

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

Section 2 How we change for 2007

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

Changes to this Plan

- Your share of the non-Postal premium will be decreased by 2% for Self Only or 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 letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 850-383-3311 or write to us at Capital Health Plan, 2140 Centerville Place, Tallahassee, FL 32308. You may also request replacement cards through our Web site: www.capitalhealth.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 physicians and other health care professionals in our service area that we employ or contract with to provide covered services to our members. We credential Plan providers according to national standards. You must select a primary care physician to direct all of your medical care. Capital Health Plan offers you a choice of primary care physicians at many different locations in the greater Tallahassee area.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site, www.capitalhealth.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 in the provider directory, which we update periodically. The list is also on our Web site, www.capitalhealth.com. Primary care physician offices in our two health centers at Centerville Road and Governors Square Boulevard also offer the convenience of lab, x-ray, and vision care.

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. Capital Health Plan's Directory of Physicians and Service Providers list the primary care physicians and their office locations. You can make your selections from this list. This directory is provided to all new members at the time of enrollment, on request by calling CHP's Member Services Department at 850-383-3311, or on our website at www.capitalhealth.com. This directory is subject to change and is updated on a regular basis. On occasion, some physicians may not accept new patients. CHP's Member Services staff gladly will assist you with your selection of a primary care physician.

- **Primary care**

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

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

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after 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 Plan optometrist, chiropractor, or podiatrist for covered services without a referral. Female members also may see a Plan gynecologist for one annual routine exam without a referral. You may see a Plan dermatologist for up to five visits per 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 are referred to a specialist

- 1) We process routine visits to specialists through an automated system. You can confirm your referral and obtain your referral number within 3 to 5 working days by dialing 850-383-3530 and following the instructions given. This information also can be obtained on our website at www.capitalhealth.com by going to *CHPConnect*
- 2) Once you receive authorization, your primary care physician's staff will schedule your appointment with the specialist. Sometimes your primary care physician will ask you to schedule the appointment yourself. If you schedule your own appointment, please allow five working days for the necessary records to arrive at the specialist's office. If your appointment is scheduled within five working days from the date your primary care physician refers you, you will want to make arrangements to hand-carry any required records or x-rays.
- 3) Your referral to the specialist will be for a specific number of visits and is valid for 60 days.
- 4) If the specialist recommends additional services, office visits, diagnostics tests, surgery, hospitalization, or other specialty care, you **MUST** call your primary care physician for authorization before the services are scheduled.
- 5) However, routine lab tests do not require authorization from your primary care physician. The physician ordering the lab tests will give you appropriate lab orders and directions.

6) X-rays may be done at Capital Health Plan's x-ray departments located at 2140 Centerville Place in Tallahassee or 1491 Governors Square Boulevard in Tallahassee, unless other arrangements have been made by your primary care physician.

7) If you have any questions regarding the referral system, please call CHP's Member Services Department at 850/383-3311 or visit www.capitalhealth.com.

- **Hospital care**

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

If you are hospitalized when your enrollment begins

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 850-383-3311. 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 cases, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

How to get approval for...

- **Your hospital stay**

Your CHP primary care physician (PCP) or a specialist on referral from your PCP will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

- **Maternity care**

Maternity Care is defined as hospital services provided to a Member for normal pregnancy, delivery, miscarriage, or pregnancy complications within the CHP service area only, unless the need for these services was not, and reasonably could not have been, anticipated before leaving the service area.

What happens when you do not follow the precertification rules when using non-network facilities

Capital Health Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. 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.

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. Capital Health Plan members can access out-of-area urgent and emergency care at any affiliated Blue Cross and Blue Shield provider in the country through the BlueCard® network and claims automatically will be routed to CHP.

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. However, for certain services your primary care 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 “utilization management.” Your physician must obtain authorization for the following services:

- Specialty care
- Hospital care
- Diagnostic services
- All non-emergent surgeries
- Mental Health/Substance Abuse care
- Growth Hormone Therapy
- Surgical treatment of morbid obesity
- Antifungal Drugs Prescribed Specifically for Onychomycosis
- High Dose Narcotics
- Breast Reduction Surgery
- Power Wheelchairs
- Proton Pump Inhibitors (PPIs)
- Provigil
- Psoriasis Agents (Amevive, Raptiva, and Enbrel)
- Turbinate Reduction

Section 4 Your costs for covered services

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

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive 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 \$250 per admission.

Deductible

We do not have a deductible.

Coinsurance

We do not have coinsurance.

Your catastrophic protection out-of-pocket maximum

After your copayments total \$1500 per person or \$3000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription drugs

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

Waivers

In some instances, a Capital Health Plan provider may ask you to sign a “waiver” before you receive care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the content of the contracts that the Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at Capital Health Plan

Benefits

See page 8 for how our benefits changed this year. Page 58 is a benefits summary. Make sure that you review the benefits that are available under this plan.

Benefits	14
Section 5 Benefits Overview.....	16
Section 5(a) Medical services and supplies provided by physicians and other health care professionals.....	17
Diagnostic and treatment services.....	17
Lab, X-ray and other diagnostic tests.....	17
Preventive care, adult.....	18
Preventive care, children.....	18
Maternity care.....	19
Family planning.....	19
Infertility services.....	20
Allergy care.....	20
Treatment therapies.....	20
Physical and occupational therapies.....	21
Speech therapy.....	21
Hearing services (testing, treatment, and supplies).....	21
Vision services (testing, treatment, and supplies).....	21
Foot care.....	22
Orthopedic and prosthetic devices.....	22
Durable medical equipment (DME).....	23
Home health services.....	24
Chiropractic.....	24
Alternative treatments.....	24
Educational classes and programs.....	24
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	25
Surgical procedures.....	25
Reconstructive surgery.....	26
Oral and maxillofacial surgery.....	27
Organ/tissue transplants.....	27
Anesthesia.....	29
Section 5(c) Services provided by a hospital or other facility, and ambulance services.....	30
Inpatient hospital.....	30
Outpatient hospital or ambulatory surgical center.....	31
Extended care benefits/Skilled nursing care facility benefits.....	31
Hospice care.....	31
Ambulance.....	32
Section 5(d) Emergency services/accidents.....	33
Emergency within our service area.....	33
Emergency outside our service area.....	34
Ambulance.....	34
Section 5(e) Mental health and substance abuse benefits.....	35
Section 5(f) Prescription drug benefits.....	37
Covered medications and supplies.....	38
Section 5(g) Special features.....	39
Feature.....	39

Section 5(h) Dental benefits.....	40
Accidental injury benefit.....	40
Service.....	40
Summary of benefits for Capital Health Plan - 2007.....	57

Section 5 Benefits Overview

Our benefit package is described in Section 5. Make sure that you carefully review the benefits.

Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about benefits, contact us at 850-383-3311 or at our website at www.capitalhealth.com.

Our benefit package offers the following unique features:

Capital Health 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. Capital Health Plan is solely responsible for the selection of these providers in your area. To receive our most recent provider directory, call 850-383-3311; or visit our website at www.capitalhealth.com.

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.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician's office • Office medical consultations • Second surgical opinion 	\$15 per visit to your primary care physician \$25 per visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center 	\$20 per visit
<ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility • At home 	Nothing
<i>Not covered:</i>	<i>All charges.</i>
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing

Benefit Description	You pay
Preventive care, adult	
Routine physical which includes: Routine screenings, such as: <ul style="list-style-type: none"> • 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 - Double contrast barium enema – every five years starting at age 50 - Colonoscopy screening – every ten years starting at age 50 	\$15 per visit to your primary care physician \$25 per visit to a specialist
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	\$15 per visit to your primary care physician \$25 per visit to a specialist
Routine Pap test Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see Diagnostic and treatment services.	\$15 per visit to your primary care physician \$25 per visit to a specialist
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	Nothing
Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) <ul style="list-style-type: none"> • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older 	\$15 per visit to your primary care physician \$25 per visit to a specialist
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	\$15 per visit to your primary care physician \$25 per visit to a specialist
Well-child care charges for routine examinations, immunizations and care (up to age 22) <ul style="list-style-type: none"> • Examinations, such as: <ul style="list-style-type: none"> - Eye exams through age 17 to determine the need for vision correction, - Hearing exams through age 17 to determine the need for hearing correction, 	\$15 per visit to your primary care physician \$25 per visit to a specialist

Preventive care, children - continued on next page

Benefit Description	You pay
Preventive care, children (cont.)	
<ul style="list-style-type: none"> - Examinations done on the day of immunizations (up to age 22) 	\$15 per visit to your primary care physician \$25 per visit to a specialist
Maternity care	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 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 (you do not need to precertify the normal length of stay). We will extend your inpatient stay for you or your baby if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	\$15 for initial visit to your primary care physician \$25 for initial visit to a specialist \$250 per admission
<p><i>Not covered:</i></p> <p><i>Routine sonograms to determine fetal age, size or sex.</i></p>	<p><i>All charges.</i></p>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	\$15 per visit to your primary care physician \$25 per visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> 	<p><i>All charges.</i></p>

Benefit Description	You pay
Infertility services	
Diagnosis and treatment of infertility such as: <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) 	\$15 per visit to your primary care physician \$25 per visit to a specialist
<i>Not covered:</i> <ul style="list-style-type: none"> • Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> - in-vitro fertilization - embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT) • Services and supplies related to ART procedures • Cost of donor sperm • Cost of donor egg • Fertility drugs 	<i>All charges.</i>
Allergy care	
Testing and treatment <ul style="list-style-type: none"> • Allergy injections 	\$15 per visit to your primary care physician \$25 per visit to a specialist
Allergy serum	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> • Provocative food testing • Sublingual allergy desensitization 	<i>All charges.</i>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 27.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We only cover GHT when we preauthorize the treatment. Your primary care physician will request preauthorization. Ask us to authorize GHT before you being treatment; otherwise, we will only cover GHT services from the date you submit the information. If we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See Services requiring our prior approval in Section 3.</p>	\$15 per office visit to your primary care physician. \$25 per office visit to a specialist.
<i>Not covered:</i>	<i>All charges.</i>

Benefit Description	You pay
Physical and occupational therapies	
<p>Up to two consecutive months per condition for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p>	<p>\$25 per office visit to a specialist</p> <p>\$25 per outpatient visit</p> <p>Nothing per visit 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	
<p>Up to two consecutive months per condition for the services of speech therapists.</p>	<p>\$25 per office visit to a specialist</p> <p>\$25 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Speech therapy beyond two consecutive months per condition</i> 	<p><i>All charges</i></p>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • Hearing testing for children through age 17, (see <i>Preventive care, children</i>) 	<p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>All other hearing testing</i> • <i>Hearing aids, testing and examinations for them</i> 	<p><i>All charges.</i></p>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) The initial pair of eyeglasses is limited to the cost of the lens and up to \$25 for the frame and must be obtained only at CHP's Eye Care Centers. • Annual eye refractions, including eye exam to determine the need for vision correction for children through age 17. • Annual eye refractions <p><i>Note: See Preventive care, children for eye exams for children.</i></p>	<p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> • <i>Eyeglasses, except initial pair following cataract surgery or an accidental injury which requires corrective lenses.</i> 	<p><i>All charges.</i></p>

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

Benefit Description	You pay
Vision services (testing, treatment, and supplies) (cont.)	
<ul style="list-style-type: none"> • An examination and fitting for contact lenses. CHP Eye care offers this service on a fee for service basis. • Contact lenses and examinations for them. • Replacements for any lenses provided during the same calendar year. 	All charges.
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above • Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery) 	All charges.
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • 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: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 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. • Braces and covered prosthetic devices (except cardiac pacemaker) are limited to the first such item prescribed for each specific medical condition • Oxygen for home use including equipment is covered • Cardiac pacemakers 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Orthopedic and corrective shoes • Arch supports • Foot orthotics • Heel pads and heel cups • Lumbosacral supports • Corsets, trusses, elastic stockings, support hose, and other supportive devices 	All charges

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay
Orthopedic and prosthetic devices (cont.)	
<ul style="list-style-type: none"> <i>All other prosthetic devices, including braces used during athletic activities, are excluded.</i> 	<i>All charges</i>
Durable medical equipment (DME)	
<p>Durable Medical Equipment that has been prescribed by your plan physician and authorized by CHP as a Covered Service. CHP reserves the right to rent or purchase the most cost-effective DME that meets the Member's needs. Maximum payment by CHP for durable medical equipment will be \$2,500 annually for a covered person. This benefit covers a wide variety of durable medical equipment, and continuing development of patient care equipment makes it impractical to provide a complete listing of covered durable medical equipment such as:</p> <ul style="list-style-type: none"> • Crutches • Canes • Manual wheelchairs • Basic hospital beds • Walkers • Blood glucose monitors; and • Insulin pumps. 	All charges over \$2500 per person per year.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cost to repair or replace DME except when authorized by CHP</i> • <i>DME that has not been authorized by CHP</i> • <i>Durable Medical Equipment that is for patient convenience and/or comfort</i> • <i>Water therapy devises such as Jacuzzis, hot tubs, swimming pools, or whirlpools</i> • <i>Exercise and massage equipment</i> • <i>Electric scooters</i> • <i>Hearing aids</i> • <i>Dental braces, air conditioners, humidifiers, water purifiers, hypo-allergenic pillows, mattresses or waterbeds, emergency alert equipment.</i> • <i>This exclusion includes but is not limited to:</i> <ul style="list-style-type: none"> - <i>Modifications to motor vehicles</i> - <i>Modifications to homes, such as wheelchair lifts or ramps</i> - <i>Escalators or elevators, stair glides, handrails, heat appliances and dehumidifiers.</i> 	<i>All charges.</i>

Benefit Description	You pay
Home health services	
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. The Plan physician periodically will review the program for continuing appropriateness and need. • Services include oxygen therapy, intravenous therapy and medications. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<i>All charges.</i>
Chiropractic	
<ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	\$25 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services that maintain rather than improve a physical function,</i> • <i>Services that we determine will not result in significant improvement of the member's condition within a 62-day period.</i> 	<i>All Charges:</i>
Alternative treatments	
<i>No Benefit</i>	<i>All Charges</i>
Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking cessation • Diabetes self-management • Newborn care • CPR for infant and child • CPR for adults • Asthma management • Weight loss • Cholesterol/heart disease class • Kids and family healthy eating and active living series 	Nothing

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

Benefit Description	You pay
Surgical procedures	
<ul style="list-style-type: none"> • A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity (bariatric surgery) – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over (see page 12, Services requiring our prior approval) <ul style="list-style-type: none"> - Presence of morbid obesity, defined as a body mass index (BMI) exceeding 40 or greater than 35 in conjunction with severe co-morbidities such as cardiopulmonary complications or severe diabetes; and - An adequately documented history of adaptation of sound nutritional principles as evidenced by a 10% weight reduction; and - An adequately documented history of consistent participation in an exercise program for 12 months that is similar to that described in the CHP Weight Management Program for Morbidly Obese Patients including regular PCP visits to document compliance; and 	<p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p> <p>You pay nothing for physician services at a hospital or outpatient surgery center.</p>

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
<ul style="list-style-type: none"> - An adequately documented absence of active substance abuse or major uncontrolled psychiatric disorder; or - Life threatening morbid obesity with evidence of imminently life threatening co-morbid conditions that cannot be treated safely and effectively through other means. • Insertion of internal prosthetic devices. See 5(a), Orthopedic and prosthetic devices, for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay hospital benefits for a pacemaker and surgery benefits for insertion of the pacemaker.</p>	<p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p> <p>You pay nothing for physician services at a hospital or outpatient surgery center.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<p><i>All Charges.</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - The condition produced a major effect on the member's appearance and - The condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$15 per office visit to your primary care physician</p> <p>\$25 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> 	<p><i>All Charges.</i></p>

Reconstructive surgery - continued on next page
Benefits Section 5(b)

Benefit Description	You pay
Reconstructive surgery (cont.)	
<ul style="list-style-type: none"> • <i>Surgeries related to sex transformation</i> 	<i>All Charges.</i>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • Surgical treatment of TMJ (Related dental care for TMJ is excluded) 	<p>\$15 per office visit to your primary care physician \$25 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<i>All charges.</i>
Organ/tissue transplants	
<p>Solid Organ Transplants are limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart-lung • Kidney • Liver • Pancreas • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Lung: Single/double <p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses. The medical necessity limitation is considered satisfied if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myelogenous leukemia - Severe combined immunodeficiency 	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> - Severe or very severe aplastic anemia • Autologous transplants for: <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced neuroblastoma - Advanced non-Hodgkin's lymphoma • Autologous tandem transplants for: <ul style="list-style-type: none"> - Recurrent germ cell tumors (including testicular cancer) <p>Blood or Marrow Stem Cell Transplants: Not Subject to Medical Necessity</p> <ul style="list-style-type: none"> • Allogeneic transplants for: <ul style="list-style-type: none"> - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for: <ul style="list-style-type: none"> - Multiple myeloma - Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors - Breast cancer - Epithelial ovarian cancer <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer must be approved by the Plan's medical director in accordance with the Plan's protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Any service in connection with the implant of an artificial organ, including the implant of the artificial organ.</i> • <i>Transplants not listed as covered</i> • <i>Any organ which is sold rather than donated to the Member</i> • <i>The cost for services associated with the identification of a potential donor from a local, state, or national listing except for Bone Marrow transplants coverage for reasonable costs of searching for donor will be limited to a search among family members and donors identified thru the National Bone Marrow Donor Program</i> • <i>Services related to the acquisition of an organ or tissue for a recipient who is not a covered member of CHP</i> • <i>Any service related to the transplantation of any non-human organ or tissue</i> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor.</i> 	<i>All Charges</i>

Benefit Description	You pay
Organ/tissue transplants (cont.)	
<ul style="list-style-type: none"> • <i>Implants of artificial organs</i> 	<i>All Charges</i>
Anesthesia	
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing
Professional services provided in – <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center 	Nothing
<ul style="list-style-type: none"> • Office visit 	\$25 per visit

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, Your costs for covered services for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

Benefit Description	You pay
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. • Special duty nursing when medically necessary; and • Private rooms when medically necessary during inpatient hospitalization. <p>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	\$250 per admission
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Dressings , splints , casts , and sterile tray services • Medical supplies and equipment, including oxygen • Blood or blood plasma, if not donated or replaced • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies) 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> 	<i>All Charges</i>

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
<ul style="list-style-type: none"> • <i>Private nursing care, except when medically necessary</i> 	<i>All Charges</i>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays , and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma , if not donated or replaced • Pre-surgical testing • Dressings, casts , and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	Nothing
<i>Not covered: Blood and blood derivatives not replaced by the member</i>	<i>All charges.</i>
Extended care benefits/Skilled nursing care facility benefits	
<p>Extended care/skilled nursing facility (SNF): The Plan provides a comprehensive range of benefits for up to 60 days per admission with subsequent admission available 180 days from discharge date of previous admission when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.</p> <p>All necessary services are covered, including:</p> <ul style="list-style-type: none"> • Bed, board and general nursing care • Drug biologicals supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor. 	Nothing
<i>Not covered: Custodial care</i>	<i>All Charges.</i>
Hospice care	
<p>Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. 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, with a life expectancy of approximately six months or less</p>	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All Charges</i>

Benefit Description	You pay
Ambulance	
<ul style="list-style-type: none">Local professional ambulance service when medically appropriate	Nothing

Section 5(d) Emergency services/accidents

Important things you should keep in mind about these benefits:

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

What is a medical emergency?

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

What to do in case of emergency:

If you are in an emergency situation, please call your primary care physician. 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 should notify the Plan within 48 hours unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been notified timely.

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 that care can be 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

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor’s office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors’ services 	<p>\$20 per visit.</p> <p>\$20 per visit</p> <p>\$100 per visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care and follow-up care recommended by non-plan providers that has not been approved by the Plan or provided by Plan providers.</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area.</i> 	<p><i>All Charges.</i></p>

Emergency within our service area - continued on next page

Benefit Description	You pay
Emergency within our service area (cont.)	
<ul style="list-style-type: none"> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.</i> 	<i>All Charges.</i>
Emergency outside our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services 	\$20 per visit \$20 per visit \$100 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All Charges.</i>
Ambulance	
Professional ambulance service when medically appropriate. Note: See 5(c) for non-emergency service.	Nothing
<p><i>Not covered: Air ambulance - unless medically necessary and approved by the Plan's Medical Director.</i></p>	<i>All Charges.</i>

Section 5(e) Mental health and substance abuse benefits

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

Important things you should keep in mind about these benefits:

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

Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	Your cost sharing responsibilities are no greater than for other illnesses 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 	\$25 per visit
<p>Diagnostic tests</p> <ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>\$25 per visit</p> <p>\$250 per admission</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All Charges.</i>
<p>Preauthorization</p>	<p>To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:</p> <p>1) We process routine visits to specialists through an automated system. You can confirm your referral and obtain your referral number within three to five working days by dialing 850-383-3530 and following the instructions given.</p>

	<p>2) Once you receive authorization, your primary care physician's staff will schedule your appointment with the specialist. Many times, however, your physician will ask you to schedule the appointment yourself. If you schedule your own appointment, please allow five working days for the necessary records to arrive at the specialist's office. If your appointment is scheduled within five working days from the date your primary care physician refers you, you will want to make arrangements to hand-carry any required records or x-rays.</p> <p>3) Your referral to the specialist will be for a specific number of visits and is valid for 60 days.</p> <p>4) If the specialist recommends additional services, office visits, diagnostics tests, surgery, hospitalization, or other specialty care, you MUST call your primary care physician for authorization before the services are scheduled.</p> <p>5) However, routine lab tests do not require authorization from your primary care physician. The physician ordering the lab tests will give you appropriate lab orders and directions.</p> <p>6) X-rays may be done at Capital Health Plan's X-ray departments located at 2140 Centerville Place in Tallahassee or 1491 Governors Square Boulevard in Tallahassee, unless other arrangements have been made by your primary care physician.</p> <p>7) If you have any questions regarding the referral system, please call CHP's Member Services Department at 850-383-3311.</p>
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f) Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Certain Prescription Drugs require prior coverage authorization. For instructions on how to obtain prior authorization, please contact Member Services at 850-383-3311 Monday through Friday, 8 a. m. to 5 p.m.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy. We administer an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. Brand name drugs not on the preferred list are dispensed at a higher copay. To request a prescription drug brochure, call 850/383-3311 or go to www.capitalhealth.com
- **These are the dispensing limitations.** Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply or one commercially prepared unit (i.e. one inhaler, one vial ophthalmic medication or insulin). You pay a \$30 copay per prescription unit or refill for any brand drug that appears on the plan's Preferred Medication List when generic substitution is not available and a \$15 copay per prescription unit or refill for generic drugs. For brand drugs not on the plan's Preferred Medication List you pay \$50. If a generic drug is available, and at the request of the member or the prescribing physician a brand name prescription is dispensed, you pay the price difference between the generic and name brand drug as well as the copay for the preferred or non-preferred brand name drug per prescription unit or refill. Prescription refills will not be covered until at least 75 % of the previous prescription has been used by the member (based on the dosage schedule prescribed by the physician). 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.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. If there is no generic equivalent available, you will still have to pay the brand name copay.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.
- **When you do have to file a claim.** When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment. See page 10.

Benefit Description	You pay
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy?</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as Not Covered. • Insulin with a \$15 copay charge applied to each vial. • Diabetic supplies limited to needles, syringes, and test strips. • Disposable needles and syringes for the administration of covered medications. • Prenatal vitamins • Drugs for sexual dysfunction (see Prior authorization below) • Oral and injectable contraceptive drugs <p>Note: We cover injectable contraceptive drugs under the Family Planning Benefit.</p>	<p>\$15 per prescription for generic drugs</p> <p>\$30 per prescription for preferred brand name prescription drugs</p> <p>\$50 per prescription for non-preferred brand name prescription drugs.</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes including appetite suppressants</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Medical supplies such as dressing and antiseptics</i> • <i>Nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Vitamins except pre-natal vitamins</i> • <i>Nonprescription medicines</i> • <i>Smoking cessation drugs and medications, including nicotine patches</i> 	<p><i>All Charges.</i></p>

Section 5(g) Special features

Feature	Description
Services for deaf and hearing impaired	TDD Line: 850/383-3534
CHPConnect	<p>CHPConnect a secure, online electronic Personal Health Records</p> <ul style="list-style-type: none">• A personal history of your doctor's visits and procedures• Diagnoses• Current medications• Children's immunizations and visit dates• Referrals• Benefits-including copayments• Prescription drug information <p>Call 850-383-3311 or go online to www.capitalhealth.com for additional information.</p>

Section 5(h) Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You Pay
Accidental injury benefit	
<p>We cover restorative services and supplies necessary to promptly (within 62 days of an accidental dental injury) repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.</p> <p>Accidental dental injury means an injury to sound natural teeth (not previously compromised by decay), caused by a sudden unintentional, and unexpected event or force. This term does not include injuries to the mouth, structures within the oral cavity, or natural teeth caused by biting or chewing, surgery, or treatment for a disease or illness.</p>	Nothing

Dental benefits

Dental Benefits	You Pay
Service	
<i>We have no other dental benefits.</i>	<i>All charges.</i>

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under Services requiring our prior approval on page 12.**

We do not cover the following:

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

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3.

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">a) Write to us within 6 months from the date of our decision; andb) Send your request to us at: Capital Health Plan, ATTN: Grievance Coordinator, P. O. Box 15349, Tallahassee, FL. 32317-5349; andc) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andd) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none">a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orb) Write to you and maintain our denial - go to step 4; orc) 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	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within</p> <ul style="list-style-type: none">• 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. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none">• 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. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>

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

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

5

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

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

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

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

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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 850-383-3311 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:

If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or

- You may call OPM's Health Insurance Group 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

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

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. The Plan will not pay in a secondary position for visits beyond the benefit limits.

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We, Capital Health Plan, offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

• Should I enroll in Medicare?

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

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

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

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

The Original Medicare Plan (Part A or Part B)

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

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

We will not waive any of your copayments.

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 850-383-3311 or see our Web site at www.capitalhealth.com.

The plan will not pay in a secondary position for visits beyond the benefit limits.

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

Medicare Advantage (Part C)

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and our Medicare Advantage plan: You may enroll in CHP's Medicare Advantage plan and also remain enrolled in our FEHB plan. Your care must continue to be authorized by your CHP primary care physician, and we will not waive any of your copayments.

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

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

Medicare prescription drug coverage (Part D)

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

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or

OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

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

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

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.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 13
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Custodial care means care that serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding and using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel. In determining whether a person is receiving custodial care, consideration is given to the level of care and medical supervision required and furnished. A determination that care received is custodial is not based on the patient's diagnosis, type of condition, degree of functional limitation, or rehabilitation potential. Custodial care that lasts 90 days or more is sometimes known as long term care.
Experimental or investigational service	When CHP determines that an evaluation, treatment, therapy, or device is experimental/ investigational, it will not be covered by the Plan. CHP makes these determinations based in part on information obtained from the United States Food and Drug Administration, the Florida Department of Health, and the most recently published medical literature in the United states, Canada, or Great Britain. A consensus of opinion among experts is sought that would show that the evaluation, treatment, therapy, or device is considered safe and effective as compared with the standard means for treatment or diagnosis of the condition in question.
Medical necessity	Medical necessity means, for coverage and payment purposes, that a medical service or supply is required for the identification, treatment, or management of a condition, and is, in the opinion of CHP: 1) consistent with the symptom, diagnosis, and treatment of the Member's condition; 2) widely accepted by the practitioners' peer group as efficacious and reasonably safe based on scientific evidence; 3) universally accepted in clinical use so that omission of the service or supply in these circumstances raises questions regarding the accuracy of diagnosis or the appropriateness of the treatment; 4) not experimental or investigational; 5) not for cosmetic purposes; 6) not primarily for the convenience of the Member, the Member's family, the physician, or other provider; and 7) the most appropriate level of service, care, or supply that safely can be provided to the Member. When applied to inpatient care, medical necessity further means that the services cannot be provided safely to the Member in an alternative setting.
Morbid obesity	A condition in which an individual's body mass index (BMI) exceeds 40 or is greater than 35 in conjunction with severe co-morbidities such as cardiopulmonary complications or severe diabetes; eligible members must be age 18 or over.
Us/We	Us and We refer to Capital Health Plan
You	You refers to the enrollee and each covered family member.

Section 11 FEHB Facts

Coverage information

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure/health for enrollment information as well as:

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

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

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

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

Types of coverage available for you and your family

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns 22 or has a change in marital status, divorce, or when your child under age 22 marries.

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

Children's Equity Act

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

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

If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;

If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or

If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

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

When benefits and premiums start

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2007 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2006 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

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

When you lose benefits

• When FEHB coverage ends

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

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

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

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

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse’s enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse’s employing or retirement office to get RI 70-5, the *Guide To Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM’s Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

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

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

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

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);

You decided not to receive coverage under TCC or the spouse equity law; or

You are not eligible for coverage under TCC or the spouse equity law.

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

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

- **Getting a Certificate of Group Health Plan Coverage**

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

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at 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 information about Federal and State agencies you can contact for more information.

Section 12 Three Federal Programs complement FEHB benefits

Important information

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

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

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

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

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

Why should you consider applying for coverage under the **Federal Long Term Care Insurance Program(FLTCIP)**?

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums. If you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions about your health. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **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. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses.

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

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses for you and your dependents which are not covered or reimbursed by FEHBP coverage or other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents., which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

What expenses can I pay with an FSAFEDS account?

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

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

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

AND MUCH MORE! Visit www.FSAFEDS.com

Who is eligible to enroll?

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

When can I enroll?

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

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

Who is SHPS?

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

Who is BENEFEDS?

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

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

Important Information

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

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

Dental Insurance

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

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluation, sealants and x-rays
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures
- Class D (Orthodontic) services with a 24 month waiting period

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

Vision Insurance

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

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

What plans are available?

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

Premiums

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

Who is eligible to enroll?

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

Enrollment types available

- Self-only, which covers only the enrolled employee or annuitant
- Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee, and
- Self and family, which covers the enrolled employee or annuitant and all eligible family members.

Which family members are eligible to enroll?

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

When can I enroll

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

How do I enroll?

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

When will coverage be effective?

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

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

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

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

Summary of benefits for Capital Health Plan - 2007

Do not rely on this chart alone. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.

We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You pay	You pay
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$15 primary care; \$25 specialist	17, 18
Services provided by a hospital:		
Inpatient	\$250 per admission copay	30
Outpatient	Nothing	30
Emergency benefits:		
In-area	\$100 per emergency room visit	33
Out-of-area	\$100 per emergency room visit	34
Mental health and substance abuse treatment:		
Prescription drugs:	\$15 generic \$30 preferred brand name \$50 non-preferred brand name	37
Dental care:	No benefit.	40
Vision care:	Limited benefit.	21
Special features:	TDD Line: 850/383-3534	39
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$1,500/Self Only or \$3,000/ Family enrollment per year Copayments for prescription drugs do not count toward this protection	13

2007 Rate Information for Capital Health Plan

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

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

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

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

Tallahassee, Fl.

High Option Self Only	EA1	112.45	37.48	243.64	81.21	133.06	16.87
High Option Self and Family	EA2	297.99	99.33	645.65	215.21	352.62	44.7