

Community Blue

www.bcbswny.com and www.bsneny.com

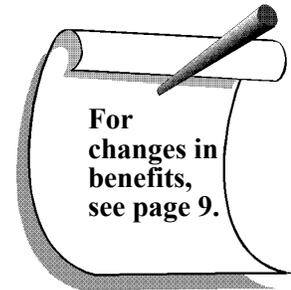
2009

A Health Maintenance Organization

Serving:

Western New York, Northeastern New York (Capital Region),
Northeastern New York (Clinton, Essex)

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



Enrollment code for Northeastern New York- Clinton, Essex:

- BS1 High Option - Self Only
- BS2 High Option - Self and Family

Enrollment code for Western New York:

- BX1 High Option - Self Only
- BX2 High Option - Self and Family

Enrollment code for Northeastern New York- Capital Region:

- BZ1 High Option - Self Only
- BZ2 High Option - 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>



RI 73-857

**Important Notice from Community Blue About
Our Prescription Drug Coverage and Medicare**

OPM has determined that the Community Blue's prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. 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 will coordinate benefits with Medicare.

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

Please be advised

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug 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 most other people pay. You may also have to wait until the next open enrollment period 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	7
General Features of our High Option.....	7
Your Rights	8
Your medical and claims records are confidential	8
Service Area	8
Section 2 We are a new plan for 2009.....	9
Section 3. How you get care	10
Identification cards.....	11
Where you get covered care	11
• Plan providers	11
• Plan facilities	11
What you must do to get covered care	11
• Primary care.....	11
• Specialist care	11
• Hospital care	12
• If you are hospitalized when your enrollment begins.....	12
How to get approval for	12
• Your hospital stay	12
• How to precertify an admission.....	13
• Maternity care.....	13
• What happens when you do not follow the precertification rules when using non-network facilities.....	13
Circumstances beyond our control.....	13
Services requiring our prior approval	13
Section 4 Your costs for covered services.....	13
Copayments.....	14
High Option Benefits	14
High Option Overview	-1
Section 5(a) Medical services and supplies provided by physicians and other health care professionals.....	15
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals	23
Section 5(c) Services provided by a hospital or other facility, and ambulance services	28
Section 5(d) Emergency services/accidents	31
Section 5(e) Mental health and substance abuse benefits	33
Section 5(f) Prescription drug benefits	34
Section 5(g) Dental benefits.....	36
Section 5(h) Special features.....	37
Section 6 General exclusions – things we don’t cover	38
Section 7 Filing a claim for covered services	39
Section 8 The disputed claims process.....	40
Section 9 Coordinating benefits with other coverage	42
When you have other health coverage	50
What is Medicare?	50

• Should I enroll in Medicare?	50
• The Original Medicare Plan (Part A or Part B)	51
• Medicare Advantage (Part C)	51
• Medicare prescription drug coverage (Part D)	52
TRICARE and CHAMPVA	46
Workers' Compensation	46
Medicaid.....	46
When other Government agencies are responsible for your care	46
When others are responsible for injuries.....	46
When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage	46
Section 10 Definitions of terms we use in this brochure	47
Section 11 FEHB Facts	48
Coverage Information	55
• No pre-existing coverage limitation	55
• Where you can get information about enrolling in the FEHB program	55
• Types of coverage available to you and your family	55
• Children's Equity Act.....	55
• When benefits and premiums start	56
• When you retire	56
When you lose benefits	56
• When FEHB coverage ends.....	56
• Upon divorce	57
• Temporary Continuation of Coverage (TCC).....	57
• Converting to individual coverage	57
• Getting a Certificate of Group Health Plan Coverage.....	57
Section 12 Three Federal Programs complement FEHB benefits	51
The Federal Flexible Spending Account Program - FSAFEDS.....	58
The Federal Long Term Care Insurance Program - FLTCIP	58
The Federal Employees Dental and Vision Insurance Program - FEDVIP	59
Summary of benefits for Community Blue - 2009	53
2009 Rate Information for Community Blue.....	54

Introduction

This brochure describes the benefits of under our contract #2817 with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Community Blue's administrative offices is:

Physical Address:

Community Blue
257 West Genesee Street
Buffalo, NY 14202

Mailing Address:

Community Blue
PO Box 80
Buffalo, NY 14240

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, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on page {not applicable as Community Blue was not offered in 2008}. 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 Community Blue.
- 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 fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.

- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 716-884-2800 (WNY)/518-220-5800 (NENY) or 1-800-544-2583 (WNY)/1-800-459-7587(NENY) 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); o
 - 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.

3. Get the results of any test or procedure.

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

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

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

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

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

Want more information on patient safety?

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

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

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

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

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

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

Section 1 Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. 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, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

General features of our High Option

Community Blue is offering a single option which we will refer to as the "High Option" throughout this document.

You will benefit from the following key features and value-added benefits:

\$10 copayment for both primary care and specialist visits

\$0 copayment for well and sick visits for primary care pediatricians (ages: birth-19)

\$0 Generic Oral Contraceptives

Access to a nationwide network of providers while traveling or while temporarily living out of the area.

Community-based health and wellness programs

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

How we pay providers

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

Preventive care services

Preventive care services are generally paid as first dollar coverage or after a small deductible or copayment. First dollar coverage may be limited to a maximum dollar amount each year.

Health education resources and accounts management tools

Your rights

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. 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.

- Not for profit

If you want more information about us, call 716-884-2800 (WNY)/518-220-5800 (NENY) or 1-800-544-2583 (WNY)/1-800-459-7587 (NENY), or write to PO Box 80 Buffalo, NY 14240. You may also contact us by fax at 716-887-6914 (WNY)/518-220-5770 (NENY) or visit our Web site at www.bcbswny.com or www.bsneny.com.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

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:

Western New York:

Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans and Wyoming

Northeastern New York- Capital Region:

Albany, Columbia, Fulton, Greene, Montgomery, Rensselaer, Saratoga, Schenectady, Warren, Washington

Northeastern New York- Clinton, Essex

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 We are a new plan for 2009

This Plan is new to the FEHB Program. We are being offered for the first time during the 2009 Open Season.

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 716-884-2800 (WNY)/518-220-5800 (NENY) or 1-800-544-2583 (WNY)/1-800-459-7587 (NENY) or write to us at PO Box 80 Buffalo, NY 14240. You may also request replacement cards through our Web site: www.bcbswny.com or www.bsneny.com.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance, if you use our point-of-service program, you can also get care from non-Plan providers but it will cost you more. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.

- **Plan facilities**

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

What you must do to get covered care

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

- **Primary care**

Your primary care physician can be a . 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**

Community Blue’s Open Access program allows you to receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

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, except in pre-approved circumstances where there is not a specialist in the network for your condition. 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.

• **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

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 716-884-2800 (WNY)/518-220-5800 (NENY) or 1-800-544-2583 (WNY)/1-800-459-7587 (NENY). If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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 physician will contact us to obtain precertification for the following inpatient procedures:

Bariatric Surgery
Transplant procedures
Other procedures as necessary.

You may call the customer service telephone number on your identification card if you would like to check on the status of your precertification.

- **How to precertify an admission**

Typically, your physician will request precertification for an admission, however, if you would like to verify if the admission request has been submitted and/or approved, simply call the customer service telephone number on the back of your identification card.

- **Maternity care**

It is not necessary to seek precertification for a standard maternity admission.

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

Non-network facilities are only payable in emergency situations. If you choose to have non-emergency services rendered at a non-network facility, you will be responsible for all charges. In very rare cases where a network facility does not exist to treat a certain condition, your physician may request an out-of-network referral.

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process prior authorization. Your physician must obtain prior authorization for the following::

Growth hormone therapy (GHT)

Magnetic Resonance Imaging (MRI)

Magnetic Resonance Angiography (MRA)

Computerized Axial Tomography (CAT) Scans

Positron Emission Tomography (PET) Scans

Transplant Services

Non-emergency services to be performed by a non-participating provider

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 certain services.

Example: When you see your primary care physician you pay a copayment of \$10 per office visit and when you go in the hospital, you pay \$250 per admission.

Cost-sharing Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g. deductible, coinsurance, and copayments) for the covered care you receive.

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

Note: Community Blue High Option does not have a deductible

Coinsurance Coinsurance is the percentage of our allowance that you must pay for your care. This only applies for select services, including:

Durable medical equipment (50% coinsurance)

Prosthetics and orthotics (50% coinsurance).

Your catastrophic protection out-of-pocket maximum

Does not apply to Community Blue High Option.

Differences between our Plan allowance and the bill

When using a network provider for covered services, charges in excess of our allowed amount cannot be billed to you.

Example: We allow \$100 for a service that your network physician typically charges \$150 for. Because your physician is in our network, he/she will not bill you for the difference between the charges of \$150 and our allowance of \$100. You will only be responsible for any applicable copayment or coinsurance.

When Government Facilities Bill Us

Facilities of the Department of Government Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement for certain services and supplies they provide to you or a family member. They may not seek more than the governing laws allow

High Option Benefits

Page 55 is the Summary of Benefits of the High Option. Make sure you review the benefits that are available.

High Option Overview-1

Section 5(a) Medical services and supplies provided by physicians and other health care professionals.....15

 Diagnostic and treatment services.....15

 Lab, X-ray and other diagnostic tests.....15

 Preventive care, adult.....16

 Preventive care, children.....17

 Maternity care17

 Family Planning17

 Infertility services17

 Allergy care.....18

 Treatment therapies.....18

 Physical and occupational therapies19

 Speech therapy19

 Hearing services (testing, treatment, and supplies).....19

 Vision services (testing, treatment, and supplies).....19

 Foot care.....20

 Orthopedic and prosthetic devices20

 Durable medical equipment (DME).....21

 Home health services21

 Chiropractic.....21

 Alternative treatments22

 Educational classes and programs.....22

Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals23

 Surgical procedures.....23

 Reconstructive surgery.....24

 Oral and maxillofacial surgery.....25

 Organ/tissue transplants25

 Anesthesia27

Section 5(c) Services provided by a hospital or other facility, and ambulance services28

 Inpatient hospital.....28

 Outpatient hospital or ambulatory surgical center29

 Extended care benefits/Skilled nursing care facility benefits30

 Hospice care.....30

 Ambulance30

Section 5(d) Emergency services/accidents31

 Emergency within our service area31

 Emergency outside our service area.....31

 Ambulance32

Section 5(e) Mental health and substance abuse benefits33

 In-Network benefits33

Section 5(f) Prescription drug benefits34

 Covered medications and supplies.....34

Section 5(g) Dental benefits.....36

Section 5(h) Special features.....37

Summary of benefits for Community Blue - 200953

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	High Option
Professional services of physicians <ul style="list-style-type: none"> • In physician's office 	\$10 per office visit \$10 per visit to your primary care physician \$10 per visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion • At home 	\$10 per office visit You pay nothing when physician services are provided in the hospital.
Not Covered: Experimental or Investigational Services	<i>All charges.</i>
Lab, X-ray and other diagnostic tests	High Option
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap test s • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing if you receive these services during your office visit; otherwise, \$10 per office visit

Benefit Description	You Pay
Preventive care, adult	High Option
Routine physical every year which includes: Routine screenings, limited to: <ul style="list-style-type: none"> • Total Blood Cholesterol • Chlamydial infection • Colorectal Cancer Screening, including • 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 	\$10 per office visit \$10 per PCP visit \$10 per specialist visit \$75 in outpatient department of a hospital or ambulatory surgical facility
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	\$10 per office visit
Routine Pap test Note: You do not pay a separate copayment for a Pap test performed during your routine annual examination	\$10 per office visit
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): <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older 	\$10 per office visit
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	<i>All charges.</i>

Benefit Description	You Pay
Preventive care, children	High Option
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics 	Covered in full if provided by primary pediatrician.
For well-child care charges for routine examinations, immunizations and care (to age 3)	\$10 per office visit
<ul style="list-style-type: none"> Examinations, limited to: Examinations for amblyopia and strabismus – limited to one screening examination (ages 2 through 6) Examinations done on the day of immunizations (ages 3 up to age 22) 	\$10 per office visit
Maternity care	High Option
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> Prenatal care Delivery Postnatal care 	\$10 for initial visit. Remainder of maternity care is covered in full after \$250 copayment for the maternity hospital stay
<i>Not covered:</i>	<i>All charges.</i>
Family Planning	High Option
A range of voluntary family planning services, limited to: <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 Note: We cover oral contraceptives under the prescription drug benefit.	\$10 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> <i>Reversal of voluntary surgical sterilization</i> <i>Genetic counseling</i> 	<i>All Charges.</i>
Infertility services	High Option
Diagnosis and treatment of infertility, except as shown in <i>Not covered</i> .	\$10 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> <i>Infertility services after voluntary sterilization</i> <i>Fertility drugs</i> <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> <i>artificial insemination</i> <i>in vitro fertilization</i> 	<i>All Charges.</i>

Infertility services - continued on next page

Benefit Description	You Pay
Infertility services (cont.)	High Option
<ul style="list-style-type: none"> • <i>embryo transfer and gamete intra-fallopian transfer (GIFT)</i> • <i>intraovaginal insemination (IVI)</i> • <i>intra-cervical insemination (ICI)</i> • <i>intrauterine insemination (IUI)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg .</i> 	<i>All Charges.</i>
Allergy care	High Option
<ul style="list-style-type: none"> • Testing and treatment, including materials (such as allergy serum) • Allergy injections 	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<i>All charges.</i>
Treatment therapies	High Option
<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 on page 25.</p> <ul style="list-style-type: none"> • 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. Call for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Other services</i> under <i>How to get approval for ...</i> in Section 3.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapies 	\$10 per office visit
<i>Not covered:</i>	<i>All Charges.</i>

Benefit Description	You Pay
Physical and occupational therapies	
<ul style="list-style-type: none"> 60 aggregate visits per calendar year for the services of each of the following: <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 and when a physician:</p> <ul style="list-style-type: none"> orders the care; identifies the specific professional skills the patient requires and the medical necessity for skilled services; and indicates the length of time the services are needed. 	\$10 per office visit \$10 per outpatient visit Nothing per visit during covered inpatient admission
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Long-term rehabilitative therapy Exercise programs 	<p><i>All Charges.</i></p>
Speech therapy	
<ul style="list-style-type: none"> 60 visits per calendar year 	\$10 per office visit \$10 per outpatient visit Nothing per visit during covered inpatient admission.
<p><i>Not covered:</i></p>	<p><i>All Charges.</i></p>
Hearing services (testing, treatment, and supplies)	
First hearing aid and testing only when necessitated by accidental injury	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Hearing testing Hearing aids, testing and examinations for them, except for accidental injury 	<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) <p>Note: See <i>Preventive care, children</i> for eye exams for children</p>	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Eyeglasses or contact lenses and examinations for them, except as shown above Eye exercises and orthoptics 	<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.)	High Option
<ul style="list-style-type: none"> • <i>Radial keratotomy and other refractive surgery</i> 	<i>All Charges.</i>
Foot care	High Option
<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>	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<i>All Charges.</i>
Orthopedic and prosthetic devices	High Option
<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. <p>Note: See 5(b) for coverage of the surgery to insert the device.</p>	<p>\$10 per office visit</p> <p>50% coinsurance of plan allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Prosthetic replacements provided less than X years after the last one we covered</i> 	<i>All Charges.</i>

Benefit Description	You Pay
Durable medical equipment (DME)	High Option
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. <p>Note: Call us at 716-884-2800 (WNY)/518-220-5800 (NENY) or 1-800-544-2583 (WNY)/1-800-459-7587 (NENY) as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	50% of the plan allowance
Home health services	High Option
<p>90 days per calendar year up to a maximum plan payment of \$75 per day when:</p> <ul style="list-style-type: none"> • A registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) provides the services; • The attending physician orders the care; • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services ; and • The physician indicates the length of time the services are needed. 	\$10 per office visit
<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	High Option
<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 	\$10 per office visit

Benefit Description	You Pay
Alternative treatments	High Option
Acupuncture – by a doctor of medicine or osteopathy for: anesthesia, pain relief	\$10 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> • Biofeedback 	<i>All Charges.</i>
Educational classes and programs	High Option
Coverage is limited to: <ul style="list-style-type: none"> • Smoking Cessation – Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. • Diabetes self management. 	\$10 per office visit

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.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. 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.).
- **YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You Pay
Surgical procedures	High Option
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • 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 • Electroconvulsive therapy • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) 	\$10 per office visit
<ul style="list-style-type: none"> • 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 • Insertion of internal prosthetic devices . See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Surgically implanted contraceptives • Intrauterine devices (IUDs) • Treatment of burns • Assistant surgeons- we cover up to 25% of our allowance for the surgeon's charge 	\$10 per office visit

Surgical procedures - continued on next page

Benefit Description	You Pay
Surgical procedures (cont.)	High Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> 	<i>All Charges.</i>
Reconstructive surgery	High Option
<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 <i>Prosthetic devices</i> for coverage) 	\$10 per office visit
<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 if repair is initiated within</i> • <i>Surgeries related to sex transformation or sexual dysfunction</i> 	<i>All Charges.</i>

Benefit Description	You Pay
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 • Other surgical procedures that do not involve the teeth or their supporting structures 	\$10 per office visit
<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 subject to medical necessity and experimental/investigational review. Refer to <i>Other services</i> in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description.</p> <ul style="list-style-type: none"> • Heart • Cornea • Heart/lung • Single, double or lobar lung • Kidney • Liver • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Intestinal transplants • Small intestine • Small intestine with the liver • Small intestine with multiple organs, such as the liver • Lung • Single/bilateral/lobar 	Nothing
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses:</p> <ul style="list-style-type: none"> • Allogeneic transplants for 	Nothing

Organ/tissue transplants - continued on next page
Section 5(b)

Benefit Description	You Pay
Organ/tissue transplants (cont.)	High Option
<ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	<i>All Charges.</i>
Anesthesia	High Option
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 • Office 	Nothing

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.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. 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).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM \$500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

Benefit Description	You Pay
Inpatient hospital	High Option
<p>Room and board, such as</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>Note: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, we base our payment on the average semiprivate rate of the most comparable hospital in the area.</p> <p>Note: When the non-PPO hospital bills a flat rate, we prorate the charges to determine how to pay them, as follows: 30% room and board and 70% other charges.</p>	\$250 per admission
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • 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.) 	\$250 per admission

Benefit Description	You Pay
Inpatient hospital (cont.)	High Option
<p>Note: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay Hospital benefits and when the anesthesiologist bills, we pay Surgery benefits.</p>	\$250 per admission
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Any part of a hospital admission that is not medically necessary(see definition), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting</i> • <i>Custodial care; see definition.</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>Private nursing care</i> 	<i>All Charges.</i>
Outpatient hospital or ambulatory surgical center	High Option
<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>	\$75 copayment
<p>Not covered: Blood and blood derivatives not replaced by the member</p>	<i>All Charges.</i>

Benefit Description	You Pay
Extended care benefits/Skilled nursing care facility benefits	High Option
<p>Skilled nursing facility (SNF): We cover semiprivate room, board, services and supplies in a SNF for up to 30 days per confinement when:</p> <ul style="list-style-type: none"> • You are admitted directly from a precertified hospital stay of at least 3 consecutive days; and • You are admitted for the same condition as the hospital stay; and • Your skilled nursing care is supervised by a physician and provided by an R.N., L.P.N., or L.V.N.; and • SNF care is medically appropriate. 	Nothing
Extended care benefit:	Nothing
Skilled nursing facility (SNF):	Nothing
<i>Not Covered: Custodial care</i>	<i>All Charges.</i>
Hospice care	High Option
	Nothing.
<i>Not covered: Independent nursing, homemaker services.</i>	<i>All Charges.</i>
Ambulance	High Option
<ul style="list-style-type: none"> • Local professional ambulance service when medically appropriate 	\$50

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, with special sections for members who are age 65 or over. 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:

Emergencies within our service area-Go to the nearest Emergency Room. Follow up with your Primary Care Physician to advise of your condition and for any follow up care that may be needed.

Emergencies outside our service area-Go to the nearest Emergency Room. Follow up with your Primary Care Physician to advise of your condition and for any follow up care that may be needed.

Benefit Description	You pay
Emergency within our service area	High Option
<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>Note: We waive the ER copay if you are admitted to the hospital.</p>	<p>\$10 per visit at a doctor’s office</p> <p>\$35 per visit at an urgent care center</p> <p>\$50 per visit in the ER of a hospital</p>
Not covered: Elective care or non-emergency care	All charges
Emergency outside our service area	High Option
<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>Note: We waive the ER copay if you are admitted to the hospital.</p>	<ul style="list-style-type: none"> • \$10 per visit at a doctor’s office <p>\$35 per visit at an urgent care center \$50 per visit in the ER of a hospital</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> 	All charges

Benefit Description	You pay
Emergency outside our service area (cont.)	High Option
Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area	All charges
Ambulance	High Option
Professional ambulance service Note: See 5(c) for non-emergency service.	\$50
<i>Not covered: Air ambulance</i>	<i>All Charges.</i>

Section 5(e) Mental health and substance abuse benefits

When you receive In-Network care, you must get our approval for services and follow a treatment plan we approve. If you do, cost-sharing and limitations for In-Network 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 descriptions below.

Benefit Description	You Pay
In-Network benefits	High Option
<p>All diagnostic and treatment services 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: In-Network 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>	<p>Your cost sharing responsibilities are no greater than for other illnesses or conditions.</p>
<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 	<p>\$10 per visit</p>
<p>Diagnostic tests</p>	<p>\$10 per visit</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>Standard inpatient hospital copayment of \$250 applies</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>	<p><i>All Charges.</i></p>

Lifetime maximum

Out-of-Network inpatient care for the treatment of alcoholism and drug abuse is limited to one treatment program (28-day maximum) per lifetime.

Precertification

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive these Out-of-Network benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by \$500. See Section 3 for details.

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.
- 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, with special sections for members who are age 65 or over. 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 licensed physician must write the prescription – or – A plan physician or licensed dentist must write the prescription.

Where you can obtain them. You may fill the prescription at an in-network pharmacy or by mail. We pay a higher level of benefits when you use a network pharmacy. – or – You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication.

We use a formulary.

We have 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. To order a prescription drug brochure, call 1-800-544-2583 (WNY) or 1-800-459-7587 (NENY).

These are the dispensing limitations

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.

Why use generic drugs?

When you do have to file a claim.

Benefits Description	You Pay
Covered medications and supplies	High Option
<p>Each new enrollee will receive a description of our prescription drug program, a combined prescription drug/Plan identification card, a mail order form/patient profile and a preaddressed reply envelope.</p> <p>You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail:</p> <ul style="list-style-type: none"> • Plan specific • Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as Not covered. • Insulin 	<p>\$5 per generic, formulary drug at a retail pharmacy (up to a 30 day supply)</p> <p>\$30 per brand name, formulary drug at a retail pharmacy (up to a 30 day supply)</p> <p>\$50 per non-formulary drug at a retail pharmacy (up to a 30 day supply)</p> <p>\$12.50 per generic, formulary drug through our mail order pharmacy (up to a 90 day supply—2.5 x retail copay)</p> <p>\$75 per brand name, formulary drug through our mail order pharmacy (up to a 90 day supply—2.5 x retail copay)</p> <p>\$125 per non-formulary drug through our mail order pharmacy (up to a 90 day supply—2.5 x retail copay)</p>

Covered medications and supplies - continued on next page

Benefits Description	You Pay
Covered medications and supplies (cont.)	High Option
<ul style="list-style-type: none"> • Needles and syringes for the administration of covered medications • Contraceptive drugs and devices 	<p>\$5 per generic, formulary drug at a retail pharmacy (up to a 30 day supply)</p> <p>\$30 per brand name, formulary drug at a retail pharmacy (up to a 30 day supply)</p> <p>\$50 per non-formulary drug at a retail pharmacy (up to a 30 day supply)</p> <p>\$12.50 per generic, formulary drug through our mail order pharmacy (up to a 90 day supply—2.5 x retail copay)</p> <p>\$75 per brand name, formulary drug through our mail order pharmacy (up to a 90 day supply—2.5 x retail copay)</p> <p>\$125 per non-formulary drug through our mail order pharmacy (up to a 90 day supply—2.5 x retail copay)</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</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> 	<p><i>All Charges.</i></p>

Section 5(g) 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.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Note: 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. We do not cover the dental procedure. See Section 5 (c) for inpatient hospital benefits.

Accidental injury benefit	You Pay
Accidental injury benefit	High Option
<p>We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.</p>	<p>At a physician’s office, a \$10 copayment applies.</p> <p>At an outpatient/ambulatory facility, a \$75 copayment applies.</p> <p>At an inpatient facility a \$250</p>

Dental benefits

We have no other dental benefits.

Section 5(h) Special features

Feature	Description
Online Services	<p>Our Online Services system available through our website allows you to:</p> <ul style="list-style-type: none"> • Receive free e-newsletters with articles on a range of health topics • Search for both local and out-of-area providers • Look up the status of a prescription drug • Order ID cards • Change address • Access an online member guide, specific to your benefits (only available on insured products) • Change your primary care physician • Review claims history • Access frequently used forms <p>You will also have access to our <i>MyHealth</i> online wellness portal which will assist you in identifying opportunities to maintain and improve your health through health risk assessments, personal health history, claims information and a number of other key factors.</p>
Services for the deaf and hearing impaired	Members may reach our TDD line at 716-886-7863 (WNY)/1-877-513-1470 (NENY).
Reciprocity benefit	We have reciprocal arrangements with BlueCross BlueShield plans across the country to provide coverage under a “Guest Membership” for students away at school or covered members temporarily living outside of our coverage area.
High risk pregnancies	Our Right Start Program is designed to give mothers the information they need to take care of themselves and their babies during and after pregnancy. Information is provided to the expectant mother to help her understand nutritional needs, recognize the symptoms of pre-term labor, understand the stages of pregnancy, and answer questions that may arise.
Centers of excellence	In collaboration with the BlueCross BlueShield Association, we participate in Blue Centers of Distinction. Our programs currently include cardiac surgery, rare/complex cancers and Bariatric surgery. Transplant services are accessed through the Association’s BCQT network.
Travel benefit/services overseas	Through the BlueCard® Worldwide program, we are able to offer care in more than 200 countries nationwide.

Section 6 General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **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** (see specifics regarding transplants).

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 (see specifics regarding transplants);
- 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 7 Filing a claim for covered services

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 1-800-544-2583 (WNY) or 1-800-459-7587 (NENY).

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

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

Submit your claims to: Community Blue, P.O. Box 80, Buffalo, NY 14240-0080

Prescription drugs

Submit your claims to: Medco Health Solutions, Inc., P.O. Box 14711, Lexington, KY 40512

Other supplies or services

Submit your claims to: Community Blue P.O. Box 80, Buffalo, New York 14240-0080

Deadline for filing your claim

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

When we need more information

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

Section 8 The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3. Disagreements between you and the CDHP or HDHP fiduciary regarding the administration of an HSA or HRA are not subject to the disputed claims process.

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: Community Blue P.O. Box 80, Buffalo, New York 14240-0080; 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</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>

Step	Description
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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 1-800-844-2583 (WNY) or 1-800-459-7587 (NENY) 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 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9 Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you 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.

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 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.

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

Claims process when you have the Original Medicare Plan – You 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. To find out if you need to do something to file your claim, call us at 716-884-2800 (WNY)/518-220-5800 (NENY) or 1-800-544-2583 (WNY)/1-800-459-7587 (NENY) or see our Web site at www.bcbswny.com or www.bsneny.com.

We waive some costs if the Original Medicare Plan is your primary payer – We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other health care professionals.

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:

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, coinsurance, or deductibles. 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.

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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

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		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) 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 #3 above	✓	
5) 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	✓	
6) 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 #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓ *	
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	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD (for the 30 month coordination period)		✓
• Medicare based on ESRD (after the 30 month coordination period)	✓	
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.

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.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/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.

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.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services.
Covered services	Care we provide benefits for, as described in this brochure.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services.
Experimental or investigational service	<p>Experimental or investigational means that we determine the service is not of proven benefit for the particular diagnosis or treatment of your particular condition, or not generally recognized by the medical community as reflected in the published peer-review medical literature as effective or appropriate for this particular diagnosis or treatment of your particular condition.</p> <p>Governmental approval of a service will be considered, but is not necessarily sufficient, to render a service of proven benefit or appropriate or effective for a particular diagnosis or treatment of your particular condition.</p>
Group health coverage	Coverage sponsored by an employer group with whom we have a group health insurance contract.
Medical necessity	Care which has a proven benefit for the particular diagnosis or treatment of your particular condition that has been broadly recognized by the medical community as reflected in the published peer-review medical literature as effective or appropriate for this particular diagnosis or treatment of your particular condition.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. Community Blue determines our allowances through negotiations with providers in our network.
Us/We	Us and We refer to Community Blue.
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 you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the 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 2009 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 2008 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 one day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temp extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement not beyond the 60th day after the end of the end of 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 for 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 Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

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

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents, which are not covered or reimbursed by FEHBP or FEDVIP coverage or any 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 any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

Where can I get more information about FSAFEDS?

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.

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

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

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

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, 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 up to a 24-month waiting period

Vision Insurance

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

Additional Information

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

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877- 889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP***It's important protection**

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. 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. 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. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Summary of benefits for Community Blue - 2009

- **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.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$10 \$10primary care; \$10specialist	15
Services provided by a hospital:		
• Inpatient	\$250 per admission copay	28
• Outpatient	\$75 per visit	29
Emergency benefits:	\$50 per occurrence	31
Mental health and substance abuse treatment:	Regular cost sharing	33
Prescription drugs:		
• Retail pharmacy	\$5/\$30/\$50 per 30 day supply	34-35
• Mail order	2.5 copayments per 90 days supply	34-35
Dental care:	No benefit.	36
Vision care:	\$10 per office visit.	19-20
Special features:		37

2009 Rate Information for Community Blue

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the Guide to Federal Benefits 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 Guide to Benefits *for Career United States Postal Service Employees*, RI 70-2, and to the rates shown below.

The rates shown below do not apply to *Postal Service Inspectors*, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

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 Guide to Federal Benefits.

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

Northeastern New York: Clinton, Essex

High Option Self Only	BS1	\$155.66	\$141.35	\$337.26	\$306.26	\$179.45	\$117.56
High Option Self and Family	BS2	\$352.56	\$444.40	\$763.88	\$962.87	\$406.42	\$390.54

Western New York

High Option Self Only	BX1	\$155.66	\$63.37	\$337.26	\$137.31	\$179.45	\$39.58
High Option Self and Family	BX2	\$352.56	\$253.66	\$763.88	\$549.60	\$406.42	\$199.80

Northeastern New York: Capital Region

High Option Self Only	BZ1	\$155.66	\$122.11	\$337.26	\$264.58	\$179.45	\$98.32
High Option Self and Family	BZ	\$352.56	\$392.79	\$763.88	\$851.05	\$406.42	\$338.93