# Blue Choice

http://www.excellusbcbs.com

Excellus

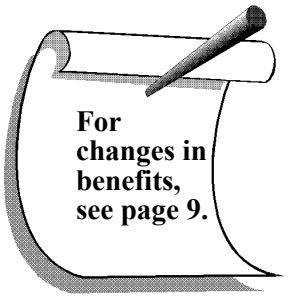
A nonprofit independent licensee of the BlueCross BlueShield Association

# 2012

## A Health Maintenance Organization (High and Standard Option)

**Serving: The New York Counties of Monroe, Livingston, Wayne, Ontario, Seneca and Yates.**

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




**Enrollment codes for this Plan:**

**MK1 High Self Only**

**MK2 High Self and Family**

**MK4 Standard Self Only**

**MK5 Standard Self and Family**

***This Plan has an Excellent Accreditation from the National Committee for Quality Assurance (NCQA), an independent, non-profit organization dedicated to improving health care quality and service. See the 2012 guide for more information on accreditation.***

Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

**Important Notice from Blue Choice About**

**Our Prescription Drug Coverage and Medicare**

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

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan 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.

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**Please be advised**

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If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15th through December 7th) 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 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
- How we pay providers ....7
- Your rights ....7
- Your medical and claims records are confidential ....8
- Service Area ....8

Section 2. How we change for 2012 ....9
- Program-wide changes ....9
- Changes to this Plan ....9

Section 3. How you get care ....10
- Identification cards ....10
- Where you get covered care ....10
  - Plan providers ....10
  - Plan facilities ....10
- What you must do to get covered care ....10
  - Primary care ....10
  - Specialty care ....10
  - Hospital care ....11
  - If you are hospitalized when your enrollment begins ....11
- You need prior Plan approval for certain services ....11
  - Inpatient hospital admission ....11
  - How to request precertification for an admission or get prior authorization for Other services ....-1
  - Maternity care ....13
  - To file an appeal with OPM ....14
  - How to request precertification for an admission or get prior authorization for Other services ....12
  - Other services ....12

Section 4. Your costs for covered services ....15
- Copayments ....15
- Cost-sharing ....15
- Deductible ....15
- Coinsurance ....15
- Your catastrophic protection out-of-pocket maximum ....15
- When Government facilities bill us ....15

Section 5. Benefits ....14
- High and Standard Options Benefits ....16
- Non-FEHB benefits available to Plan members ....46

Section 6. General exclusions – things we don't cover ....47
Section 7. Filing a claim for covered services ....48
Section 8. The disputed claims process ....50
Section 9. Coordinating benefits with other coverage ....52
- When you have other health coverage ....52
- What is Medicare? ....52

- Should I enroll in Medicare? ....52
- The Original Medicare Plan (Part A or Part B) ....53
- Tell us about your Medicare coverage ....53
- Medicare Advantage (Part C) ....54
- Medicare prescription drug coverage (Part D) ....54

TRICARE and CHAMPVA ....56
Workers' Compensation ....56
Medicaid ....56
When other Government agencies are responsible for your care ....56
When others are responsible for injuries ....56
When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage ....56
Clinical Trials ....56

Section 10. Definitions of terms we use in this brochure ....58
Section 11. FEHB Facts ....60

Coverage Information ....60
- No pre-existing condition limitation ....60
- Where you can get information about enrolling in the FEHB Program ....60
- Types of coverage available for you and your family ....60
- Children's Equity Act ....61
- When benefits and premiums start ....62
- When you retire ....62

When you lose benefits ....62
- When FEHB coverage ends ....62
- Upon divorce ....62
- Temporary Continuation of Coverage (TCC) ....62
- Converting to individual coverage ....63
- Getting a Certificate of Group Health Plan Coverage ....63

Section 12. Other Federal Programs ....64

The Federal Flexible Spending Account Program - FSAFEDS ....58
The Federal Employees Dental and Vision Insurance Program - FEDVIP ....58
The Federal Long Term Care Insurance Program - FLTCIP ....59

Index ....68
Summary of benefits for Blue Choice High Option - 2012 ....69
Summary of benefits for Blue Choice Standard Option - 2012 ....70
2012 Rate Information for Blue Choice ....74

# Introduction

This brochure describes the benefits of Blue Choice under our contract (CS 2506) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for the Blue Choice administrative office is:

Excellus BlueCross BlueShield - Blue Choice
165 Court St
Rochester, NY 14647

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, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each Plan annually. Benefit changes are effective January 1, 2012, and changes are summarized on page 9. Rates are shown at the end of this brochure.

# Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means Blue Choice.
- 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, Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and Systems Support, 1900 E Street, NW, Washington, DC 20415-3650.

# Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Please review your claims history periodically to ensure services are not being billed to your accounts that were never rendered.

- 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 585-238-4466 and explain the situation.
  - If we do not resolve the issue:

**CALL - THE HEALTH CARE FRAUD HOTLINE**

**202-418-3300**

**OR WRITE TO:**

**United States Office of Personnel Management**

**Office of the Inspector General Fraud Hotline**

**1900 E Street NW Room 6400**

**Washington, DC 20415-1100**

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child age 26 or over (unless he/she is disabled and incapable of self-support prior to age 26).
- 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 if you are no longer enrolled in the Plan.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly by your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

## Preventing Medical Mistakes

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

**1. Ask questions if you have doubts or concerns.**

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

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

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

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

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

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

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

**Patient Safety Links**

- www.ahrq.gov/consumer/**.** 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/**.** 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.

**Never Events**

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use Blue Choice preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs, neither your FEHB plan nor you will incur costs to correct the medical error.

# 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 the most recent provider directory. We give you a choice of enrollment in a High Option or a Standard Option Plan.

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.**

Questions regarding what protections apply and what protections do not apply to a grandfathered health plan, and what might cause a plan to change status from grandfathered to non-grandfathered may be directed to us at 1-800-462-0108. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

This plan is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

## 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.

## Your rights

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

There are New York state laws that Excellus BlueCross BlueShield administers to protect your private health information.

Excellus BlueCross BlueShield is a non-profit organization.

Excellus BlueCross BlueShield, has been serving the Rochester community for over 70 years, with products such as Blue Choice. Blue Choice is a Health Maintenance Organization (HMO) that emphasizes comprehensive medical, surgical and preventive care through a network of more than 3,000 area physicians in private offices and multi-specialty group practices at the Plan's four health centers. Blue Choice is Rochester's leader in quality. That means you get first-class coverage with the value you need.

Each member selects his or her own primary care doctor from within the private office option or from the medical center option. Members of the same family can select different delivery systems. To be eligible for coverage, all services, except for emergency care, must be provided, arranged, or authorized in advance by the member's primary care physician.

A woman may see her Plan obstetrician/gynecologist or certified nurse midwife directly with no need to be referred by her primary care doctor. Routine exams are limited to two per year.

Benefits for urgent care outside of this Plan's provider network may be covered. This Plan also offers a Guest Membership through the Away From Home Care® Program, a network of BlueCross and BlueShield HMOs that can coordinate your medical care. A Guest Membership is a courtesy enrollment for members who are temporarily residing outside of their Home HMO service area for at least 90 days.

The Away From Home Care® Program is available in most states and the District of Columbia. This benefit is designed to bring you peace of mind if you have one of the following situations:

- **Students -** Dependent attending school outside of the HOME HMO service area.
- **Families Apart -** Family members living in different HMO service areas
- **Long-Term Traveler -** Long Term Work assignment ,Extended Vacation or retirees with a dual residence outside of the HOME HMO service area.

If you want more information about us, call 800-462-0108, or write to Blue Choice Member Services, 165 Court Street, Rochester, NY 14647. You may also contact us by fax at 585-238-3659 or visit our website at www.excellusbcbs.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 includes: **Monroe, Livingston, Wayne, Ontario, Seneca and Yates Counties in New York State**.

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

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

# Section 2. How we change for 2012

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

**Program-wide changes**

- Sections 3, 7 and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public Law 111-148.

**Changes to our Blue Choice High Option only, Codes MK1 and MK2**

- Your share of the non-Postal premium will **decrease** for Blue Choice High Option Self Only and **decrease** for Blue Choice High Option Self and Family. (See page 74.)
- There are no proposed benefit changes for Blue Choice High Option in 2012.

**Changes to our Blue Choice Standard Option only, MK4 and MK5**

- Your share of the non-Postal premium will **decrease** for Blue Choice Standard Option Self Only and **decrease** for Blue Choice Standard Option Self and Family.(See page 74).
- The prescription drug benefits will change as follows:

  Retail for 30 day supply;

  - Tier 1 - Generic **decreasing** from $10 to $7
  - Tier 2 – Preferred brand increasing from $30 to $50
  - Tier 3 – Non-preferred brand increasing from $50 to $100

  Mail Order for 90 day

  - Tier 1 - Generic **decreasing** from $20 to $14
  - Tier 2 – Preferred brand increasing from $60 to $100
  - Tier 3 – Non-preferred brand increasing from $100 to $200

# Section 3. How you get care

**Identification cards**

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your 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 800-462-0108 or write to us at 165 Court Street, Rochester, NY 14647. You may also request replacement cards through our Web site at www.excellusbcbs.com

**Where you get covered care**

You are covered for care received from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance.

- **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 at www.excellusbcbs.com.

- **Plan facilities**

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

**What you must do to get covered care**

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. To determine if a physician is a participating provider and accepting new patients, you can refer to our Provider Directory or contact us at 800-462-0108.

- **Primary care**

Your primary care physician can be a family practitioner, internal medicine provider, pediatrician, general medicine provider or obstetrician/gynecologist. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see an eye doctor once every 12 months or an acupuncturist without a referral.

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

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals.

Your primary care physician will create 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. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - 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 800-462-0108. 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;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

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

**You need prior Plan approval for certain services**

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval process only applies to care shown under *Other services.*

- **Inpatient hospital admission**

**Precertification** is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

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

We call this review and approval process *precertification.* Your physician must obtain precertification for the following services:

1. Air ambulance,
2. All inpatient admissions,
3. All referrals to non-participating providers,
4. Ambulatory surgery,
5. Chemotherapy and radiation treatment,
6. Colonoscopy and endoscopy procedures,
7. Durable Medical Equipment including diabetic equipment,
8. Home health care,
9. Home infusion therapy,
10. Inpatient physical rehabilitation,
11. Kidney dialysis,
12. Magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), and cat scans,
13. Mental health services,
14. Nutritional counseling,
15. Organ and bone marrow transplants,
16. Outpatient alcohol or drug abuse,
17. Pain management,
18. Occupational, speech and physical therapy,
19. Skilled nursing facility care, and
20. Sleep apnea studies.

**How to request precertification for an admission or get prior authorization for Other services**

First, your physician, your hospital, you, or your representative, must call us at 800-462-0108 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and

number of planned days of confinement.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the time end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

- **Emergency inpatient admission**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

You do not need a referral from your primary care physician for maternity care; however, the care must be received from a Participating Provider for you to receive benefits.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

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

**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.

**If you disagree with our pre-service claim decision**

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must to follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or

2. Ask you or your provider for more information.

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

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

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

## Section 4. Your costs for covered services

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

| | |
|---|---|
| **Copayments** | A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc. when you receive services.<br><br>Example: Under High Option, when you see your primary care physican you pay a copayment of $20 per office visit and when you go in the hospital, you pay a $240 copay. |
| **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** | We do not have a deductible. |
| **Coinsurance** | Coinsurance is the percentage of our negotiated fee that you must pay for your care.<br><br>Example: In our Plan, you pay 50% of our allowance for acupuncture services and 50% for prosthetic and orthopedic devices. |
| **Your catastrophic protection out-of-pocket maximum** | We do not have a catastrophic protection out-of-pocket maximum. |
| **When Government facilities bill us** | Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information. |

# High and Standard Options Benefits

See page 9 for how our benefits changed this year. Page 69 and page 70 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.


Section 5. High and Standard Option Benefits Overview ....18
Section 5(a). Medical services and supplies provided by physicians and other health care professionals ....19
- Diagnostic and treatment services ....19
- Lab, X-ray and other diagnostic tests ....19
- Preventive care, adult ....20
- Preventive care, children ....20
- Maternity care ....20
- Family planning ....21
- Infertility services ....21
- Allergy care ....22
- Treatment therapies ....22
- Physical and occupational therapies ....23
- Speech therapy ....23
- Hearing services (testing, treatment, and supplies) ....23
- Vision services (testing, treatment, and supplies) ....24
- Foot care ....24
- Orthopedic and prosthetic devices ....24
- Durable medical equipment (DME) ....25
- Home health services ....25
- Chiropractic ....26
- Alternative treatments ....26
- Educational classes and programs ....26

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals ....27
- Surgical procedures ....27
- Reconstructive surgery ....28
- Oral and maxillofacial surgery ....29
- Organ/tissue transplants ....29
- Anesthesia ....34

Section 5(c). Services provided by a hospital or other facility, and ambulance services ....35
- Inpatient hospital ....35
- Outpatient hospital or ambulatory surgical center ....36
- Extended care benefits/Skilled nursing care facility benefits ....36
- Rehabilitation Hospital ....36
- Hospice care ....37
- Ambulance ....37

Section 5(d). Emergency services/accidents ....38
- Emergency within our service area ....39
- Emergency outside our service area ....39
- Ambulance ....39

Section 5(e). Mental health and substance abuse benefits ....40
- Professional Services ....38
- Diagnostics ....39
- Inpatient hospital or other covered facility ....39
- Outpatient hospital or other covered facility ....39

Not covered ....39
Section 5(f). Prescription drug benefits ....42
Covered medications and supplies ....43
Section 5(g). Dental benefits ....44
Accidental injury benefit ....44
Section 5(h). Special features ....45
Flexible benefits option ....45
Reciprocity benefit ....45
Centers of Excellence ....45
Non-FEHB benefits available to Plan members ....46
Summary of benefits for Blue Choice High Option - 2012 ....69
Summary of benefits for Blue Choice Standard Option - 2012 ....70

## Section 5. High and Standard Option Benefits Overview

This Plan offers a Health Maintenance Organization (HMO) called Blue Choice. Our benefit package is described in Section 5. Make sure that you review the benefits carefully.

Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the General exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filling advice, or more information about Blue Choice benefits, contact us at 800-462-0108 or at our Web site at www.excellusbcbs.com.

- **High Option and Standard Option**

Our benefit package offers the following unique features:

- **Free preventative care ( See benefits on page 20)**
- **Annual eye exams and $60 allowance** towards eyeglasses or contacts annually under High Option.
- **Eye exams and $60 allowance towards eyeglasses or contacts every 2 years** under Standard Option. ( Annually for children up to age 19)
- **AfterHours Program at Lifetime Health Medical Group locations.** Your primary care physician does not need to be one of the Lifetime Health Medical Group physicians to utilize the AfterHours alternative to the emergency room for minor illnesses and injuries. The AfterHours program can save you time and money. No appointment an no referral is required.

Log onto our Secure Web site at www.excellusbcbs.com for the below features:

- **Health Coaching, the Support You Need when You Need It.**
  Our Health Coaching program can provide you with answers to virtually any health care question. And it doesn't cost you a dime. Our health coaches are available anytime over the phone at 1-800-348-9786 or online.
- **Healthcare Advisor.** Managing the quality and cost of your health care is important. Healthcare Advisor makes it easy. With Healthcare Advisor, you can get easy-to-understand recommendations about health care choices for you and your family, including:
  - Research health conditions
  - Learn about treatment options
  - Estimate treatment costs
  - Learn how to prepare for a procedure
  - Compare medication choices and costs.
- **Healthy Living.** Save on health and fitness programs, find out how often to seek preventive health screenings, or get help to quit smoking.
- **Healthwise Knowledgebase.** An online tool with over 6000 health topics for you to review.

## 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** | **Standard Option** |
| Professional services of physicians<br>• In an urgent care center<br>• During a hospital stay<br>• In a skilled nursing facility | Nothing | Nothing |
| • Office medical consultation<br>• Second surgical opinion<br>• Injectable drugs in the physician's office<br><br>***Note:*** You pay an additional $20 copay for an injectable drug administered in the physicians's office | $20 copayment per visit to your primary care physician<br><br>$20 copayment per visit to a specialist | $25 copayment per visit to your primary care physician<br><br>$40 copayment per visit to a specialist |
| Professional services of physicians<br>• In physician's office | $20 copayment per visit to your primary care physician<br><br>$20 copayment per visit to a specialist | $25 copayment per visit to your primary care physician<br><br>$40 copayment per visit to a specialist |
| At home | $20 copayment per office visit | $25 copayment per office visit |
| **Lab, X-ray and other diagnostic tests** | **High Option** | **Standard Option** |
| Tests, such as:<br>• Blood tests<br>• Urinalysis<br>• Non-routine Pap tests<br>• Pathology | Nothing | $25 copayment per visit |
| X-rays<br>• Non-routine mammograms<br>• CAT Scans/MRI<br>• Ultrasound<br>• Electrocardiogram and EEG | $20 copayment per visit | $40 copayment per visit |

| Benefit Description | You Pay | |
|---|---|---|
| **Preventive care, adult** | **High Option** | **Standard Option** |
| Routine physical every 1- 5 years which include:<br>Routine screenings, such as:<br>• Total Blood Cholesterol - once every three years<br>• Colorectal Cancer Screening, including<br>- Fecal occult blood test | Nothing | Nothing |
| Sigmoidoscopy screening – every five years starting at age 50<br>Double contrast barium enema – every five years starting at age 50<br>Colonoscopy screening – every ten years starting at age 50 | Nothing | Nothing |
| Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older | Nothing | Nothing |
| Routine Pap test | Nothing | Nothing |
| Routine mammogram | Nothing | Nothing |
| • Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): | Nothing | Nothing |
| *Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* | *All charges* | *All charges* |
| **Preventive care, children** | **High Option** | **Standard Option** |
| • Childhood immunizations recommended by the American Academy of Pediatrics | Nothing | Nothing |
| • Well-child care charges for routine examinations, immunizations and care (up to age 22)<br>• Examinations, such as:<br>- Eye exams through age 18 to determine the need for vision correction<br>- Ear exams through age 18 to determine the need for hearing correction<br>- Examinations done on the day of immunizations (up to age 22) | Nothing | Nothing |
| **Maternity care** | **High Option** | **Standard Option** |
| Complete maternity (obstetrical) care, such as:<br>• Prenatal care<br>• Delivery<br>• Postnatal care<br>Note: Here are some things to keep in mind:<br>• You do not need to precertify your normal delivery. | Prenatal/Postnatal Office Visits $5 per office visit for the first 10 visits. Remainder covered in full.<br>Physician Delivery-20% coinsurance or $100 per admission(whichever is less)<br>Inpatient Facility - $240 per admission | Prenatal/Postnatal Office Visits $5 per office visit for the first 10 visits. Remainder covered in full.<br>Physician Delivery-20% coinsurance or $200 per admission(whichever is less)<br>Inpatient Facility - $500 per admission |

*Maternity care - continued on next page*

| Benefit Description | You Pay | |
|---|---|---|
| **Maternity care (cont.)** | **High Option** | **Standard Option** |
| • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.<br>• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision.<br>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). | Prenatal/Postnatal Office Visits $5 per office visit for the first 10 visits. Remainder covered in full.<br>Physician Delivery-20% coinsurance or $100 per admission(whichever is less)<br>Inpatient Facility - $240 per admission<br>Routine Newborn Nursery is covered in full | Prenatal/Postnatal Office Visits $5 per office visit for the first 10 visits. Remainder covered in full.<br>Physician Delivery-20% coinsurance or $200 per admission(whichever is less)<br>Inpatient Facility - $500 per admission<br>Routine Newborn Nursery is covered in full |
| *Not covered: Routine sonograms to determine fetal age, size or sex* | *All charges* | *All charges* |
| **Family planning** | **High Option** | **Standard Option** |
| A range of voluntary family planning services, limited to:<br>• Voluntary sterilization (See Surgical procedures Section 5 (b))<br>• Surgically implanted contraceptives<br>• Injectable contraceptive drugs (such as Depo provera)<br>• Intrauterine devices (IUDs)<br>• Diaphragms<br>Note: We cover injectable fertility drugs under medical benefits and oral contraceptives under the prescription drug benefit. | $20 copayment per office visit<br>$50 copayment per outpatient/ambulatory care | $25 copayment per visit to your primary care physician<br>$40 copayment per visit to a specialist<br>$50 copayment per outpatient/ambulatory care |
| *Not covered:*<br>• *Reversal of voluntary surgical sterilization*<br>• *Genetic counseling* | *All charges* | *All charges* |
| **Infertility services** | **High Option** | **Standard Option** |
| Diagnosis and treatment of infertility such as:<br>• Artificial insemination:<br>- Intravaginal insemination (IVI)<br>- Intracervical insemination (ICI)<br>- Intrauterine insemination (IUI)<br>• Fertility drugs<br>Note: We cover injectible fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit. | $20 copayment per office visit | $25 copayment per visit to your primary care physician<br>$40 copayment per visit to a specialist |
| *Not covered:*<br>• *Assisted reproductive technology (ART) procedures, such as:* | *All charges* | *All charges* |

*Infertility services - continued on next page*

| Benefit Description | You Pay | |
|---|---|---|
| **Infertility services (cont.)** | **High Option** | **Standard Option** |
| - *in vitro fertilization*<br>- *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)*<br>• *Services and supplies related to ART procedures*<br>• *Cost of donor sperm*<br>• *Cost of donor egg.* | *All charges* | *All charges* |
| **Allergy care** | **High Option** | **Standard Option** |
| • Testing and treatment<br>• Allergy injections | $20 copayment per office visit | $25 PCP copay/$40 specialist copay |
| *Not covered: provocative food testing, sublingual allergy desensitization* | *All charges* | *All charges* |
| **Treatment therapies** | **High Option** | **Standard Option** |
| • Chemotherapy and radiation therapy | $20 copayment per office visit | $25 copayment per office visit |
| Drugs used in the treatment of cancer including chemotherapeutic agents and adjunctive medications that can be self-administered and are dispensed by a pharmacy – Covered under the prescription rider, see Section 5(f) prescription drug benefits. | $20 copayment for the drug | $25 copayment for the drug |
| Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 29-34. | | |
| • Respiratory and inhalation therapy<br>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy<br>• Growth hormone therapy (GHT) | | |
| Note: Growth hormone is covered under the prescription drug benefit. | | |
| Note: – We only cover GHT when we preauthorize the treatment. 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 *Other services under You need prior Plan approval for certain services* on page 12. | | |
| Dialysis – hemodialysis and peritoneal dialysis | Nothing | Nothing |

| Benefit Description | You Pay | |
|---|---|---|
| **Physical and occupational therapies** | **High Option** | **Standard Option** |
| 60 visits for the services of each of the following:<br>• qualified physical therapists and<br>• occupational therapists<br>• speech therapists<br><br>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.<br><br>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided. | $20 copayment per office visit<br><br>$20 copayment per outpatient visit<br><br>Nothing per visit during covered inpatient admission<br><br>***Note:*** Visits are limited to 60 visits per person, per calendar year for physical, occupational, or speech therapy or a combination of all three | $40 copayment per office visit<br><br>$40 copayment per outpatient visit<br><br>Nothing per visit during covered inpatient admission<br><br>***Note:*** Visits are limited to 60 visits per person, per calendar year for physical, occupational, or speech therapy or a combination of all three |
| *Not covered:*<br>• *Long-term rehabilitative therapy*<br>• *Exercise programs* | *All charges* | *All charges* |
| **Speech therapy** | **High Option** | **Standard Option** |
| 60 combined visits per calendar year for care in which in the judgment of the Plan's Medical Director can be expected to result in a significant improvement through short-term therapy. | $20 copayment per office visit<br><br>$20 copayment per outpatient visit | $40 copayment per office visit<br><br>$40 copayment per outpatient visit |
| **Hearing services (testing, treatment, and supplies)** | **High Option** | **Standard Option** |
| • For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist<br><br>Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.* | $20 copayment per office visit<br><br>Nothing for 2 hearing aids once every 3 yrs for children up to age 19 | $40 copayment per office visit<br><br>Nothing for 2 hearing aids once every 3 yrs for children up to age 19 |
| • External hearing aids<br>• Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants<br><br>Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.* | $20 copayment per office visit<br><br>Nothing for 2 hearing aids once every 3 yrs for children up to age 19 | $40 copayment per office visit<br><br>Nothing for 2 hearing aids once every 3 yrs for children up to age 19 |
| *Not covered:*<br>• *Hearing services that are not shown as covered* | *All charges* | *All charges* |

| Benefit Description | You Pay | |
|---|---|---|
| **Vision services (testing, treatment, and supplies)** | **High Option** | **Standard Option** |
| • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)<br>• Annual eye refractions<br><br>Note: See *Preventive care, children* for eye exams for children. | Nothing<br><br>$20 copayment per office visit | Nothing<br><br>$40 copayment for one routine eye exam every 2 years, every year for children up to age 19 |
| • $60 toward the purchase of one pair of either prescription eyeglasses or contact lenses once every twelve months | All charge balances over the $60 annual allowance once every year | All charge balances over the $60 annual allowance once every 2 years, every year for children to age 19 |
| *Not covered:*<br>• *Eye exercises and orthoptics*<br>• *Radial keratotomy and other refractive surgery* | *All charges* | *All charges* |
| **Foot care** | **High Option** | **Standard Option** |
| Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. | $20 copayment per office visit | $25 copayment per office visit |
| *Not covered:*<br>• *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.*<br>• *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery).* | *All charges* | *All charges* |
| **Orthopedic and prosthetic devices** | **High Option** | **Standard Option** |
| • Artificial limbs and eyes;<br>• Stump hose | 50% | 50% |
| • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy<br>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.<br>• External hearing aids<br>• Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants | Nothing for 2 hearing aids once every 3 yrs for children up to age 19 | Nothing for 2 hearing aids once every 3 yrs for children up to age 19 |
| • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. | Nothing | Nothing |

*Orthopedic and prosthetic devices - continued on next page*

| Benefit Description | You Pay | |
|---|---|---|
| **Orthopedic and prosthetic devices (cont.)** | **High Option** | **Standard Option** |
| Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services. | Nothing | Nothing |
| *Not covered:*<br>• *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups*<br>• *Lumbosacral supports*<br>• *Corsets, trusses, elastic stockings, support hose, and other supportive devices*<br>• *Prosthetic replacements provided less than 3 years after the last one we covered.* | *All charges* | *All charges* |
| **Durable medical equipment (DME)** | **High Option** | **Standard Option** |
| We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:<br>• Oxygen;<br>• Dialysis equipment;<br>• Hospital beds;<br>• Wheelchairs;<br>• Crutches;<br>• Walkers;<br>• Audible prescription reading devices;<br>• speech generating devices;<br>• Blood glucose monitors;<br>• Insulin pumps.<br><br>Note: Call us at 585-454-4810 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. | 50% of the plan allowance for durable medical equipment that your physician or other licensed/ authorized provider and our Medical Director determine to be medically necessary, subject to precertification.<br><br>Diabetic DME $20 per 30 day rental/supply | 50% of the plan allowance for durable medical equipment that your physician or other licensed/ authorized provider and our Medical Director determine to be medically necessary, subject to precertification.<br><br>Diabetic DME $25 per 30 day rental/supply |
| *Not covered:*<br>Motorized wheelchairs | *All charges* | *All charges* |
| **Home health services** | **High Option** | **Standard Option** |
| • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide.<br>• Services include oxygen therapy, intravenous therapy and medications. | Nothing | Nothing for the first 40 visits per calendar year<br><br>All charges after the first 40 visits |
| *Not covered:* | *All charges* | *All charges* |

*Home health services - continued on next page*

| Benefit Description | You Pay | |
|---|---|---|
| **Home health services (cont.)** | **High Option** | **Standard Option** |
| • *Nursing care requested by, or for the convenience of, the patient or the patient's family.*<br>• *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.* | *All charges* | *All charges* |
| **Chiropractic** | **High Option** | **Standard Option** |
| • Manipulation of the spine and extremities<br>• Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application | $20 copayment per office visit | $40 copayment per office visit |
| *Not covered:*<br>• *naturopathic services, hypnotherapy, biofeedback* | *All charges* | *All charges* |
| **Alternative treatments** | **High Option** | **Standard Option** |
| Acupuncture – by a doctor of medicine or osteopathy for:<br>• anesthesia<br>• pain relief | 50% of plan allowance<br>Up to 10 visits per calendar year. | All charges |
| *Not covered:*<br>• *Naturopathic services*<br>• *Hypnotherapy*<br>• *Biofeedback* | *All charges* | *All charges* |
| **Educational classes and programs** | **High Option** | **Standard Option** |
| Coverage is provided for:<br>• Tobacco Cessation programs, including individual/group/telephone counseling, and for over the counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence. | Nothing for one-on-one counseling, medication recommendations, and free nicotine replacement products if recommended when you call the **Quit For Life Program** today at 1-800-442-8904.<br>Nothing for prescription drugs approved by the FDA to treat tobacco dependence. | Nothing for one-on-one counseling, medciations recommendations, and free nicotine replacement products if recommended when you call the **Quit For Life Program** today at 1-800-442-8904.<br>Nothing for prescription drugs approved by the FDA to treat tobacco dependence. |
| • Diabetes self management | $20 copayment per office visit | $25 copayment per office visit |
| • Childhood obesity education | Nothing | Nothing |

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

**Important things you should keep in mind about these benefits:**

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

**YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

| Benefit Description | You pay | |
|---|---|---|
| **Surgical procedures** | **High Option** | **Standard Option** |
| A comprehensive range of services, such as:<br>• Operative procedures<br>• Treatment of fractures, including casting<br>• Normal pre- and post-operative care by the surgeon<br>• Correction of amblyopia and strabismus<br>• Endoscopy procedures<br>• Biopsy procedures<br>• Removal of tumors and cysts<br>• Correction of congenital anomalies (see *Reconstructive surgery* )<br>• Surgical treatment of morbid obesity (bariatric surgery)<br>- Patients must be morbidly obese; which is defined as a body mass index (BMI) greater than or equal to 40.<br>- If comorbid condition(s) exist (e.g., coronary heart disease, diabetes, degenerative arthritis of weight-bearing joints) patients must have BMI greater than or equal to 35. Documentation of the level of severity of the comorbid existing medical condition must be submitted by the primary care physician.<br>- The condition of morbid obesity must be of at least 5 years duration.<br>- Documentation of repeated attempts to lose weight prior to request for surgery.<br>• Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information | $20 copayment per office visit<br>$50 facility copayment per outpatient/ambulatory procedure and $20 physician fee<br>Inpatient services:<br>20% coinsurance or $100 copayment, (whichever is less) per inpatient surgical procedure | $40 copayment per office visit<br>$50 facility copayment per outpatient/ambulatory procedure and $40 physician fee<br>Inpatient services:<br>20% coinsurance or $200 copayment, (whichever is less) per inpatient surgical procedure |

*Surgical procedures - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Surgical procedures (cont.)** | **High Option** | **Standard Option** |
| • Voluntary sterilization (e.g., tubal ligation, vasectomy)<br>• Treatment of burns<br><br>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. | $20 copayment per office visit<br><br>$50 facility copayment per outpatient/ambulatory procedure and $20 physician fee<br><br>Inpatient services:<br><br>20% coinsurance or $100 copayment, (whichever is less) per inpatient surgical procedure | $40 copayment per office visit<br><br>$50 facility copayment per outpatient/ambulatory procedure and $40 physician fee<br><br>Inpatient services:<br><br>20% coinsurance or $200 copayment, (whichever is less) per inpatient surgical procedure |
| *Not covered:*<br>• *Reversal of voluntary sterilization*<br>• *Routine treatment of conditions of the foot; see Foot care* | *All charges* | *All charges* |
| **Reconstructive surgery** | **High Option** | **Standard Option** |
| • Surgery to correct a functional defect<br>• Surgery to correct a condition caused by injury or illness if:<br>- the condition produced a major effect on the member's appearance and<br>- the condition can reasonably be expected to be corrected by such surgery<br>• 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.<br>• All stages of breast reconstruction surgery following a mastectomy, such as:<br>- surgery to produce a symmetrical appearance of breasts<br>- treatment of any physical complications, such as lymphedemas<br>- breast prostheses and surgical bras and replacements (see *Prosthetic devices*)<br><br>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. | $20 copayment per office visit<br><br>$50 facility copayment per outpatient/ambulatory procedure and $20 physician fee<br><br>Inpatient services:<br><br>20% coinsurance or $100 copayment, (whichever is less) per inpatient surgical procedure | $40 copayment per office visit<br><br>$50 facility copayment per outpatient/ambulatory procedure and $40 physician fee<br><br>Inpatient services:<br><br>20% coinsurance or $200 copayment, (whichever is less) per inpatient surgical procedure |
| *Not covered:*<br>• *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* | *All charges* | *All charges* |

*Reconstructive surgery - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Reconstructive surgery (cont.)** | **High Option** | **Standard Option** |
| • *Surgeries related to sex transformation* | *All charges* | *All charges* |
| **Oral and maxillofacial surgery** | **High Option** | **Standard Option** |
| Oral surgical procedures, limited to:<br>• Reduction of fractures of the jaws or facial bones;<br>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;<br>• Removal of stones from salivary ducts;<br>• Excision of leukoplakia or malignancies;<br>• Excision of cysts and incision of abscesses when done as independent procedures; and<br>• Other surgical procedures that do not involve the teeth or their supporting structures. | $20 copayment per office visit<br>$50 facility copayment per outpatient/ambulatory procedure and $20 physician fee<br>Inpatient services:<br>20% coinsurance or $100 copayment, (whichever is less) per inpatient surgical procedure | $40 copayment per office visit<br>$50 facility copayment per outpatient/ambulatory procedure and $40 physician fee<br>Inpatient services:<br>20% coinsurance or $200 copayment, (whichever is less) per inpatient surgical procedure |
| *Not covered:*<br>• *Oral implants and transplants*<br>• *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* | *All charges* | *All charges* |
| **Organ/tissue transplants** | **High Option** | **Standard Option** |
| These Solid organ transplants are subject to medical necessity and experimental/investigative review. Refer to *Other services* in Section 3 for prior authorization procedures. Solid Transplants are limited to:<br>• Cornea<br>• Heart<br>• Heart/lung<br>• Intestinal transplants<br>- Small intestine<br>- Small intestine with the liver<br>- Small intestine with multiple organs, such as the liver, stomach, and pancreas<br>• Kidney<br>• Liver<br>• Lung: single/bilateral/<br>• Pancreas<br>• Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis | 20% coinsurance or $100 copayment, (whichever is less) per inpatient surgical procedure | 20% coinsurance or $200 copayment, (whichever is less) per inpatient surgical procedure |

*Organ/tissue transplants - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Organ/tissue transplants (cont.)** | **High Option** | **Standard Option** |
| These **tandem blood or marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures.<br>• Autologous tandem transplants for<br>- AL Amyloidosis<br>- Multiple myeloma (de novo and treated)<br>- Recurrent germ cell tumors (including testicular cancer) | 20% coinsurance or $100 copayment, (whichever is less) per inpatient surgical procedure | 20% coinsurance or $200 copayment, (whichever is less) per inpatient surgical procedure |
| **Blood or marrow stem cell transplants** limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.<br>• Allogeneic transplants for<br>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia<br>- Advanced Hodgkin's lymphoma with reoccurrence (relapsed)<br>- Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed)<br>- Acute myeloid leukemia<br>- Advanced Myeloproliferative Disorders (MPDs)<br>- Advanced neuroblastoma<br>- Amyloidosis<br>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)<br>- Hemoglobinopathy<br>- Infantile malignant osteopetrosis<br>- Kostmann's syndrome<br>- Leukocyte adhesion deficiencies<br>- Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia)<br>- Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)<br>- Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfillippo's syndrome, Maroteaux-Lamy syndrome variants)<br>- Myelodysplasia/Myelodysplastic syndromes<br>- Paroxysmal Nocturnal Hemoglobinuria<br>- Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)<br>- Severe combined immunodeficiency<br>- Severe or very severe aplastic anemia | 20% coinsurance or $100 copayment, (whichever is less) per inpatient surgical procedure | 20% coinsurance or $200 copayment, (whichever is less) per inpatient surgical procedure |

*Organ/tissue transplants - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Organ/tissue transplants (cont.)** | **High Option** | **Standard Option** |
| - Sickle cell anemia<br>- X-linked lymphoproliferative syndrome<br>• Autologous transplants for<br>- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia<br>- Advanced Hodgkin's lymphoma with reoccurrence (relapsed)<br>- Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed)<br>- Amyloidosis<br>- Breast Cancer<br>- Ependymoblastoma<br>- Epithelial ovarian cancer<br>- Ewing's sarcoma<br>- Multiple myeloma<br>- Medulloblastoma<br>- Pineoblastoma<br>- Neuroblastoma<br>- Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors | 20% coinsurance or $100 copayment, (whichever is less) per inpatient surgical procedure | 20% coinsurance or $200 copayment, (whichever is less) per inpatient surgical procedure |
| **Mini-transplants performed in a clinical trial setting** (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan.<br><br>Refer to *Other services* in Section 3 for prior authorization procedures:<br>• Allogeneic transplants for<br>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia<br>- Advanced Hodgkin's lymphoma with reoccurrence (relapsed)<br>- Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed)<br>- Acute myeloid leukemia<br>- Advanced Myeloproliferative Disorders (MPDs)<br>- Amyloidosis<br>- Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL)<br>- Hemoglobinopathy<br>- Marrow failure and related disorders (i.e., Fanconi's, PNH, Pure Red Cell Aplasia)<br>- Myelodysplasia/Myelodysplastic syndromes | 20% coinsurance or $100 copayment, (whichever is less) per inpatient surgical procedure | 20% coinsurance or $200 copayment, (whichever is less) per inpatient surgical procedure |

*Organ/tissue transplants - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Organ/tissue transplants (cont.)** | **High Option** | **Standard Option** |
| - Paroxysmal Nocturnal Hemoglobinuria<br>- Severe combined immunodeficiency<br>- Severe or very severe aplastic anemia<br>• Autologous transplants for<br>- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia<br>- Advanced Hodgkin's lymphoma with reoccurrence (relapsed)<br>- Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed)<br>- Amyloidosis<br>- Neuroblastoma | 20% coinsurance or $100 copayment, (whichever is less) per inpatient surgical procedure | 20% coinsurance or $200 copayment, (whichever is less) per inpatient surgical procedure |
| *Not covered:*<br>• *Donor screening tests and donor search expenses, except those performed for the actual donor*<br>• *Transplants not listed as covered* | *All charges* | *All charges* |
| These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.<br><br>If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.<br>• Allogeneic transplants for<br>- Advanced Hodgkin's lymphoma<br>- Advanced non-Hodgkin's lymphoma<br>- Beta Thalassemia Major<br>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma<br>- Multiple myeloma<br>- Multiple sclerosis<br>- Sickle Cell anemia<br>• Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for<br>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia | 20% coinsurance or $100 copayment, (whichever is less) per inpatient surgical procedure | 20% coinsurance or $200 copayment, (whichever is less) per inpatient surgical procedure |

*Organ/tissue transplants - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Organ/tissue transplants (cont.)** | **High Option** | **Standard Option** |
| - Advanced Hodgkin's lymphoma<br>- Advanced non-Hodgkin's lymphoma<br>- Breast cancer<br>- Chronic lymphocytic leukemia<br>- Chronic myelogenous leukemia<br>- Colon cancer<br>- Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)<br>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma<br>- Multiple myeloma<br>- Multiple sclerosis<br>- Myeloproliferative disorders (MSDs)<br>- Non-small cell lung cancer<br>- Ovarian cancer<br>- Prostate cancer<br>- Renal cell carcinoma<br>- Sarcomas<br>- Sickle cell anemia<br>• Autologous Transplants for<br>  • Advanced Childhood kidney cancers<br>  • Advanced Ewing sarcoma<br>  • Advanced Hodgkin's lymphoma<br>  • Advanced non-Hodgkin's lymphoma<br>  • Breast Cancer<br>  • Childhood rhabdomyosarcoma<br>  • Chronic myelogenous leukemia<br>  • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL)<br>  • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma<br>  • Epithelial Ovarian Cancer<br>  • Mantle Cell (Non-Hodgkin lymphoma)<br>  • Multiple sclerosis<br>  • Small cell lung cancer<br>  • Systemic lupus erythematosus<br>  • Systemic sclerosis | 20% coinsurance or $100 copayment, (whichever is less) per inpatient surgical procedure | 20% coinsurance or $200 copayment, (whichever is less) per inpatient surgical procedure |

*Organ/tissue transplants - continued on next page*

| Benefit Description | You pay | |
|---|---|---|
| **Organ/tissue transplants (cont.)** | **High Option** | **Standard Option** |
| *Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/ stem cell transplant donors in addition to the testing of family members. maximum $2,500 each.* | | |
| *Not covered:*<br>• *Donor screening tests and donor search expenses, except as shown above*<br>• *Implants of artificial organs*<br>• Transplants not listed as covered | All Charges | All Charges |
| **Anesthesia** | **High Option** | **Standard Option** |
| Professional services provided in –<br>• Hospital (inpatient) | Nothing | Nothing |
| Professional services provided in –<br>• Hospital outpatient department<br>• Skilled nursing facility<br>• Ambulatory surgical center<br>• Office | Nothing | 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.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

| Benefit Description | You pay | |
|---|---|---|
| **Inpatient hospital** | **High Option** | **Standard Option** |
| Room and board, such as<br>• Ward, semiprivate, or intensive care accommodations;<br>• General nursing care;<br>• Meals and special diets.<br><br>Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. | $240 copayment per admission | $500 copayment per admission |
| Other hospital services and supplies, such as:<br>• Operating, recovery, maternity, and other treatment rooms<br>• Prescribed drugs and medicines<br>• Administration of blood and blood products<br>• Blood or blood plasma, if not donated or replaced<br>• Dressings, splints, casts, and sterile tray services<br>• Medical supplies and equipment, including oxygen | Nothing | Nothing |
| • Anesthetics, including nurse anesthetist services<br>• Take-home items<br>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) | Nothing | Nothing |
| *Not covered:*<br>• *Custodial care*<br>• *Non-covered facilities, such as nursing homes, schools*<br>• *Personal comfort items, such as telephone, television, barber services, guest meals and beds*<br>• *Private nursing care* | *All charges* | *All charges* |

| Benefit Description | You pay | |
|---|---|---|
| **Outpatient hospital or ambulatory surgical center** | **High Option** | **Standard Option** |
| • Operating, recovery, and other treatment rooms<br>• Prescribed drugs and medicines<br>• Diagnostic laboratory tests, X-rays , and pathology services<br>• Administration of blood, blood plasma, and other biologicals<br>• Blood and blood plasma, if not donated or replaced<br>• Pre-surgical testing<br>• Dressings, casts, and sterile tray services<br>• Medical supplies, including oxygen<br>• Anesthetics and anesthesia service<br><br>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. | $50 outpatient/ambulatory care facility fee | $50 outpatient/ambulatory care facility fee |
| *Not covered: Blood and blood derivatives not replaced by the member* | *All charges* | *All charges* |
| **Extended care benefits/Skilled nursing care facility benefits** | **High Option** | **Standard Option** |
| Skilled nursing facility (SNF):<br><br>The Plan provides a comprehensive range of benefits with no dollar limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. Lifetime maximum of 360 days. | $240 copayment per admission<br><br>***Note:*** Coverage is provided for up to 120 days per calendar year | $500 copayment per admission<br><br>***Note:*** Coverage is provided for up to 45 days per calendar year |
| *Not Covered :*<br>• *Independent nursing*<br>• *Homemaker services* | *All charges* | *All charges* |
| **Rehabilitation Hospital** | **High Option** | **Standard Option** |
| The Plan provides up to 60 days per calendar year of inpatient care in a Rehabilitation Hospital for comprehensive physical medicine and rehabilitation. The hospitalization must be primarily for rehabilitation (alcohol and substance abuse programs are excluded) and only for a condition which, in the sole judgement of your Plan doctor and the Plan Medical Director, can be expected to result in significant improvement of your condition. | $240 copayment per admission | $500 copayment per admission |

| Benefit Description | You pay | |
|---|---|---|
| **Hospice care** | **High Option** | **Standard Option** |
| Supportive and palliative care for a terminally ill member is covered in the home or hospice facilty. Services include inpatient and outpatient care and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stage of illness, with a life expectancy of approximately six months or less. | Nothing | $500 copayment<br>***Note:*** Coverage for up to 210 days |
| *Not covered:*<br>• *Independent nursing*<br>• *Homemaker services* | *All charges* | *All charges* |
| **Ambulance** | **High Option** | **Standard Option** |
| Local professional ambulance service when medically appropriate | $50 per emergency | $100 per emergency |

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

**Important things you should keep in mind about these benefits:**

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

**What is a medical emergency?**

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

**What to do in case of emergency:**

**Emergencies within our service area**

- In an emergency situation, please call your primary care doctor.
- In an extreme emergency, if you are unable to contact your doctor, contact the local emergency system (e.g., 911-telephone system) or go to the nearest hospital emergency room or medical facility. Be sure to advise the medical personnel that you are a Plan member so they can notify us.
- You or a family member must notify us within 48 hours by calling our Customer Service Department at the toll-free number listed on the back of your ID card, unless it was not reasonably possible to notify the Plan. It is your responsibility to ensure that the Plan has been timely notified.
- If you are hospitalized in a non-plan facility and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.
- Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition. To be covered by this Plan, any follow-up care recommended by non-plan providers must be approved by the Plan or provided by Plan providers.
- If the emergency results in an admission to a hospital, the emergency copay is waived.

**Emergencies outside our service area**

- Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness. If an emergency situation occurs, call the local emergency system (e.g., 911-telephone system) or go to the nearest hospital emergency room or medical facility. Be sure to advise the medical personnel that you are a Plan member so they can notify us.
- You or a family member must notify us within 48 hours by calling our Customer Service Department at the toll free number listed on the back of your ID card, unless it was not reasonably possible to notify the Plan. It is your responsibility to ensure that the Plan has been timely notified.
- If you are hospitalized in a non-plan facility and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.
- If the emergency results in an admission to a hospital, the emergency copay is waived.

| Benefit Description | You pay | |
|---|---|---|
| **Emergency within our service area** | **High Option** | **Standard Option** |
| • Emergency care at a doctor's office<br>• Emergency care at an urgent care center<br>• Emergency care as an outpatient at a hospital, including doctors' services<br><br>Note: We waive the ER copay if you are admitted to the hospital. | • $20 copayment per visit<br>• $25 copayment per visit<br>• $50 copayment per visit | • $25 copayment per visit<br>• $35 copayment per visit<br>• $100 copayment per visit |
| *Not covered: Elective care or non-emergency care* | *All charges* | *All charges* |
| **Emergency outside our service area** | **High Option** | **Standard Option** |
| • Emergency care at a doctor's office<br>• Emergency care at an urgent care center<br>• Emergency care as an outpatient at a hospital, including doctors' services<br><br>Note: We waive the ER copay if you are admitted to the hospital. | • $20 per visit<br>• $25 per visit<br>• $50 per visit | • $25 copayment per visit<br>• $35 copayment per visit<br>• $100 copayment per visit |
| *Not covered:*<br>• *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*<br>• *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*<br>• *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area* | *All charges* | *All charges* |
| **Ambulance** | **High Option** | **Standard Option** |
| Professional ambulance service when medically appropriate.<br><br>Note: See 5(c) for non-emergency service. | $50 copayment for emergency transport | $100 copayment for emergency transport |
| *Not covered: Air ambulance* | *All charges* | *All charges* |

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

You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are 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 FOR THESE SERVICES.** 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. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan
- 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.

| Benefit Description | You pay | |
|---|---|---|
| **Professional Services** | **High Option** | **Standard Option** |
| When part of a treatment plan we approve, we cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, or clinical social workers,. | Your cost-sharing responsibilities are no greater than for other illnesses or conditions | Your cost sharing responsibilities are no greater than for other illnesses or conditions |
| Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include:<br>• Diagnostic evaluation<br>• Crisis intervention and stabilization for acute episodes<br>• Medication evaluation and management (pharmacotherapy)<br>• Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment<br>• Treatment and counseling (including individual or group therapy visits)<br>• Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling<br>• Professional charges for intensive outpatient treatment in a provider's office or other professional setting<br>• Electroconvulsive therapy | $20 copayment per visit | $40 copayment per visit |

| Benefit Description | You pay | |
|---|---|---|
| **Diagnostics** | **High Option** | **Standard Option** |
| • Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner<br>• Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility<br>• Inpatient diagnostic tests provided and billed by a hospital or other covered facility | Nothing for labs, $20 copayment per x-ray<br>nothing for inpatient diagnostic tests | $25 copayment per visit for labs, $40 copayment per x-ray<br>nothing for inpatient diagnostic tests |
| **Inpatient hospital or other covered facility** | **High Option** | **Standard Option** |
| Inpatient services provided and billed by a hospital or other covered facility<br>• Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services | $240 copayment per admission | $500 copayment per admission |
| **Outpatient hospital or other covered facility** | **High Option** | **Standard Option** |
| Outpatient services provided and billed by a hospital or other covered facility<br>• Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, or facility-based intensive outpatient treatment | $20 copayment per visit<br>$240 per admission | $40 copayment per visit<br>$500 per admission |
| **Not covered** | **High Option** | **Standard Option** |
| • Services that are not part of a preauthorized approved treatment plan | | |

| | |
|---|---|
| **Preauthorization** | To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following authorization processes:<br>The preauthorization procedure must be followed regardless of whether the member is within the Plan's service area or not. Preauthorization need not be obtained for emergency care. In making the determination to issue preauthorization, the Plan will examine the circumstances surrounding the member's condition and the care provided, including reasons for providing or prescribing the care and any unusual circumstances. However, the fact that the member's doctor prescribed the care does not automatically mean that the care qualifies for the Plan's payments under this Certificate. The provider, prior to recommending or ordering any preauthorized services, must call Blue Choice at 800-462-0116. For obtaining provider directories, call our Member Service Department at 800-462-0108. |
| **Limitation** | We may limit your benefits if you do not obtain a treatment plan. |

## Section 5(f). Prescription drug benefits

**Important things you should keep in mind about these benefits:**

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- 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.

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

- **Who can write your prescription.** A licensed physician, healthcare provider or dentist must write the prescription.
- **Where you can obtain them.** You must fill prescriptions at a participating Plan Pharmacy or through our participating mail sevice pharmacy, PrimeMail®. In addition to the many local pharmacies that are available, our nationwide pharmacy network provides access to more than 60,000 pharmacies. Specialty medications listed on our specialty pharmacy list must be obtained from one of our participating specialty pharmacies. However, the first time a new prescription for a specialty medication is purchased, you may fill it at a participating network pharmacy of your choice. To review our current specialty medication listing or for information on using PrimeMail®, please visit our Web site at www.excellusbcbs.com or call our Customer Service Department at the toll-free number listed on the back of your ID card.
- **We use a formulary.** We have an open formulary. If your physician believes a brand-named product is necessary or there is no generic available, your physician may prescribe a brand-named drug from our formulary list. Your 3-Tier prescription drug benefit allows you to make informed choices and encourages value when choosing your prescription medications. Your copayment will vary depending upon the tier in which your prescription medication is placed. **Tier One** drugs are typically generics and have the lowest copayment. **Tier Two** drugs are brand drugs with unique, significant clinical advantages and offer greater value over other products in the same drug class. **Tier Three** drugs are all other brand drugs, including new brand drugs and drugs that have generic equivalents. Tier Three drugs have the highest copayment amount. The current 3-Tier Formulary Guide is available on our Web site at www.excellusbcbs.com. To request a printed copy of the 3-Tier Formulary Guide, please call our Customer Service Department at the toll-free number listed on the back of your ID card.
- **These are the dispensing limitations.** You may purchase up to a 90-day supply at one time at a Plan pharmacy and are required to pay a copayment for each 30-day supply you purchase. The amount you pay is based upon a three-tier copayment structure. When you purchase your medications through PrimeMail mail service pharmacy, you can receive a 90-day supply and pay 2 copays for each 90-day supply. The amount you pay is based upon a three-tier copayment structure.
- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a brand-name. If you receive a name brand drug when a Federally-approved generic drug is available, you will have to pay the **Tier 1 copay**, plus the difference in cost between the pharmacy's charge for the more costly brand name medication and our price for the less expensive generic drug. If your prescription has no approved generic available, your benefit will not be affected.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.
- **When you do have to file a claim.** The participating pharmacy will electronically submit your claim at the point of sale. If you do not use a participating pharmacy, there is no benefit.

| Benefit Description | You pay | |
|---|---|---|
| **Covered medications and supplies** | **High Option** | **Standard Option** |
| We cover the following medications and supplies prescribed by a licensed physician or health care provider and obtained from a Plan pharmacy or through our mail service pharmacy:<br>• Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered.*<br>• Diabetic supplies limited to blood glucose monitors, insulin pumps, insulin infusion devices, oral agents for controlling blood sugar, and diabetes self-management education: $20 (High Option) or $25 (Standard Option) per 30-day supply.<br>• Disposable needles and syringes for the administration of covered medications: $20 (High Option) or $25 (Standard Option) per 30-day supply.<br>• Drugs for sexual dysfunction<br>• Contraceptive drugs and devices<br>• Growth hormones<br>• Oral fertility drugs<br>• Specialty medications are covered at participating network specialty pharmacies. The first time a new prescription for a specialty medication is purchased, the member may have it filled at a participating pharmacy of his choice.<br>• Drugs used in the treatment of cancer including chemotherapuetic agents and adjunctive medications that can be self-administered and are dispensed by a pharmacy are covered under the prescription drug rider and subject to the cost sharing in the rider. | **At a Retail Pharmacy (for each 30 day supply)**<br>• $10 per Tier 1 (generic) prescription or refill<br>• $30 per Tier 2 (preferred brand ) prescription or refill<br>• $50 per Tier 3 (non preferred brand) prescription or refill<br><br>**Mail Order Pharmacy (for each 90 day supply)**<br>• $20 per Tier 1 (generic ) prescription or refill<br>• $60 per Tier 2 (preferred brand) prescription or refill<br>• $100 per Tier 3 (non preferred brand) prescription or refill<br><br>***Note:*** Insulin: $20 per 30-day supply<br><br>***Note:*** If there is no generic equivalent available, you will still have to pay the brand name or non-preferred brand copay. | **At a Retail Pharmacy (for each 30 day supply)**<br>• $7 per Tier 1 (generic) prescription or refill<br>• $50 per Tier 2 (preferred brand ) prescription or refill<br>• $100 per Tier 3 (non preferred brand) prescription or refill<br><br>**Mail Order Pharmacy (for each 90 day supply)**<br>• $14 per Tier 1 (generic ) prescription or refill<br>• $100 per Tier 2 (preferred brand) prescription or refill<br>• $200 per Tier 3 (non preferred brand) prescription or refill<br><br>***Note:*** Insulin: $25 per 30-day supply<br><br>***Note:*** If there is no generic equivalent available, you will still have to pay the brand name or non-preferred brand copay. |
| *Not covered:*<br>• *Drugs and supplies for cosmetic purposes*<br>• *Drugs to enhance athletic performance*<br>• *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies*<br>• *Vitamins, nutrients and food supplements even if a physician prescribes or administers them*<br>• *Nonprescription medicines*<br><br>Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See page 26.) | *All charges* | *All charges* |

## 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.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 *Coordinating benefits with other coverage.*
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

| Benefit Desription | You Pay | |
|---|---|---|
| **Accidental injury benefit** | **High Option** | **Standard Option** |
| 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. | $20 copayment per office visit | $40 copayment per office visit |

**Dental benefits**

We have no other dental benefits.

## Section 5(h). Special features

| Feature | Description |
|---|---|

| Special Feature | Description |
|---|---|
| **Flexible benefits option** | Under the flexible benefits option, we determine the most effective way to provide services.<br>• We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue.<br>• Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process.<br>• By approving an alternative benefit, we do not guarantee you will get it in the future.<br>• The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits.<br>• If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request.<br>• Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claim process (see Section 8). |
| **Reciprocity benefit** | Coverage provided worldwide when life threatening or authorized by your Primary Care Physician. If you become ill while traveling you will now have access to the BlueCard program. With BlueCard you have access to a provider finder 24 hours a day by calling 1-800-810-BLUE. |
| **Centers of Excellence** | Excellus BlueCross BlueShield works with other BlueCross Plans to identify Centers of Excellence which offer quality care in specialized areas. When necessary the Plan's Medical Director will recommend that members with diseases and conditions that cannot be handled by our providers, be sent to Centers of Excellence. |

# Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums. These programs and materials are the responsibility of the Plan, and all appeals must follow their guidelines. For additional information contact the Plan at the toll free number on your ID card or visit their Web site at www.excellusbcbs.com.

**Welcome to Blue365**

- Blue365 is an online destination that complements your health coverage. You will have access to discounts and savings from select companies, **all included as part of your Excellus BlueCross BlueShield membership at no additional cost.**
- Blue365 includes exclusive discounts from select local companies and industry-leading, national brands in four main categories:
- **Health and Wellness -** Exclusive discounts on health and wellness products and services, including fitness, exercise, nutrition and elective procedures. Choose from:
  - Gold's Gym®
  - Curves®
  - eDiets®
  - Kronos Optimal Health®
  - Davis Vision®
  - QualSight LASIK®
  - LasikPlus®, and
  - GlobalFit™
  - You can also save on hearing aids from Beltone™ and TruHearing
- **Family Care -** Decision support tools for family care, including how to choose a caregiver or a long-term care insurance provider. Members can also access emotional support to deal with care of a family member from companies like Seniorlink Care™.
- **Healthy Travel -** Blue365 offers exclusive travel savings for healthy spa vacations and wellness getaways from companies like Westin Hotels® and Fairmont Hotels & Resorts.
- **Financial Well-Being -** Blue365 includes information to help plan for healthcare in retirement and learn about Medicare and long-term care insurance.
- Excellus BlueCross BlueShield cares about maintaining healthy lifestyles and improving your overall health. Blue365 is one way to help you make healthy choices every day and throughout life. Explore all the healthy choices,discounts and more from Blue365 at www.excellusbcbs.com/Blue365

**It's the Quit For Life™ Program**

- You know tobacco is bad for you. Yet, no matter how hard you try, you can't seem to quit. The Quit For Life program is an award-winning support program to help you quit using tobacco for good. This **FREE** program offers one-on-one coaching from our highly trained Quit Coaches and much more.

**StepUp**

- Step Up is a **FREE** web-based program designed to improve your health through physical activity and healthy eating.
- Step Up helps you set healthy goals and shows you easy ways to achieve them. You can even challenge friends, family or your entire organization to be healthier with our Healthy Competition option.

Health Improvement Programs will help you build a strategy for lifelong health. Get the tools you need to start on the path to a healthier lifestyle at www.excellusbcbs.com.

# 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 it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. F**or information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services.*

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergencyservices/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.
- Services, drugs or supplies billed by Blue Choice Preferred acute care facilities for inpatient care related to specific medical errors and hospital axquired-conditions known as Never Events.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to sex transformations.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials, this plan does not cover these costs.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.

# Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

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

If you need to file the claim, here is the process:

**Medical and hospital benefits**

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. For claims questions and assistance, call us at (585) 454-4810.

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

- Covered member's name, date of birth, address, phone number 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 payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

**Submit your claims to:**

**Excellus BlueCross BlueShield**

**P.O. Box 22999**

**Rochester, NY 14692**

**Prescription drugs**

**Submit your claims to: Same as above**

**Other supplies or services**

**Submit your claims to: Same as above**

**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.

**Post-service claims procedures**

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

**Authorized Representative**

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

## Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit excellusbcbs.com .

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

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** | Ask us in writing to reconsider our initial decision. You must:<br><br>a) Write to us within 6 months from the date of our decision; and<br><br>b) Send your request to us at: Excellus BlueCross BlueShield, P.O. Box 22999, Rochester NY, 14692 ; and<br><br>c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and<br><br>d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.<br><br>e) Include your email address (optional for member), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.<br><br>We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4. |
| **2** | In the case of a post-service claim, we have 60 days from the date we receive your request to:<br><br>a) Pay the claim or<br><br>b) Write to you and maintain our denial or.<br><br>c) Ask you or your provider for more information<br><br>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.<br><br>If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.<br><br>. |
| **3** | If you do not agree with our decision, you may ask OPM to review it.<br><br>You must write to OPM within: |

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance x, 1900 E Street, NW, Washington, DC 20415-xxxx.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

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

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent.

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

**4** 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 you did not indicate that your claim was a claim for urgent care, then call us at (585) 454-4810 We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance Group III at (202) 606-0737 between 8 a.m. and 5 p.m. eastern time.

# Section 9. Coordinating benefits with other coverage

**When you have other health coverage**

You must tell us if you or a covered family member has coverage under any other health plan or has 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 payor 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 payor, we will pay the benefits described in this brochure.

When we are the secondary payor, 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
- 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 (1-800-633-4227), (TTY 1-877-486-2048) 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 do not 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, (TTY 1-800-325-0778) 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 do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

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.

**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 payor, we process the claim first.

When Original Medicare is the primary payor, 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 1-800-462-0108 or see our Web site at www.excellusbcbs.com.

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

- Medical services and supplies provided by physicians and other health care professionals. You can find more information about how our plan coordinates benefits with Medicare by contacting Customer Service at 1-800-462-0108.

- **Tell us about your Medicare coverage**

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

- **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), (TTY 1-877-486-2048) or at www.medicare.gov.

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

  **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 payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, 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 payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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 Payor Chart | | |
|---|---|---|
| **A. When you - or your covered spouse - are age 65 or over and have Medicare and you...** | **The primary payor 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 payor before eligibility due to ESRD **(for 30 month coordination period)** | | ✓ |
| • Medicare was the primary payor 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 a one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the program.

**Workers' Compensation**

We do not cover services that:

- You (or a covered family member) 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 Program, 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.

**Clinical Trials**

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.

- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This plan covers some of these costs, providing the plan determines the services are medically necessary. For more specific information, see benefits under Section 5 starting on page 16. We encourage you to contact the plan to discuss specific services if you participate in a clinical trial.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials, this plan does not cover these costs.

## 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. |
| **Clinical Trials Cost Categories** | Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy<br><br>Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care<br><br>Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes |
| **Coinsurance** | Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 15. |
| **Copayment** | A copayment is a fixed amount of money you pay when you receive covered services. See page 15. |
| **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). |
| **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. This plan does not have a deductible. |
| **Experimental or investigational service** | Blue Choice uses published peer-reviewed medical literature about the efficiency and improvement outcomes of technology, along with the United States Food and Drug Administration approval for marketing of medical devices, drugs or biologicals for a particular diagnosis or condition. |
| **Health care professional** | A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law. |
| **Medical necessity** | Medically necessary care is care which, according to the Plan's criteria is: (a) consistent with the symptoms or diagnosis and treatment of the member's condition, disease, ailment or injury, (b) in accordance with standards of acceptable medical practice, (c) not solely for the member's convenience, or that of the member's doctor or other provider, (d) the most appropriate supply, place of service, or level of service which can safely be provided to the member, (e) provided for the direct care and treatment of the member's condition, illness, disease or injury, and (f) when applied to hospitalization, the member requires acute care as a bed patient due to the nature of the services rendered, or the member's condition, and the member could not have received safe or adequate care in any other setting (e.g. as an outpatient). |
| **Pre-service claims** | Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits. |
| **Never Events** | Errors in medical care that are clearly identifiable, preventable, and serious in their consequences, such as surgery performed on a wrong body part, and specific conditions that are acquired during your hospital stay, such as severe bed sores. |
| **Post-service claims** | Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits. |

**Us/We**

Us and We refer to Blue Choice

**Urgent care claims**

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 1-800-462-0108. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

**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 Benefits ,* 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
- What happens when your enrollment ends
- 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. For information on your premium deductions, you must also contact 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 dependent children under age 26, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 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 of changes in family member status including your marriage, divorce, annulment, or when your child reaches age 26.

**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.**

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

| Children | Coverage |
|---|---|
| Natural, adopted children, and stepchildren | Natural, adopted children and stepchildren are covered until their 26th birthday. |
| Foster Children | Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information. |
| Children Incapable of Self-Support | Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information. |
| Married Children | Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday. |
| Children with or eligible for employer-provided health insurance | Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday. |

You can find additional information at www.opm.gov/insure .

- **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 2012 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 2011 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.

  If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

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

**When you lose benefits**

- **When FEHB coverage ends**

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

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

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

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

- **Upon divorce**

  If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage 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 Benefits 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 26, 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 Benefits 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. Other Federal Programs

**Important information about 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, insulin, products, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26) 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.
- If you are a new or newly eligible employee, you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA or LEX HCFSA and/or DCFSA, but you must enroll by October 1. If you are hired or become eligible on or after October 1, you must wait and enroll during the Federal Benefits Open Season held each fall.

**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 Empolyees Dental and Vision Insurance Program – *FEDVIP*

**Important Information**

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program, and was 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 for enrollment.

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**

All dental plans provide a comprehensive range of services including:

- 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 for dependent children up to age 19.

**Vision Insurance**

All 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/vision and www.opm.gov/insure/dental. These sites also provide 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 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 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 such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted living facility or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. 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. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

## Pre-existing Condition Insurance Program(PCIP)

**Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.**

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY): 1-866-561-1604.

## Notes:

***Notes:***

# Index


**Accidental injury**.....28, 44
Allergy care.....22
Allogeneic (donor) bone marrow transplant .....30-32
Alternative treatment.....26
Ambulance.....12, 25, 35, 37-39
Anesthesia.....5, 26-27, 34, 36
Autologous bone marrow transplant...22, 30-32
**Biopsy**.....22
Blood and blood plasma.....35-36
Breast cancer screening.....20
**Casts**.....35-36
Changes for 2012.....9
Chemotherapy.....12, 22, 43
Childbirth.....13, 20-21, 35
Chiropractic.....26
Cholesterol tests.....20
Claims.....13-14 , 48-49 58
Coinsurance.....15, 58
Colorectal cancer screening.....20
Contraceptive devices and drugs.....21, 43
Coordination of benefits.....52-57
Cost-sharing.....15, 58
Covered providers.....10
**Deductible**.....15, 58
Definitions.....58
Dental care.....36, 44, 47, 56, 64-65
Disputed claims review.....50-51
Donor expenses (transplants).....32, 34
Durable medical equipment (DME)...12, 25
**Educational classes and programs**.....26
Effective date of enrollment...10-11, 58, 60
Emergency.....7-8, 13, 18, 38-39
Experimental or investigational...29, 47, 58
Eyeglasses.....18, 24, 68-69
**Family planning**.....21-22
Fecal occult blood test.....20
**General Exclusions**.....47
**Hearing services/aids**.....20, 23-24, 46
Home health services.....12, 25, 65
Home nursing care.....25, 36
Hospice care.....37
Hospital.....35-36
**Immunizations**.....20
Infertility.....21-22
Inhospital physician care.....19
Inpatient Hospital Benefits.....35-36
Insulin.....43
**Laboratory and pathological services**...19
**Magnetic Resonance Imagings (MRIs)** .....12, 19
Mail Order Prescription Drugs...42-43, 69-70
Mammograms.....19-20
Maternity Benefits.....12, 20-21
Medicaid.....56
Medically necessary.....12, 25, 58
Medicare.....52-55
Mental Conditions/Substance Abuse Benefits.....12, 40-41
**Newborn care**.....21
Non-FEHB Benefits.....46
Nursery charges.....21
**Obstetrical care**.....20-21
Occupational therapy.....23
Office visits.....19
Oral and maxillofacial surgery.....29
Orthopedic devices.....24-25
Outpatient facility care.....36
Oxygen.....25, 35
**Pap test**.....19-20
Physical examination.....20
Physical therapy.....23
Physician.....19
Precertification...11-14, 20, 25, 27, 35, 40-41, 51, 58
Prescription drugs.....42-43
Preventive care, adult.....20
Preventive care, children.....20
Preventive services.....20
Prostate cancer screening.....20
Prosthetic devices.....24-25
Psychologist.....40
Psychotherapy.....40
**Radiation therapy**.....12, 22
Renal dialysis.....12, 22
Room and board.....35
**Second surgical opinion**.....19
Skilled nursing facility care...11-12, 19, 34, 36
Speech therapy.....23
Sterilization procedures.....21, 28
Substance abuse.....36, 40-41
Surgery.....5, 12, 27-29, 35-36
Anesthesia.....34,36
Outpatient.....27-29, 35-36
Reconstructive.....28-29
Syringes.....43
**Temporary continuation of coverage**...55, 62-63
Transplants.....29-33
Treatment therapies.....22-23,
**Vision services**...18, 20, 24, 46, 54, 64-65, 69-70
**Well child care**.....20
Wheelchairs.....25
Workers' compensation.....55-56
**X-rays**.....19

# Summary of benefits for Blue Choice High Option - 2012

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

| Benefits | You pay | Page |
|---|---|---|
| **Medical services provided by physicians:** | | |
| Diagnostic and treatment services provided in the office | Office visit copay: $20 primary care; $20 specialist | 19 |
| **Services provided by a hospital:** | | |
| • Inpatient | $240 per admission copay | 35 |
| • Outpatient | $50 per visit | 36 |
| **Emergency benefits:** | | |
| • In-area | $50 copay (waived if admitted) | 38-39 |
| • Out-of-area | $50 copay (waived if admitted) | 38-39 |
| **Mental health and substance abuse treatment:** | Regular cost-sharing | 40-41 |
| **Prescription drugs:** | | 42-43 |
| • Retail pharmacy - per 30 day supply | $10 per tier 1 generic prescription<br>$30 per tier 2 preferred brand name prescription<br>$50 per tier 3 non-preferred brand prescription | 42-43 |
| • Mail order up to a 90 Day supply | $20 per tier 1 generic prescription<br>$60 per tier 2 preferred brand name prescription<br>$100 per tier 3 non-preferred brand prescription | 42-43 |
| **Dental care:** | Limited benefits | 44 |
| **Vision care:** | One refraction and $60 toward eyeglasses or contact lenses annually<br>You pay a $20 copay per visit | 24 |
| **Special features:** | **Blue365 - Health and wellness programs and discounts** | 45-46 |
| **Protection against catastrophic costs** (out-of-pocket maximum)**:** | No out of pocket maximum | 15 |

# Summary of benefits for Blue Choice Standard Option - 2012

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

| Benefits | You pay | Page |
|---|---|---|
| **Medical services provided by physicians:** | | |
| Diagnostic and treatment services provided in the office: | Office visit copay: $25 primary care; $40 specialist | 19 |
| **Services provided by a hospital:** | | |
| • Inpatient | $500 per admission copay | 35 |
| • Outpatient | $50 copay per visit | 36 |
| **Emergency benefits:** | | |
| • In-area | $100 copay (waived if admitted) | 38-39 |
| • Out-of-area | $100 copay (waived if admitted) | 38-39 |
| **Mental health and substance abuse treatment:** | Regular cost-sharing | 40-41 |
| **Prescription drugs:** | | |
| • Retail pharmacy - per 30 day supply | $7 per tier 1 generic prescriptions<br>$50 per tier 2 preferred brand prescriptions<br>$100 per tier 3 non-preferred brand prescriptions | 42-43 |
| • Mail order - up to a 90 day supply | $14 per tier 1 generic prescriptions<br>$100 per tier 2 preferred brand prescriptions<br>$200 per tier 3 non-preferred brand prescriptions | 42-43 |
| **Dental care:** | Limited benefits | 44 |
| **Vision care:** | $40 copay per visit every two years, every year for children to age 19<br>All charges after $60 eyewear allowance every 2 years, every year for children to age 19 | 24 |
| **Special Features** | **Blue365 - Health and wellness programs and discounts** | 45-46 |
| **Protection against catastrophic costs** (out-of-pocket maximum): | No out of pocket maximum | 15 |

# Notes

***Notes:***

## Notes

# Notes

## 2012 Rate Information

For 2012 health premium information, please see http://www.opm.gov/insure/health/tribes/rates/ or contact your tribe's Human Resources department.