Bluegrass Family Health

http://www.bgfh.com

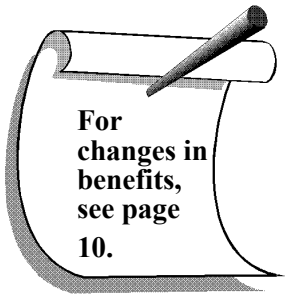
Bluegrass Family Health

2011

A Health Maintenance Organization (high deductible health plan)

Serving: All of Kentucky and Southern Indiana.

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 9 for requirements.



Enrollment code for this Plan:

KV1 High Deductible Health Plan (HDHP)-Self Only
KV2 High Deductible Health Plan (HDHP)-Self and Family

Special Notice: This plan will no longer be offered in the state of Tennessee. Enrollees in this service area must choose another health plan during Open Season for the 2011 plan year. Please see Section 2.

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

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

RI 73-850

Important Notice from Bluegrass Family Health About

Our Prescription Drug Coverage and Medicare

OPM has determined that the Bluegrass Family Health 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.

Please be advised

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

Medicare's Low Income Benefits

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

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

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

Table of Contents

Introduction

This brochure describes the benefits of Bluegrass Family Health under our contract (CS 2910) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Bluegrass Family Health administrative offices is:

Bluegrass Family Health
Government Programs
651 Perimeter Drive, Suite 300
Lexington, KY 40517

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, 2011, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2011, and changes are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

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

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

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

Stop Health Care Fraud!

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

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

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

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

- Please review your claims history periodically for accuracy 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 859-269-4475 or Toll Free at 800-787-2680 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 was 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 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.

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

3. Get the results of any test or procedure.

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

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

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

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

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

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

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 participating providers. This new policy will help 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 will encourage 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 you nor your FEHB plan will incur costs to correct the medical error.

Section 1. Facts about this HMO plan

This Plan offers you a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. When you receive services from participating providers, you will not have to submit claim forms. You pay only the deductible, coinsurance and copay amounts described in this brochure. When you receive emergency services from non-participating providers, you may have to submit claim forms.

The High Deductible Health Plan (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component is a health plan product that provides traditional health care coverage and a tax advantaged way to help you build savings for future medical needs. An HDHP with an HSA or HRA is designed to give you greater flexibility and discretion over how you use your health care benefits. As an informed consumer, you decide how to utilize your plan coverage with a high deductible and out-of-pocket expenses limited by catastrophic protection. And, you decide how to spend the dollars in your HSA or HRA.

You may consider:

- Using the most cost effective provider
- Actively pursuing a healthier lifestyle and utilizing preventive care benefits
- Becoming an informed health care consumer so you can be more involved in the treatment of any medical condition or chronic illness.

The type and extent of covered services, and the amount we allow, may be different from other plans. Read our brochure carefully to understand the benefits and features of this HDHP. Internal Revenue Service (IRS) rules govern the administration of all HDHPs sold in conjunction with an HSA. The IRS Website at http://www.treas.gov/offices/public-affairs/hsa/faq has additional information about HDHPs.

You should join an HDHP 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.

This plan is a "grandfathered health plan" under the Affordable Care Act. A grandfathered plan must preserve basic health coverage that was already in effect when the law passed. Specifically, this plan cannot eliminate all or substantially all benefits to diagnose or treat a particular condition; it cannot increase your coinsurance (the percentage of a bill you pay); and any increases in deductibles, out-of-pocket limits, and other copayments (the fixed-dollar amount you pay) must be minimal. As a grandfathered health plan, this plan has also decided to follow immediate reforms that apply to non-grandfathered plans.

Questions regarding what protections apply and what protections do not apply to a non-grandfathered health plan may be directed to us at 1-800-787-2680**.** You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

General features of our High Deductible Health Plan (HDHP)

HDHPs have higher annual deductibles and annual out-of-pocket maximum limits than other types of FEHB plans. FEHB Program HDHPs also offer health savings accounts or health reimbursement arrangements. Please see below for more information about these savings features.

Preventive care services

Preventive care services are generally paid as first dollar coverage.

Annual deductible

The annual deductible must be met before Plan benefits are paid for care other than preventive care services.

Health Savings Account (HSA)

You are eligible for an HSA if you are enrolled in an HDHP, not covered by any other health plan that is not an HDHP (including a spouse's health plan, but does not include specific injury insurance and accident, disability, dental care, vision care, or long-term coverage), not enrolled in Medicare, not received VA benefits within the last three months, not covered by your own or your spouse's flexible spending account (FSA), and are not claimed as a dependent on someone else's tax return.

- You may use the money in your HSA to pay all or a portion of the annual deductible, copayments, coinsurance, or other out-of-pocket costs that meet the IRS definition of a qualified medical expense.
- Distributions from your HSA are tax-free for qualified medical expenses for you, your spouse, and your dependents, even if they are not covered by a HDHP.
- You may withdraw money from your HSA for items other than qualified medical expenses, but it will be subject to income tax and, if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.
- For each month that you are enrolled in an HDHP and eligible for an HSA, the HDHP will pass through (contribute) a portion of the health plan premium to your HSA. In addition, you (the account holder) may contribute your own money to your HSA up to an allowable amount determined by IRS rules. Your HSA dollars earn tax-free interest.
- You may allow the contributions in your HSA to grow over time, like a savings account. The HSA is portable – you may take the HSA with you if you leave the Federal government or switch to another plan.

Health Reimbursement Arrangement (HRA)

If you are not eligible for an HSA, or become ineligible to continue an HSA, you are eligible for a Health Reimbursement Arrangement (HRA). Although an HRA is similar to an HSA, there are major differences.

- An HRA does not earn interest.
- An HRA is not portable if you leave the Federal government or switch to another plan.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. Your annual out-of-pocket expenses for covered services, including deductibles and copayments in-network, cannot exceed $5,000 for Self Only enrollment, or $7,500 for family coverage. Out-of-network your annual out-of-pocket expenses for covered services cannot exceed $10,000 for Self Only enrollment, or $15,000 for family.

The following services do not count towards your out-of-pocket expenses:

- Any expenses paid by us under your In-network Preventive Care benefit
- Expenses in excess of our allowance or maximum benefit limitations or expenses not covered under the Traditional medical coverage
- Any coinsurance expenses you have paid for infertility services

Health education resources and accounts management tools

HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

Connect to www.bgfh.com/feds.html for access to MyBluegrassInfo, a secure and personalized member site offering you a single source for health and benefits information.

MyBluegrassInfo gives you direct access to:

- HealthGrades tool allows you to shop for the highest-quality and most cost-effective physicians, specialists, hospitals, nursing homes and home health agencies.
- Medical Cost Calculator tool provides you with actionable information to more effectively budget and plan for health expenditures.
- Online Provider Directory
- RxEOB assists you in obtaining unbiased cost comparisons between equally effective prescription drugs.
- MedlinePlus directs you to information to help answer health questions; it also has extensive information about drugs, an illustrated medical encyclopedia, interactive patient tutorials, and latest health news.
- NurseFirst is a Toll Free service where you can choose to speak to a registered nurse or follow simple prompts directing you to the health care audio library. NurseFirst is available to you 24 hours a day, 7 days a week.
- LifeTraxx, a Wellness, Prevention and Disease Management program, gives you access to easy to read information in plain language on health topics so you can take an active part in managing your health.
- Health Education Answers is an on-line resource filled with information about wellness, as well as interactive features, surveys and games. It includes in-depth information about different health conditions as well.
- HealthyRoads in an online self-help health improvement and wellness web site that offers an online Personal Health Assessment (PHA) along with a variety of other tools including exercise and nutrition planners, health and activity trackers, a Wellness library and E-Coaching Classes which are self guided courses on a variety of health improvement topics.

Your rights

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

- Years in existence
- Profit status

If you want more information about us, call 859-269-4475 or Toll Free 800-787-2680, or write to Bluegrass Family Health Government Programs, 651 Perimeter Drive, Suite 300, Lexington, KY 40517. You may also contact us by fax at 859-335-3750 or visit our Web site at www.bgfh.com/feds.html.

Your medical and claims records are confidential

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

Service Area

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

Kentucky- All of Kentucky

Southern Indiana- Clark, Crawford, Floyd, Harrison, Jefferson, Orange, Scott, and Washington counties

You can use non-participating providers while outside our service area. If you use non-participating providers you will be responsible for your deductible and coinsurance amounts. In addition to these amounts, you are responsible for the balance over our plan allowances that the provider may bill for.

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 2011

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 Change

- Several provisions of the Affordable Care Act (ACA) affect eligibility and benefits under the FEHB Program and FSAFEDS beginning January 1, 2011. For instance, children up to age 26 will be covered under a Self and Family enrollment. Please read the information in Sections 11 and 12 carefully.
- We have reorganized organ and tissue transplant benefit information to clarify coverage.
- We have reorganized Mental health and substance abuse benefits to clarify coverage.

Changes to this Plan

- Your share of the non-Postal premium will stay the same for Self Only and Self and Family. See page 86.
- This Plan will no longer be offered in the following Tennessee counties under the Federal Employee Health Benefits Program during 2011: Campbell, Claiborne, Clay, Dekalb, Fentress, Hickman, Jackson, Lewis, Marshall, Montgomery, Morgan, Overton, Pickett, Putnam, Scott, Trousdale and White. You will need to choose another health plan during Open Season for the 2011 plan year.
- Beginning January 1, 2011, currently eligible over-the-counter (OTC) products that are medicines or drugs will not be eligible for reimbursement from your Health Savings Account (HSA) or your Health Reimbursement Arrangement (HRA) – unless – you have a prescription for that item written by your physician. The only exception is insulin - you will not need a prescription from January 1, 2011 forward. Other currently eligible OTC items that are not medicines or drugs will not require a prescription.
- The penalty for withdrawals from an HSA for non-medical expenses increases from 10% to 20% after January 1, 2011.
- The limit for morbid obesity has been removed. See page 38.
- You now have enhanced smoking cessation benefits. See page 37.
- The limit on infertility has been removed. See page 32.

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 Participating Provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 859-269-4475 or Toll free at 800-787-2680 or write to us at Bluegrass Family Health, Government Programs, 651 Perimeter Drive, Suite 300, Lexington, KY 40517. You may also request replacement cards through MyBluegrassInfo: www.bgfh.com.

Where you get covered care

You should seek care from "Participating Providers" and "Participating Facilities." When utilizing Participating Providers and Facilities, you will pay only the deductibles, coinsurance and copays listed in this brochure, up to the maximum out of pocket limit.

- **Participating providers**

Participating 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 Participating Providers according to national standards.

We list Participating Providers in the provider directory, which we update periodically. The list is also on our Web site www.bgfh.com/feds.html.

- **Participating facilities**

Participating 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.

- **Non-Participating Providers and Facilities**

You may choose either Participating or Non-Participating providers. When you use providers and facilities that are part of the network, you may have a larger part of your medical bills covered. You can use other doctors, but at a higher cost.

What you must do to get covered care

It depends on the type of care you need. You can go to any provider you want, but we must approve some care in advance.

- **Continuity of Care**

If you are receiving treatment from a Participating Provider and that provider's agreement to provide medically necessary services terminates for reasons other than medical competence, fraud or professional behavior, you may be entitled to continue treatment by the terminating provider if at the time of the provider's termination you are disabled, being treated for a congenital condition, being treated for a life-threatening illness, or you are past the twenty-fourth week of pregnancy.

The treating provider must contact us and request continuity of treatment. The maximum duration of continued treatment with the terminated provider may not exceed ninety (90) days from the date of the provider's termination; 9 months in the case of a member diagnosed with a terminal illness; or through the delivery of a child, in the case of a member past the 24th week of pregnancy.

- **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 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 859-269-4475 or Toll Free at 800-787-2680. If you are new to the FEHB Program, we will arrange for you to receive care and reimburse you for your covered expenses while you are in the hospital beginning on the effective date of your coverage.

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

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

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

How to get approval for…

For services that require prior authorization/pre-certification, the Plan must approve the services before those services are obtained.

- **Your hospital stay**

In most cases, your participating physician or hospital will take care of precertification. However, you are responsible for verifying if covered services have been prior authorized by the Plan.

- **How to precertify an admission**

For prior authorization of medical services, the member's provider should call the Health Care Operations (HCO) department at 877-449-2884 or 859-335-3737.

You and your provider are responsible for ensuring that prior authorization has been obtained from the Plan's HCO department for services that require prior approval.

All elective admissions require precertification at least 14 days prior to admission. Urgent/ Emergent admissions should be called in by the physician or hospital the next business day. If, in the opinion of the physician, it is necessary for the member to be confined for a longer time than certified, the physician or the hospital may request more days be certified by contacting the HCO department with additional clinical information to warrant an extended hospitalization.

All precertifications/authorizations are based on medical necessity and benefit limitations; they are not a guarantee of payment, payment level or member eligibility. Questions regarding benefits can be answered by contacting our Customer Service department at 859-269-4475 or Toll Free at 800-787-2680.

- **Maternity care**

You do not need to precertify a maternity admission for a routine delivery. However, the Plan must be notified within 24 hours of your hospital admission. If your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

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

- If no one contacts us to obtain prior authorization/precertification prior to the service being obtained, benefits will be denied.
- If we denied the precertification request for an inpatient admission, we will not pay inpatient hospital benefits.
- When we precertified the admission but you remained in the hospital beyond the number of days we approved and did not get the additional days precertified, then the additional days will be denied.

Circumstances beyond our control

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

Services requiring our prior approval

Some services require prior 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.

You must obtain approval for certain services such as:

- Surgical treatment of morbid obesity (bariatric surgery);
- Select outpatient surgery/procedures;
- Inpatient confinements, skilled nursing facilities, rehabilitation facilities, and inpatient hospice;
- Covered transplant surgery;
- Non-emergent ambulance and air ambulance transportation services;
- Certain medications;
- Certain radiology procedures;
- Durable Medical Equipment/Orthotics - Purchases $500 or greater/All rentals, Repair/ Maintenance;
- Prosthetics-$2000 or greater;
- Cardiac rehabilitation;
- All Home Health/Home Infusion services - the ordering provider must contact Care Continuum at 502-339-8088 or toll free at 877-700-3482;
- Chiropractic services - through ACN Group 800-873-4575;
- Mental health and substance abuse care. You must contact OptumHealth Behavioral Solutions, Inc. at 877-369-2201 for information on precertification.

Providers must call Healthcare Operations at 859-335-3737 or 877-449-2884 for authorization.

This is not a conclusive list. Please refer to your Prior Authorization/Precertification List.

Section 4. Your costs for covered services

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

Copayments	A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive certain services. Example: When you have met the deductible, you pay $10 per 1st tier prescription medication you have filled.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Deductible	A specified dollar amount of covered services that must be incurred by you, either individually or combined as a covered family, before any benefits are payable by us for all or part of the remaining plan year. You must satisfy your deductible before your Traditional medical coverage begins. Your in-network deductible is $2,500 for a Self Only enrollment and $5,000 for a Self and Family enrollment. Your out-of-network deductible is $5,000 for a Self Only enrollment and $10,000 for a Self and Family enrollment. The Self and Family deductible can be satisfied by **two or more family members**. The individual limit for the Family deductible is $2,500 in-network and $5,000 out-of-network. Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan. If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance does not begin until you meet your deductible Example: In our Plan, you pay 0% of our allowance for Participating Providers for durable medical equipment.
Differences between our Plan allowance and the bill	The Usual, Customary and Reasonable (UCR) Amount is the amount that the Plan determines to be the Eligible Expense for a service. The Eligible Expense is determined by the healthcare service or procedure being performed and the usual amount paid for this procedure. If you go to a Participating Provider, you will be responsible for any Copayment, Coinsurance and/or Deductible amount. You will not be responsible for any amount billed over the UCR amount. In other words, you will not be balanced-billed by your Participating Provider. However, if you go to a Non-Participating Provider, you will be responsible for your Copayment, Coinsurance and /or Deductible amount, PLUS any amount that the Non-participating Provider bills that is above the Plan's UCR amount. This means that you can be balance-billed by your Non-participating Provider. If you use a Non-participating Provider, you may have your Provider submit a pre-determination of benefits request to the Plan's Customer Service Department. This will provide you with an estimate of the Plan's payment prior to receiving services.

Your catastrophic protection out-of-pocket maximum

Out-of-pocket maximums are the amount of out-of-pocket expenses that a Self Only or a Self and Family will have to pay in a plan year. Out-of-pocket maximums apply on a calendar year basis only.

Expenses applicable to out-of-pocket maximums– Only the deductible and those out-of-pocket expenses resulting from the application of coinsurance percentage or copay (except any penalty amounts) may be used to satisfy the out-of-pocket maximums.

Note: Once you have paid your deductible and satisfied your out-of-pocket maximums, eligible medical expenses will be covered at 100%.

HDHP If you have met your deductible, the following would apply:

In-Network:

Self Only: Your annual out-of-pocket maximum is $5,000 including the deductible

Self and Family: Your annual out-of-pocket maximum is $7,500 including the deductible

Out-of-Network:

Self Only: Your annual out-of-pocket maximum is $10,000 including the deductible

Self and Family: Your annual out-of-pocket maximum is $15,000 including the deductible.

The following cannot be included in the accumulation of out-of-pocket expenses:

• Any expenses paid by the Plan under your In-network Preventive Care benefit

• Expenses in excess of our allowance or maximum benefit limitations or expenses not covered under the Traditional medical coverage

• Any coinsurance expenses you have paid for infertility services

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

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 and supplies 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 Deductible Health Plan Benefits

See page 10 for how our benefits changed this year and page 84 for a benefits summary.

Section 5. High Deductible Health Plan Benefits Overview

This Plan offers a High Deductible Health Plan (HDHP). The HDHP benefit package is described in this Section. Make sure that you review the benefits that are available under the benefit product in which you are enrolled. Review The General Directions section, some directions have been revised which address the Affordable Care Act.

HDHP Section 5, which describes the HDHP benefits, is divided into subsections. Please read *Important things you should keep in mind about these benefits* at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about HDHP benefits, contact us at 859-269-4475 or Toll Free at 800-787-2680 or at our Web site at www.bgfh.com.

Our HDHP option provides comprehensive coverage for high-cost medical events and a tax-advantaged way to help you build savings for future medical expenses. The Plan gives you greater control over how you use your health care benefits.

When you enroll in this HDHP, we establish either a Health Savings Account (HSA) or a Health Reimbursement Arrangement (HRA) for you. We automatically pass through a portion of the total health Plan premium to your HSA or credit an equal amount to your HRA based upon your eligibility.

With this Plan, in-network preventive care is covered in full when you use Participating Providers. As you receive other non-preventive medical care, you must meet the Plan's deductible before we pay benefits according to the benefits described on page 72. You can choose to use funds available in your HSA to make payments toward the deductible or you can pay toward your deductible entirely out-of-pocket, allowing your savings to continue to grow.

This HDHP includes five key components: preventive care; traditional medical coverage health care that is subject to the deductible; savings; catastrophic protection for out-of-pocket expenses; and health education resources and account management tools.

- **Preventive care** — The Plan covers preventive care services, such as periodic health evaluations (e.g., annual physicals), screening services (e.g., routine mammograms), routine prenatal and well-child care, child and adult immunizations, disease management and wellness programs. These services are covered at 100% if you use a participating provider and the services are described in Section 5 *Preventive Care. You do not have to meet the deductible before using these services*.

- **Traditional medical coverage** — After you have paid the Plan's deductible ($2,500 for Self Only enrollment and $5,000 for Self and Family enrollment in-network and $5,000 for Self Only and $10,000 for Self and Family out-of-network), we pay benefits under Traditional medical coverage described in Section 5. The Plan typically pays 100% for in-network and 70% for out-of-network care.

  Covered services include:

  - Medical services and supplies provided by physicians and other health care professionals
  - Surgical and anesthesia services provided by physicians and other health care professionals
  - Hospital services; other facility or ambulance services
  - Emergency services/accidents
  - Mental health and substance abuse benefits
  - Prescription drug benefits

- **Savings** — Health Savings Accounts or Health Reimbursement Arrangements provide a means to help you pay out-of-pocket expenses (see below for more details).

Health Savings Accounts (HSA)

By law, HSAs are available to members who are not enrolled in Medicare, cannot be claimed as a dependent on someone else's tax return, have not received VA benefits within the last three months, or do not have other health insurance coverage other than another high deductible health plan. In 2011, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $104.17 per month for a Self Only enrollment or $208.33 per month for a Self and Family enrollment. In addition to our monthly contribution, you have the option to make additional tax advantaged contributions to your HSA, so long as total contribution do not exceed the limit established by law, which is $3,050 for an individual and $6,150 for a family. See maximum contribution information on page 23. You can use funds in your HSA to help pay your health plan deductible. You own your HSA, so the funds can go with you if you change plans or employment.

Federal tax tip: There are tax advantages to fully funding your HSA as quickly as possible. Your HSA contribution payments are fully deductible on your Federal tax return. By fully funding your HSA early in the year, you have the flexibility of paying qualified medical expenses from tax-free HSA dollars or after tax out-of-pocket dollars. If you don't deplete your HSA and you allow the contributions and the tax-free interest to accumulate, your HSA grows more quickly for future expenses.

HSA features include:

- Chard Snyder, Inc. has been selected by us to administer your account and provide a debit card. Fifth Third Bank will handle the fiduciary responsibilities
- Your contributions to the HSA are tax deductible
- You may establish pre-tax HSA deductions from your paycheck to fund your HSA up to IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.)
- Your HSA earns tax-free interest
- You can make tax-free withdrawals for qualified medical expenses for you, your spouse and dependents (see IRS publication 502 for a complete list of eligible expenses)
- Your unused HSA funds and interest accumulate from year to year
- It's portable - the HSA is owned by you and is yours to keep, even when you leave Federal employment or retire
- When you need it, funds up to the actual HSA balance are available

Important consideration if you want to participate in a Health Care Flexible Spending Account (HCFSA): If you are enrolled in this HDHP with a Health Savings Account (HSA), and start or become covered by a HCFSA health care flexible spending account (such as FSAFEDS offers – see Section 12), this HDHP cannot continue to contribute to your HSA. Similarly, you cannot contribute to an HSA if your spouse enrolls in an HCFSA. Instead, when you inform us of your coverage in an HCFSA, we will establish an HRA for you.

Health Reimbursement Arrangements (HRA)

If you are not eligible for an HSA, for example you are enrolled in Medicare or have another health plan, we will administer and provide an HRA instead. You must notify us that you are ineligible for an HSA.

In 2011, we will give you an HRA credit of $104.17 per month for a Self Only enrollment and $208.33 per month for a Self and Family enrollment. You can use funds in your HRA to help pay your health plan deductible and/or for certain expenses that don't count toward the deductible.

HRA features include:

- For our HDHP option, the HRA is administered by Chard Snyder, Inc.
- HRA credits are applied for each month you are eligible (prorated from your effective date to the end of the plan year).
- Tax-free credit can be used to pay for qualified medical expenses for you and any individuals covered by this HDHP
- Unused credits carryover from year to year
- HRA credit does not earn interest
- HRA credit is forfeited if you leave Federal employment or switch health insurance plans
- An HRA does not affect your ability to participate in an FSAFEDS Health Care Flexible Spending Account (HCFSA). However, you must meet FSAFEDS eligibility requirements.

- **Catastrophic protection for out-of-pocket expenses**

When you use participating providers, your annual maximum for out-of-pocket expenses (deductibles, coinsurance and copayments) for covered services is limited to $5,000 for Self Only or $7,500 for Self and Family enrollment. If you use non-participating providers, your out-of-pocket maximum is $10,000 for Self Only or $15,000 for Self and Family enrollment. However, certain expenses do not count toward your out-of-pocket maximum and you must continue to pay these expenses once you reach your out-of-pocket maximum (such as expenses in excess of the Plan's allowable amount or benefit maximum). Refer to *Section 4 Your catastrophic protection out-of-pocket maximum and HDHP Section 5 Traditional medical coverage subject to the deductible* for more details.

- **Health education resources and account management tools**

HDHP Section 5(i) describes the health education resources and account management tools available to you to help you manage your health care and your health care dollars.

As a member, you will have access to MyBluegrassInfo, a secure and personalized member website offering you a single source for health and benefits information.

Section 5. Savings – HSAs and HRAs

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Administrator	The Plan will establish an HSA for you at Fifth Third Bank, the HDHP's fiduciary (an administrator, trustee or custodian as defined by Federal tax code and approved by IRS). The Plan selected Chard Snyder, Inc. as the administrator. Chard Snyder, Inc. 3510 Irwin Simpson Road Mason, Ohio 45040 You can contact Chard Snyder's customer service line at 1-800-982-7715 or 1-513-459-9997, or visit their website (www.chard-snyder.com) for more information.	Chard Snyder, Inc. is the HRA administrator for this Plan. Chard Snyder, Inc. 3510 Irwin-Simpson Road Mason, OH 45040 You can contact Chard Snyder's customer service line at 1-800-982-7715 or 1-513-459-9997, or visit their website (www.chard-snyder.com) for more information.
Fees	There is no HSA set-up fee. The administrative fee is covered in the premium while the member is covered under the HDHP. Unlimited Fifth Third Jeanie ATM/POS Transactions. You may be charged a terminal fee by another bank when using your Fifth Third card at their ATM when making cash withdrawals and/or balance inquiries. When you are no longer covered under this HDHP, there is a $5 administrative fee that will be deducted from your HSA account every month.	There is no HRA set-up fee. *There are no transaction fees.*

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Eligibility	You must: • Enroll in this HDHP. • Have no other health insurance coverage (does not apply to specific injury, accident, disability, dental, vision or long term care coverage). • Not be enrolled in Medicare Part A or Part B • Not be claimed as a dependent on someone else's tax return. • Not have received VA benefits in the last three months • Complete and return all banking paperwork.	You must enroll in this HDHP. Eligibility is determined on the first day of the month following your effective day of enrollment and will be prorated for length of enrollment.
Funding	If you are eligible for HSA contributions, a portion of your monthly health plan premium is deposited to your HSA each month. Premium pass through contributions are based on the effective date of your enrollment in the HDHP. In addition, you may establish pre-tax HSA deductions from your paycheck to fund your HSA up to the IRS limits using the same method that you use to establish other deductions (i.e., Employee Express, MyPay, etc.). HSA participants can also make deposits through Chard Snyder's online payments feature (www.chard-snyder.com) or by mailing a check to: Chard Snyder Attention HSA Department 3510 Irwin Simpson Road Mason, Ohio 45040	Eligibility for monthly credits will be determined on the first day of the month and will be prorated for length of enrollment.
• **Self Only enrollment**	For 2011, a monthly premium pass through of $104.17 will be made by the HDHP directly to your HSA each month.	For 2011, your monthly HRA credit is $104.17.
• **Self and Family enrollment**	For 2011, a monthly premium pass through of $208.33 will be made by the HDHP directly into your HSA each month.	For 2011, your monthly HRA credit is $208.33.

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
Contributions/credits	The maximum that can be contributed to your HSA is an annual combination of HDHP premium pass through and enrollee contribution funds, which when combined, do not exceed the maximum contribution amount set by the IRS of $3,050 for an individual and $6,150 for a family. If you enroll during Open Season, you are eligible to fund your account up to the maximum contribution limit set by the IRS. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum allowable contribution. You are eligible to contribute up to the IRS limit for partial year coverage as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. To determine the amount you may contribute, take the IRS limit and subtract the amount the Plan will contribute to your account for the year. If you do not meet the 12 month requirement, the maximum contribution amount is reduced by 1/12 for any month you were ineligible to contribute to an HSA. If you exceed the maximum contribution amount, a portion of your tax reduction is lost and a 20% penalty is imposed. There is an exception for death or disability. • You may rollover funds you have in other HSAs to this HDHP HSA (rollover funds do not affect your annual maximum contribution under this HDHP). • HSAs earn tax-free interest (does not affect your annual maximum contribution). • Catch-up contribution discussed on page 26	A monthly credit will be made to your HRA by the Plan. You cannot contribute to the HRA. The HRA does not earn interest.

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
• **Self Only enrollment**	You may make an additional annual maximum contribution of $1,799.96.	You cannot contribute to the HRA.
• **Self and Family enrollment**	You may make an additional annual maximum contribution of $3,650.04.	You cannot contribute to the HRA.
Access funds	For prescriptions, the pharmacist will be able to provide you with the discounted rate at the point of sale, so you can use your debit card for the purchase. For doctor/medical visits, you will receive a bill from your doctor or hospital and an Explanation of Benefits (EOB) from us. Make sure the EOB matches your bill, then you can write your HSA MasterCard number on the paper invoice and mail it back as payment. You can also use Fifth Third's Online Bill Payer (www.53.com) to pay electronically from your account. While the debit card and on-line bill payer are free of charge, if you wish to have checks you must purchase those. Your HSA account allows you one free check per month. You will be charged $2 for each additional check clearing on your HSA account in any one given month.	You can access your HRA by the following methods: • Debit card – The Debit Card must be activated in order to access the HRA Funds, customer service and online information. • Complete a reimbursement form, attach a receipt and mail it to Chard Snyder, Inc. Chard Snyder, Inc. 3510 Irwin-Simpson Road Mason, OH 45040 • Fax form and supporting documentation to 888-245-8452.
Distributions/withdrawals • **Medical**	You can pay the out-of-pocket expenses for yourself, your spouse or your dependents (even if they are not covered by the HDHP) from the funds available in your HSA. See IRS Publication 502 for a list of eligible medical expenses.	You can pay the out-of-pocket expenses for qualified medical expenses for individuals covered under the HDHP. Non-reimbursed qualified medical expenses are allowable if they occur after the effective date of your enrollment in this Plan. See *Availability of funds* below for information on when funds are available in the HRA. See IRS publication 502 for a list of eligible medical expenses. Physician prescribed over-the-counter drugs and Medicare Premiums are also reimbursable. Most other types of medical insurance premiums are not reimbursable.

Feature Comparison	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA) Provided when you are ineligible for an HSA
• **Non-medical**	If you are under age 65, withdrawal of funds for non-medical expenses will create a 20% income tax penalty in addition to any other income taxes you may owe on the withdrawn funds. When you turn 65, distributions can be used for any reason without being subject to the 20% penalty however, they will be subject to ordinary income tax.	Not applicable – distributions will not be made for anything other than non-reimbursed qualified medical expenses.
Availability of funds	Funds are not available for withdrawal until all the following steps are completed: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accord with the event permitting the enrollment change). • The HDHP receives record of your enrollment and initially establishes your HSA account with the fiduciary by providing information it must furnish and by contributing the minimum amount required to establish an HSA. • We send mandatory enrollment information including an HSA enrollment form, HSA Custodial Agreement and Beneficiary Form for the enrollee to complete, and the Plan administrator receives the completed paperwork back from you.	Funds are not available until: • Your enrollment in this HDHP is effective (effective date is determined by your agency in accordance with the event permitting the enrollment change). • The Plan administrator receives mandatory enrollment information back from you.
Account owner	FEHB enrollee	HDHP
Portable	You can take this account with you when you change plans, separate or retire. If you do not enroll in another HDHP, you can no longer contribute to your HSA. See page 22 for HSA eligibility.	If you retire and remain in this HDHP, you may continue to use and accumulate credits in your HRA. If you terminate employment or change health plans, only eligible expenses incurred while covered under the HDHP will be eligible for reimbursement subject to timely filing requirements. Unused funds are forfeited.
Annual rollover	Yes, accumulates without a maximum cap.	Yes, accumulates without a maximum cap.

If You Have an HSA

If you have an HSA

- **Contributions**

  All contributions are aggregated and cannot exceed the maximum contribution amount set by the IRS. You may contribute your own money to your account through payroll deductions, or you may make lump sum contributions at any time, in any amount not to exceed an annual maximum limit. If you contribute, you can claim the total amount you contributed for the year as a tax deduction when you file your income taxes. Your own HSA contributions are either tax-deductible or pre-tax (if made by payroll deduction). You receive tax advantages in any case. To determine the amount you may contribute, subtract the amount the Plan will contribute to your account for the year from the maximum contribution amount set by the IRS. You have until April 15 of the following year to make HSA contributions for the current year.

  If you newly enroll in an HDHP during Open Season and your effective date is after January 1st or you otherwise have partial year coverage, you are eligible to fund your account up to the maximum contribution limit set by the IRS as long as you maintain your HDHP enrollment for 12 months following the last month of the year of your first year of eligibility. If you do not meet this requirement, a portion of your tax reduction is lost and a 10% penalty is imposed. There is an exception for death or disability.

- **Catch-up contributions**

  If you are age 55 or older, the IRS permits you to make additional "catch-up" contributions to your HSA. The allowable catch-up contribution is $1,000. Contributions must stop once an individual is enrolled in Medicare. Additional details are available on the U.S. Department of Treasury Web site at www.ustreas.gov/offices/public-affairs/hsa/.

- **If you die**

  If you do not have a named beneficiary, if you are married, it becomes your spouse's HSA; otherwise, it becomes part of your taxable estate.

- **Qualified expenses**

  You can pay for "qualified medical expenses," as defined by IRS Code 213(d). These expenses include, but are not limited to, medical plan deductibles, diagnostic services covered by your plan, long-term care premiums, health insurance premiums if you are receiving Federal unemployment compensation, physician prescribed over-the-counter drugs, LASIK surgery, and some nursing services.

  When you enroll in Medicare, you can use the account to pay Medicare premiums or to purchase any health insurance other than a Medigap policy. You may not, however, continue to make contributions to your HSA once you are enrolled in Medicare.

  For a detailed list of IRS-allowable expenses, request a copy of IRS Publication 502 by calling 1-800-829-3676, or visit the IRS Web site at www.irs.gov and click on "Forms and Publications." Note: Although physician prescribed over-the-counter drugs are not listed in the publication, they are reimbursable from your HSA. Also, insurance premiums are reimbursable under limited circumstances.

- **Non-qualified expenses**

  You may withdraw money from your HSA for items other than qualified health expenses, but it will be subject to income tax and if you are under 65 years old, an additional 20% penalty tax on the amount withdrawn.

- **Tracking your HSA balance**

  You will receive a monthly statement on your HSA account from Fifth Third Bank. If you have more than one account with Fifth Third, you will receive a combined statement. You can check the status of your HSA at any time by logging on to www.53.com.

- **Minimum reimbursements from your HSA**

  You can request reimbursement in any amount.

If You Have an HRA

If you have an HRA

- **Why an HRA is established**

  If you don't qualify for an HSA when you enroll in this HDHP, or later become ineligible for an HSA, we will establish an HRA for you. If you are enrolled in Medicare, you are ineligible for an HSA and we will establish an HRA for you. You must tell us if you become ineligible to contribute to an HSA.

- **How an HRA differs**

  Please review the chart on page 21 which details the differences between an HRA and an HSA. The major differences are:

  - You cannot make contributions to an HRA
  - Funds are forfeited if you leave the HDHP
  - An HRA does not earn interest, and
  - HRAs can only pay for qualified medical expenses, such as deductibles, copayments, and coinsurance expenses, for individuals covered by the HDHP. FEHB law does not permit qualified medical expenses to include services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.

Section 5. Preventive care

Important things you should keep in mind about these benefits:

- Preventive care services listed in this Section are not subject to the deductible or coinsurance if you utilize Participating Providers.
- If you go to a Non-Participating Provider for these preventive care services, you will be responsible for the Out-of-Network deductible and coinsurance for the services provided. However, you may elect to use your HSA or HRA account to pay the bill, up to your account balance.
- For all other covered expenses, please see Section 5 – *Traditional medical coverage subject to the deductible.*

Benefit Description	You pay
Preventive care, adult	
Routine screenings, such as: • Cholesterol/Lipid Screening — one annually 35 years and older • Routine Prostate Specific Antigen (PSA) test — one annually for men • Prostrate Exam—one annually for men 50 years and older • Digital rectal exam (DRE)— one annually for men 50 years and older • Colorectal Cancer Screening, including - Flexible Sigmoidoscopy screening — one annually 50 years and older; - Air contrast barium enema — one annually 50 years and older; - Colonoscopy screening — one annually 50 years and older; • Screening for Sexually Transmitted Diseases (HIV, Chlamydia, Gonorrhea, Syphilis) — one annually • Routine well-woman exam including Pap test — one annually for women • Bone Density Study — one annually for women 35 years and older • Routine mammogram — one annually for women 30 years and older	In-Network: Nothing at a participating provider
Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC): • Tetanus-diphtheria (Td) booster • Influenza vaccine, annually • Pneumococcal vaccine-- one annually 65 years and older	In-Network: Nothing at a participating provider
• Routine Physicals --one annually • Routine Exams limited to: - 1 routine OB/GYN exam every 12 months including 1 Pap smear and related services - 1 routine hearing exam every 24 months	In-Network: Nothing at a participating provider
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*

Benefit Description	You pay
Preventive care, children	
Professional services, such as: • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Childhood immunizations recommended by the American Academy of Pediatrics Examinations, such as: • 1 routine hearing exam every 24 months through age 17 to determine the need for hearing correction	In-Network: Nothing at a participating provider
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams or travel.* • *Immunizations, boosters, and medications for travel or work-related exposure.*	*All charges*

Section 5. Traditional medical coverage subject to the deductible

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.
- In-network preventive care is covered at 100% (see page 28) and is not subject to the calendar year deductible. Out-of-network preventive care is covered at 70% of allowable charges after the out-of-network deductible.
- The in-network deductible is $2,500 per person or $5,000 per family enrollment. The out-of-network deductible is $5,000 for Self Only and $10,000 for Self and Family enrollment. The family deductible can be satisfied by **two or more** family members. The individual limit for the Family deductible is $2,500 in-network and $5,000 out-of-network. The deductible applies to almost all benefits under Traditional medical coverage. You must pay your deductible before your Traditional medical coverage may begin.
- Under Traditional medical coverage, you are responsible for your deductible and coinsurance for covered expenses.
- When you use participating providers, you are protected by an annual catastrophic maximum on out-of-pocket expense for covered services. After your coinsurance, copayments and deductibles total $5,000 in-network or $7,500 in-network per family enrollment in any calendar year, you do not have to pay any more for covered services from participating providers. However certain expenses do not count toward your out-of-pocket maximum (such as expense in excess of the Plan's benefit maximum, or if you use the out-of- participating providers, amounts in excess of the Plan allowance.
- 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 After the calendar year deductible…
Deductible before Traditional medical coverage begins	
The deductible applies to almost all benefits in this Section. In the **You pay** column, we say "No deductible" when it does not apply. When you receive covered services from participating providers, you are responsible for paying the allowable charges until you meet the deductible	100% of allowable charges until you meet the deductible of $2,500 per person or $5,000 per family enrollment.
After you meet the deductible, we pay the allowable charge (less your coinsurance or copayment) until you meet the annual catastrophic out-of-pocket maximum.	In-network: After you meet the deductible, you pay the indicated coinsurance or copayments for covered services. You may choose to pay the coinsurance from your HSA or HRA, or you can pay for them out-of-pocket. Out-of-network: After you meet the deductible, you pay the indicated coinsurance based on our Plan allowance, and any difference between our allowance and the billed amount

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.
- The in-network deductible is $2,500 for Self Only enrollment and $5,000 for Self and Family enrollment each calendar year. The out-of-network deductible is $5,000 for Self Only enrollment and $10,000 for Self and Family enrollment. The Self and Family deductible can be satisfied by **two or more** family members. The individual limit for Family deductible is $2,500 in-network and $5,000 out-of-network. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, coverage begins for Traditional medical services.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- 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 After the calendar year deductible…
Diagnostic and treatment services	
Professional services of physicians • In physician's office • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical or medical opinion	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI/CTA/MRA/PET Scans (see *Prior Approval*, page 13) • Nuclear Stress/Radionuclide Cardiac Imaging (see *Prior Approval*, page 13) • Ultrasound • Electrocardiogram and EEG	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount

Benefit Description	You pay After the calendar year deductible…
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care including one (1) routine ultrasound per pregnancy • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; however, we must be notified within 24 hours of your inpatient admission. See below for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay for you or your baby if medically necessary. See page 12 for other circumstances. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See *Surgical procedures* Section 5 (b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling.*	*All charges*
Infertility services	
Diagnosis and treatment of infertility: • Artificial insemination: - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI)	In-network: 50% of our Plan allowance, then all charges thereafter Out-of-Network: *All charges*

Infertility services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Infertility services (cont.)	
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization* - *embryo transfer, including, but not limited to, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services provided in the setting of ovulation induction such as ultrasounds, laboratory studies, and physician services* • *Injectable fertility drugs* • *Infertility treatment when the FSH level is 19mIU/ml or greater on day 3 of menstrual cycle* • *The purchase, freezing and storage of donor sperm and donor embryos* • *Services and supplies related to the above mentioned services, including sperm processing*	*All charges*
Allergy care	
• Testing and treatment • Allergy injections • Allergy serum	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered: *Certain allergy tests, such as:* - *skin titration (Rinkel Test),* - *cytoxicity testing (Bryan's Test),* - *urine auto injection,* - *provocative and neutralization testing for allergies,* - *or for an assessment of IgG antibodies in food allergies.*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 40. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit.	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount

Treatment therapies - continued on next page

Benefit Description	You pay After the calendar year deductible…
Treatment therapies (cont.)	
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 *Services requiring our prior approval* in Section 3.	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount
Physical and occupational therapies	
60 visits per condition per member per calendar year, beginning with the first day of treatment for the services of each of the following: • qualified physical therapists and • occupational therapists 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. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is provided for up to 60 sessions.	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*
Speech therapy	
• 60 visits per condition per member per calendar year	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Long-term rehabilitative therapy*	*All charges*
Vision services (testing, treatment, and supplies)	
• Treatment of eye diseases and injury • One routine eye exam every 12 months through age 17 (not subject to deductible) • One routine exam every 24 months ages 18 and older (not subject to deductible) • $100 allowance toward purchase of eyeglasses or contact lenses per plan year	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount

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

Benefit Description	You pay After the calendar year deductible…
Vision services (testing, treatment, and supplies) (cont.)	
Not covered: • *Fitting of contact lenses* • *Eye exercises and orthoptics* • *Services, supplies or other care for educational or training procedures used in connection with vision therapy and/or services.* • *Treatment for the correction of refractive error, including but not limited to radial keratotomy, keratomileusis or lasik eye surgery.*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose (See *Prior Approval*, page 13) • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Hearing aids up to $1,400 per ear every 36 months; the hearing aid and all related services must be prescribed by an audiologist an dispensed by a licensed audiologist or hearing instrument specialist. • Internal prosthetic devices , such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. Note: If more than one prosthetic appliance/orthotic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic/orthotic device.	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Hearing services (testing, treatment, and supplies)	
• Hearing tests for children through age 17, (as shown in Preventive care, children) • Hearing aids, as shown in Orthopedic and prosthetic devices.	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Routine hearing test or screening other than the screening of a newborn in the Hospital.* • *Services not related to the diagnosis or management of a specific illness or traumatic injuries.* • *Hearing-aids, testing and examinations for them, except as otherwise listed.*	*All charges*
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include: • Oxygen; • Dialysis equipment; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. Note: Call us at 859-269-4475 or Toll free at 800-787-2680 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. Prior approval required for DME over $500. See Section 3.	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Medical supplies and equipment purchased without a prescription such as pressure garments and band-aids* • *Home or place of business modifications such as ramps, air conditioners, seat lift chairs or supplies or attachments for any of these items.* • *Any Durable Medical Equipment, prosthesis or orthotic device having convenience or luxury features which are not medically necessary.*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Home health services	
• Home health care ordered by a 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 (see *Prior Approval*, page 13). • Services include oxygen therapy, intravenous therapy and medications.	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.* • *Services or supplies provided by the family of the covered person or volunteer ambulance associations.*	*All charges*
Chiropractic	
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application (see *Prior Approval*, Page 13)	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount
Alternative treatments	
No Benefit	*All charges*
Educational classes and programs	
• Smoking cessation programs - individual and group and counseling - telephone counseling up to 52 calls per year - appoved smoking cessation drugs (see *Presciption drug benefits*)	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount
• Childhood and adult obesity education	In-Network: Nothing Out-of-Network: 30% of our Plan allowance and any difference between our allowance and the billed amount
• Diabetes self management	In-network: Nothing Out-of-Network: 30% of our Plan allowance and any difference between our allowance and the billed amount

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.
- The in-network deductible is $2,500 for Self Only enrollment and $5,000 for Self & Family enrollment each calendar year. The out-of-network deductible is $5,000 for Self Only enrollment and $10,000 for Self and Family enrollment. The Self and Family deductible can be satisfied by **two or more** family members. The individual limit for the Family deductible is $2,500 in-network and $5,000 out-of-network. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts or copayments for eligible medical expenses and prescriptions.
- 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 After the calendar year deductible…
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Insertion of internal prosthetic devices . See 5(a) *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
• Surgical treatment of morbid obesity (bariatric surgery) Note: You must meet our Plan criteria and be approved for surgical treatment for morbid obesity. You may obtain a copy of the criteria by accessing our website at www.bgfh.com.	In-network: Nothing Out-of-network: *All charges*

Surgical procedures - continued on next page

Benefit Description	You pay After the calendar year deductible…
Surgical procedures (cont.)	
Not covered: • *Reversal of voluntary sterilization* • *Surgery primarily for cosmetic purposes*	*All charges*
Reconstructive surgery	
• Surgery to correct functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see *Prosthetic devices*) 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.	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Not covered: • *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* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Medically necessary surgical treatment of TMJ and CMJ (See Section 3); • Excision of cysts and incision of abbesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.

Oral and maxillofacial surgery - continued on next page

Benefit Description	You pay After the calendar year deductible…
Oral and maxillofacial surgery (cont.)	
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingival and alveolar bone)*	*All charges*
Organ/tissue transplants	
These **solid organ transplants** are subject to medical necessity and experimental/investigational review by the Plan. Refer to Other services in Section 3 for prior authorization procedures. • Cornea • Heart • Heart/lung • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach, and pancreas • Kidney • Liver • Lung: single/bilateral/lobar • Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	In-network: Nothing Out-of-network: *All charges*
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. Autologous tandem transplants for • AL Amyloidosis • Multiple myeloma (de novo and treated) • Recurrent germ cell tumors (including testicular cancer)	In-network: Nothing Out-of-network: All charges
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. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. For the diagnoses listed below, the medical necessity limitation is considered satisfied if the patient meets the staging description.	In-network: Nothing Out-of-network: *All charges*

Organ/tissue transplants - continued on next page

Benefit Description	You pay After the calendar year deductible…
Organ/tissue transplants (cont.)	
• Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e. myleogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinpathy - Marrow Failure and Related Disorders (i.e. Fanconi's, PNH, pure red cell aplasia) - Myelodysplasia/Myelodysplastic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Phagocytic/Hemophagocytic deficiency diseases (i.e., Wiskott-Aldrick Syndrome) - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for - Acute lymphocytic or nonlymphocytic (i.e. myleogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurrence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurrence (relapsed) - Amyloidosis - Breast Cancer - Epithelial ovarian cancer - Multiple myeloma - Neuroblastoma - Testicular, Mediastinal, Retroperitonael, and ovarian germ cell tumors	In-network: Nothing Out-of-network: *All charges*
Mini-transplants (non-myeloblative, reduced intensity conditioning) for covered transplants: Subject to medical necessity	In-network: Nothing Out-of-network: *All charges*
Tandem transplants for covered transplants: Subject to medical necessity	In-network: Nothing Out-of-network: *All charges*
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 bone marrow/stem cell transplant donors in addition to the testing of family members.	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

Benefit Description	You pay After the calendar year deductible…
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount

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 .
- The in-network deductible is $2,500 for Self Only enrollment and $5,000 for Self & Family enrollment each calendar year. The out-of-network deductible is $5,000 for Self Only enrollment and $10,000 for Self and Family enrollment. The Self and Family deductible can be satisfied by **two or more** family members. The individual limit for the Family deductible is $2,500 in-network and $5,000 out-of-network. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- 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 your Prior Authorization/Precertification List in Section 3.

Benefit Description	You Pay
Inpatient hospital	
Room and board such as; • Ward, semiprivate or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. Other hospital services and supplies, such as: • Operating, recovery, maternity and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment and any covered items billed by a hospital for use at home.	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount

Inpatient hospital - continued on next page

Benefit Description	You Pay
Inpatient hospital (cont.)	
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes and schools* • *Personal hygiene and personal comfort items, such as barber services, telephone and television* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressing, casts and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service 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.	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered: Blood and blood derivatives not replaced by the donor	*All charges*
Extended care benefits/Skilled nursing care facility benefits	
• Extended care • Skilled nursing facility (SNF) Note: Limited to 60 days per plan year when medically necessary and approved by the Plan. (See *Prior Approval*, Page 13)	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes and schools* • *Personal hygiene and personal comfort items, such as barber services, telephone and television* • *Private nursing care*	*All charges*

Benefit Description	You Pay
Hospice care	
Hospice services are covered when a covered person has been certified by a physician to be terminally ill and elects Hospice coverage in lieu of continued attempts at a cure. Hospice includes services, supplies and care to help provide comfort and relief from pain such as: • Physician services • Nursing care • Medical appliances and supplies • Drugs for symptom management and pain relief • Respite care and home health aides • Physical therapy, occupational therapy, and speech/language pathology services, and • Counseling Note: All services required for treatment of the terminal illness must be provided by or through the hospice. Some services require prior plan approval. Before granting approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Treatment for the terminal illness which is not for symptom management and pain control;* • *Care given by another healthcare provider that was not arranged for by the patient's hospice*	*All charges*
Ambulance	
Local professional ambulance service when medically necessary Note: Non urgent/non emergent ambulance transfers require prior approval (See *Prior Approval*, page 13)	In-network: Nothing Out-of-network: Nothing
Not Covered: • *Non-emergency transportation to receive services* • *Air ambulance*	*All charges*

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.
- The in-network deductible is $2,500 for Self Only enrollment and $5,000 for Self & Family enrollment each calendar year. The out-of-network deductible is $5,000 for Self Only enrollment and $10,000 for Self and Family enrollment. The Self and Family deductible can be satisfied by **two or more** family members. The individual limit for the Family deductible is $2,500 in-network and $5,000 out-of-network. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your coinsurance amounts for eligible medical expenses and prescriptions.
- 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:

In the event of a medical emergency, you should go to the nearest hospital or urgent care facility.

Services for medically necessary emergency care are covered, whether a Participating Provider or a Non-Participating Provider delivers the care. Benefits are provided for treatment of emergency medical conditions and emergency screening and stabilization services without Prior Authorization for conditions that reasonably appear to a prudent layperson to constitute an emergency medical condition based upon the patient's presenting symptoms and conditions. These services may include accident or medical care provided at a hospital, such as emergency screening and stabilization services.

Emergencies within and outside our service area:

If you are admitted to the hospital as a result of an emergency or directly from a hospital emergency room, your Provider should contact us within 24 hours of admission, or as soon as reasonably possible, to obtain authorization for the inpatient stay.

Follow-up care is not considered Emergency Care.

Benefit Description	You pay After the calendar year deductible…
Emergency within our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including physician services	In-network or out-of-network: Nothing
Not covered: • *Elective care or non-emergency care*	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including physician services	In-network or out-of-network: Nothing
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
Professional ambulance service when medically appropriate. *Note: See 5(c) for non-emergency ambulance services.*	In-network or out-of network: Nothing
Not covered: *Non-emergency transportation to receive services*	*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.
- The calendar year deductible or, for facility care, the inpatient deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- 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:

  - OptumHealth Behavioral Solutions, Inc. is a healthcare organization responsible for the management of mental health and substance abuse benefits. Members are required to initiate a call to OptumHealth Behavioral Solutions, Inc. for all of their mental health/ chemical dependency needs. OptumHealth Behavioral Solutions, Inc. can be reached at 877-369-2201.

- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- 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 After the calendar year deductible…
Professional Services	
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, clinical social workers, licensed professional counselors or marriage and family therapists.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.

Professional Services - continued on next page

Benefit Description	You pay After the calendar year deductible…
Professional Services (cont.)	
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Diagnostics	
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Inpatient hospital or other covered facility	
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations	In-network: Nothing Out-of-Network: 30% of our Plan allowance and any difference between our allowance and the billed amount.
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services such full-day hospitalization or facility-based intensive outpatient treatment	In-network: Nothing Out-of-Network: 30% of our Plan allowance and any difference between our allowance and the billed amount
Not covered	
• Services that are not part of a preauthorized approved treatment plan	All Charges

Section 5(f). Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Our Copayment levels reflect in-network pharmacies only. There are no out-of-network Prescription Drug benefits available except in an urgent or emergent situation while traveling outsite of our service area.
- 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.
- The in-network deductible is $2,500 for Self Only enrollment and $5,000 for Self & Family enrollment each calendar year. The out-of-network deductible is $5,000 for Self Only enrollment and $10,000 for Self and Family enrollment. The Self and Family deductible can be satisfied by two or more family members. The individual limit for the Family deductible is $2,500 in-network and $5,000 out-of-network. The deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- Under your Traditional medical coverage, you will be responsible for your copayment amounts for eligible medical expenses and eligible prescriptions.
- 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 Medicare.

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

- **Who can write your prescription.** A licensed physician or licensed practitioner (as allowed by law) must write the prescription.
- **Where you can obtain them.** In order to access your pharmacy benefits, you must use a participating pharmacy (except in an urgent or emergent situation) and your pharmacist must transmit the claim via computer to the Plan's pharmacy benefit manager. If you are at the pharmacy and you do not have your identification card, please instruct the pharmacist to contact the our Pharmacy Services Department at 859-335-3755 or 877-205-6308. Prescriptions purchased at participating pharmacies that have not been submitted online by the pharmacist will not be eligible for reimbursement.

  If you are outside the service area and you need to have a prescription filled, you may take your prescription and your identification card to any participating chain pharmacy such as Wal-Mart, Rite-Aid, K-Mart, CVS, Winn-Dixie, Kroger, Meijer, or Walgreen's. If the pharmacy encounters difficulty in processing the claim, please instruct the pharmacist to contact our Pharmacy Services Department at 877-205-6308 during normal business hours (Monday – Friday, between 8 am and 6 pm Eastern Time excluding holidays) or CVS Caremark PBM Call Center at 800-952-4164 after business hours, on weekends and on holidays.

  Our prescription mail order service offers a 90 day supply for maintenance medications. The 90-day mail-order supply will be modified so that coverage beyond the 12 months designated in the benefit is not provided.
- **Precertification.** Due to the nature of some medications, prior authorization (PA) may be required before the Plan will cover the medication's cost. Prior Plan Approvals (PA) are based on established clinical guidelines and the patient's medical history and only physicians may request medication PPA. If your physician has prescribed a medication that requires PA, he or she will need to contact our Pharmacy Services Department, to obtain an approval PRIOR to you receiving the medication. PA's will not be issued after the prescription has been filled. Visit our Web site at www.bgfh.com/feds.html to review our Formulary or call 877-205-6308.

- **Special limitations.** In order for some medications to be covered, step-therapy may be required. Step therapy is an electronic PA process that takes place at the time the pharmacist files the claim. For medications that are considered "second-line" agents, the system will look at the member's claims history and if a claim(s) for the required "first-line" medication(s) is found, the system will approve the claim. If "first-line" medications are not found, the system will not approve the claim and will send a message back to the pharmacy advising that the step-therapy protocol has not been met. At that time, the pharmacy may contact your physician and request that they contact the Plan for PA.

  In accordance with the Food and Drug Administration guidelines, the quantity dispensed and/or timeframe of use of certain covered medications may be limited. FDA approved maximum doses established for safety will determine quantity limits. For some medications, a one-month supply does not equal 30 units. Benefits for covered prescription medications are limited to quantities that can reasonably be consumed or used within one month, or as otherwise authorized under the Plan. Limits are based on clinical considerations including patient safety and appropriate use. The list of these medications includes, but is not limited to, narcotic analgesics, sedative/hypnotics, migraine medications and second-line antibiotics.

- **Why use generic drugs?** A generic medication is called by its chemical name; a manufacturer assigns a brand name. Brand medications may have generic equivalents. The price of the generic medication is usually lower than that of a brand name medication. Both generic and brand name products have the same active ingredients. Overall, the generic medication is just as safe and effective as the brand name medication.

- **When you do have to file a claim.** If you pay out-of-pocket for a prescription at a participating pharmacy, you may return to the pharmacy within 60 days, have the claim reprocessed online and be reimbursed for the eligible out-of-pocket expense. For all other reimbursement requests a Prescription Reimbursement Form must be filed along with the receipt for each prescription. Requests may be faxed or mailed to the Plan. If you are reimbursed by the Plan for an eligible out-of-pocket prescription expense, you will be paid based on the Plan's contracted pharmacy rates, minus your coinsurance. Requests for out-of-pocket prescription reimbursement received more than six months after the prescription was filled will not be eligible for reimbursement**.** The Prescription Reimbursement Form can be found on our web site at http://www.bgfh.com/pdf/prescription_claim_form.pdf .

Benefit Description	You pay After the calendar year deductible…
Prescription Drugs	
Covered medications and supplies	
We cover the following medications and supplies prescribed by your attending physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines for which a prescription is required by Federal law, except those listed as Not Covered. • Diabetic supplies limited to lancets and blood glucose test strips • Insulin • Disposable needles and syringes for the administration of covered medications • Contraceptive drugs and devices Limited benefits: • Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits. • One diaphragm per calendar year	In-network Retail Pharmacy (up to a 30 day supply): • Tier I: $10 Copay • Tier II: $20 Copay • Tier III: $40 Copay Mail Order (up to a 90 day supply): • Tier I: $20 Copay • Tier II: $40 Copay • Tier III: $80 Copay Out-of-network: *All charges*
• Smoking cessation drugs Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence require a written prescription.	In-Network: Nothing
Not covered: • *Compounded medications that are prepared by a pharmacist and not FDA approved in their final form* • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Fertility drugs except as provided in Section 5(a)* • *Drugs obtained at non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins and nutritional substances that can be purchased without prescription* • *Nonprescription medicines except Smoking Cessation Drugs* • *Lost, stolen or damaged drugs*	*All charges*

Section 5(g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. 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. Until you sign and return the agreement, regular contract benefits will continue. • 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. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • 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. • 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 benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
***Nurse*First**	For any of your health concerns, 24 hours a day, 7 days a week, you may call and talk with a registered nurse who will discuss treatment options and answer your health questions at 800-391-6861.
Special Delivery Maternity Program	The Special Delivery Maternity Program provides health and pregnancy materials. A RN Case Manager follows the progress and provides support throughout your pregnancy. You can be self-referred or referred by your Obstetrician. Pregnant members may also be identified and contacted by the Plan.
Centers of Excellence	We utilize nationally-recognized transplant networks, including United Resource Network (U.R.N.).

Section 5(h). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The in-network calendar year deductible is: $2,500 per person ($5,000 per family). The calendar year deductible applies to all benefits in this Section.
- After you have satisfied your deductible, your Traditional medical coverage begins.
- We cover hospitalization for dental procedures only when a non-dental serious physical and/or serious mental impairment or significant behavioral problem 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 Decription	You Pay After calendar year deductible
Accidental injury benefit	
• 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. Note: Initial evaluation must occur within 72 hours of the accident. A dentist must certify to the Plan that the tooth was a sound natural tooth that was injured as a result of an accident. • Coverage is provided for general anesthesia and hospital or ambulatory surgical facility charges in connection with dental problems for children below the age of nine (9) years, persons with Serious Mental or Physical Conditions, and persons with Significant Behavioral Problems, when certified by the treating dentist or admitting Physician.	In-network: Nothing Out-of-network: 30% Coinsurance of our Plan allowance and any difference between our allowance and the billed amount.
Dental benefits	
We have no other dental benefits	

Section 5(i). Health education resources and account management tools

Special features	Description
Health education resources	We publish an e-newsletter to keep you informed on a variety of issues related to your good health. Visit our Web site at www.bgfh.com for the most recent information on: • General health topics • Links to health care news • Wellness, Prevention and Disease Management Program • Drugs/medication interactions • Patient safety information • and several helpful Web site links.
Account management tools	The Fifth Third HSA is a personal checking account with other investment possibilities once a required balance has been reached. Chard Snyder serves as the TPA for your account set up, deposit and customer service needs. You can contact Chard Snyder's customer service line at 1-800-982-7715 or 1-513-459-9997, or visit their website (www.chard-snyder.com) for more information. • Within 7-14 business days after your account has been set up, your HSA debit MasterCard and PIN# will be mailed to the address you provided on your banking application. For security purposes, these will come as two separate mailers. Your PIN# will be needed to access on-line banking and is the code needed for using ATMs. • If you already use Fifth Third Bank's online banking, you will see your Fifth Third Bank HSA with all of your other Fifth Third Bank accounts. • If you are new to Fifth Third, visit www.53.com. Once you get to the sign on page, click "Sign On:, then click "Personal Accounts". Your "Access ID" is your 16-digit debit MasterCard number, and your "Password" is the PIN number that is mailed to you. • You will receive a monthly statement on your HSA account. If you have more than one account with Fifth Third Bank, you will receive a combined statement. • The Chard Snyder website (www.chard-snyder.com) contains more information and additional forms related to your account. • If you provide an email address on your application, you will receive an email when deposits are posted to your account for any payments made directly through Chard Snyder. • HSA participants can make deposits through Chard Snyder's online payments feature (www.chard-snyder.com) or by mailing a check to: Chard Snyder 3510 Irwin Simpson Road Mason, Ohio 45040
Consumer choice information	As a member of this HDHP, you may choose any provider. However, you will receive discounts when you see a participating provider. Directories are available online at www.bgfh.com. Pricing information for medical care is available through HealthGrades at www.bgfh.com. Pricing information for prescription drugs is available through RxEOB at www.bgfh.com.
Care support	Patient safety information is available online at www.bgfh.com.

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

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

We do not cover the following:

- 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 or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term;
- Services, drugs, or supplies related to sex transformations;
- 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;or
- Extra care costs and Research costs associated wtih Clinical Trials.

Section 7. Filing a claim for covered services

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 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 1-800-787-2680.

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 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); and,
- Receipts, if you paid for your services.

Submit your claims to:

Bluegrass Family Health
P.O. Box 22738
Lexington, KY 40522-2738

Prescription drugs

Submit your claims to:

Bluegrass Family Health
Pharmacy Reimbursement
651 Perimeter Drive, Suite 300
Lexington, KY 40517

Mental Health Claims

Submit your claims to:

UBH
P.O. Box 30757
Salt Lake City, UT 84130-0757

Chiropractic Claims

Submit your claims to:

ACN Group, Inc.
P.O. Box 212
Minneapolis, MN 55440-0212

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.

Urgent care claims procedures

If you have an urgent care claim, please contact our Customer Service Department at 1-800-787-2680. Urgent care claims must meet the definition found in Section 10 of this brochure, and most urgent care claims will be claims for access to care rather than claims for care already received. We will notify you of our decision not later than 24 hours after we receive the claim as long as you provide us with sufficient information to decide the claim. If you or your authorized representative fails to provide sufficient information to, we will inform you or your authorized representative of the specific information necessary to complete the claim not later than 24 hours after we receive the claim and a time frame for our receipt of this information. We will decide the claim within 48 hours of (i) receiving the information (ii) the end of the time frame, whichever is earlier.

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

Concurrent care claims procedures

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment as an appealable decision. If we believe a reduction or termination is warranted we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

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.

Pre-service claims procedures

As indicated in Section 3, certain care requires Plan approval in advance. We will notify you of our decision within 15 days after the 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 before the expiration 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.

If you fail to follow these pre-service claim procedures, then we will notify you of your failure to follow these procedures as long as (1) your request is made to our customer service department and (2) your request names you, your medical condition or symptom, and the specific treatment, service, procedure, or product requested. We will provide this notice within five days following the failure or 24 hours if your pre-service claim is for urgent care. Notification may be oral, unless you request written correspondence.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review as long as we 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.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond. Our deadline for responding to your claim is stayed while we await all of the additional information needed to process your claim.

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, a health care professional with knowledge of your medical condition will be permitted 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

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.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3. You may be able to appeal to the U.S. Office of Personnel Management (OPM) immediately if we do not follow the particular requirements of this disputed claims process. For more information about situations in which you are entitled to immediately appeal and how to do so, please visit www.bgfh.com/feds. 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: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Bluegrass Family Health, Attn: Appeals Coordinator, 651 Perimeter Drive, Suite 300, Lexington, KY 40517; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or b) Write to you and maintain our denial - go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision. In the case of an appeal of an urgent care claim, we will notify you of our decision not later than 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.

Step	Description
4	If you do not agree with our decision, you may ask OPM to review it. 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, Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • 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 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.
5	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at 859-269-4475 or 800-787-2680. 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 3 at 202-606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under any other health plan or 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 payor. 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; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (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. 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 859-269-4475 or Toll free at 800-787-2680 or see our Web site at www.bgfh.com/feds.html.

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

You can find more information about how our plan coordinates benefits with Medicare in Coordination of Bluegrass Family Health Benefits with Medicare at www.bgfh.com/feds.html.

- **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 also 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 Participating 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 one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMVA.

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. You must use our providers.

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

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

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

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 does not cover these costs.
- 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 • 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 • 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 an eligible expense that must be paid by the covered person for certain covered services. Coinsurance does not include deductibles or non-covered expenses during the plan year.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. (see page 14)
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	A service or supply that is available under the Plan, when medically necessary or otherwise specifically included as a benefit under your certificate of coverage, within the scope of the license of the provider performing the service, rendered while coverage with us is in force, is not experimental/investigational or otherwise excluded or limited by your certificate of coverage, or by any amendment or rider thereto, authorized in advance by us if such prior authorization is required in your certificate of coverage, and is obtained in full compliance with all plan delivery system rules. Please refer to the Plan's delivery system rules. A charge for a covered service shall be considered to have been incurred on the date the service or supply was provided.
Custodial care	Care provided primarily for maintenance of the patient or which is designed essentially to assist the patient in meeting activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness, disease, accidental injury, or condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, catheter care, feeding by utensil, tube or gastrostomy, transfer or positioning in bed, and supervision over self-administration of medications not requiring constant attention of trained medical personnel.
Deductible	A specified dollar amount of covered services that must be incurred by you, either individually or combined as a covered family, before any benefits are payable by us for all or part of the remaining plan year.

Experimental or investigational service

Services or supplies, including treatments, procedures, hospitalizations, drugs, equipment, diagnostic, biological products or medical devices, used in or directly related to the diagnosis, evaluation, or treatment of a disease, injury, illness, or other health condition which we determine in our sole discretion to be experimental/investigational, or a Peer Review Panel determines are:

1.) not of proven benefit for the particular diagnosis or treatment of the covered person's particular condition;

2.) not generally recognized by the medical community as effective or appropriate for the particular diagnosis or treatment of the covered person's particular condition; or

3.) provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

We will not cover any services or supplies, including treatment, procedures, drugs, biological products or medical devices or any hospitalization in connection with experimental or investigational services or supplies. We shall not cover any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular diagnosis or treatment of the covered person's particular condition. Government approval of a technology is not necessarily sufficient to render it of proven benefit or appropriate or effective for a particular diagnosis or treatment of the particular condition as explained below.

The Plan shall apply criteria as outlined in your certificate of coverage, in determining whether services or supplies are experimental or investigational

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

The services or supplies furnished by a Provider that are required to identify or treat a Covered Person's illness or injury and which, as determined by the Plan, are:

A. consistent with the symptom or diagnosis and treatment of the Covered Person's condition, disease, ailment, or injury;

B. appropriate with regard to standards of good medical practice;

C. not solely for the convenience of a Covered Person or Provider; and

the most appropriate supply or level of service that can be safely provided to the Covered Person. When applied to the care of an Inpatient, it further means that the Covered Person's medical symptoms or condition require that the services cannot be safely provided as an Outpatient.

Out-of-Pocket Limit

The maximum amount of coinsurance and copayments you pay every plan year. When the out-of-pocket limit is reached, coinsurance and copayments ceases for the rest of the plan year.

Any amounts not paid because a maximum benefit limit has been reached, any charges for non-covered health services, coinsurance for covered health services available by an optional rider, coinsurance amounts for prescription drugs (if prescription drugs are a covered benefit in your plan), infertility coinsurance amounts (if infertility is a covered benefit in your plan), or any amount above an eligible expense will never apply to the out-of-pocket limit. The particular out-of-pocket limit for your plan is identified on your Schedule of Benefits.

Even when the out-of-pocket maximum has been reached, you will still be required to pay any charges for non-covered services, coinsurance for covered health services available by an optional rider, coinsurance amounts for prescription drugs (if prescription drugs are a covered benefit in your plan), infertility coinsurance amounts (if infertility is a covered benefit in your plan), and any amount above an eligible expense.

Plan allowance

The plan allowance, also described as Usual, Customary and Reasonable (UCR) Amount is the amount that the Plan determines to be the eligible expense for a service. The eligible expense is determined by the healthcare service or procedure being performed and the usual amount paid for this procedure in Kentucky.

If you go to a participating provider, you will be responsible for any coinsurance and/or deductible amount. You will not be responsible for any amount billed over the UCR amount. In other words, you will not be balance-billed by your provider.

However, if you go to a non-participating provider, you will be responsible for your coinsurance and/or deductible amount, PLUS any amount that the non-participating provider bills that is above the Plan's UCR amount. This means that you can be balance-billed by your provider. If you use a non-participating provider, you may have your provider submit a pre-determination of benefits request to the Plan's Customer Service Department. This will provide you with an estimate of the Plan's payment prior to receiving services.

Urgent care

Health care or treatment with respect to which the application of the time periods for making non-urgent determinations:

1. Could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function; or

2. In the opinion of a physician with knowledge of the covered person's medical condition, would subject the covered person to severe pain that cannot be adequately managed without urgent care or treatment.

Urgent care claims

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 1-800-787-2680. 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.

Us/We

Us, We and Our refer to Bluegrass Family Health.

You

You refers to any covered person.

High Deductible Health Plan (HDHP) Definitions

Calendar year deductible

A specified dollar amount of covered services that must be incurred by you, either individually or combined as a covered family, before any benefits are payable by us for all or part of the remaining plan year.

High Deductible Health Plan (HDHP) You must satisfy your deductible before your Traditional medical coverage begins. For the HDHP, your in-network deductible is $2,500 for a Self Only enrollment and $5,000 for a Self and Family enrollment. Your out-of-network deductible is $5,000 for a Self Only enrollment and $10,000 for a Self and Family enrollment. The Self and Family deductible can be satisfied by **two or more family members**. The individual limit for the Family deductible is $2,500 in-network and $5,000 out-of-network.

Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

And, if you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Catastrophic limit

Out-of-pocket maximums are the amount of out-of-pocket expenses that a Self Only or a Self and Family will have to pay in a plan year. Out-of-pocket maximums apply on a calendar year basis only.

Expenses applicable to out-of-pocket maximums– Only the deductible and those out-of-pocket expenses resulting from the application of coinsurance percentage (except any penalty amounts) and copay amounts may be used to satisfy the out-of-pocket maximums.

Note: For the HDHP, once you have paid your deductible and satisfied your out-of-pocket maximums, eligible medical expenses will be covered at 100%.

If you have met your deductible, the following would apply:

- Self Only:
  In-network: Your annual out-of-pocket maximum is $5,000 including the deductible.
  Out of-network: Your annual out-of-pocket maximum is $10,000 including the deductible.
- Self and Family:
  In-network: Your annual out-of-pocket maximum is $7,500 including the deductible.
  Out of-network: Your annual out-of-pocket maximum is $15,000 including the deductible.

The following cannot be included in the accumulation of out-of-pocket expenses:

- Any expenses paid by the Plan under your In-network Preventive Care benefit
- Expenses in excess of our allowance or maximum benefit limitations or expenses not covered under the Traditional medical coverage
- Any coinsurance expenses you have paid for infertility services

Note: If you change options in this Plan during the year, we will credit the amount of covered expenses already accumulated toward the catastrophic out-of-pocket limit of your old option to the catastrophic protection limit of your new option.

Health Savings Account (HSA)	An HSA is a special, tax-advantaged account where money goes in tax-free, earns interest tax-free and is not taxed when it is withdrawn to pay for qualified health care services.
Health Reimbursement Arrangement (HRA)	An HRA combines a Fund with a deductible-based medical plan with coinsurance limits. The HRA Fund pays first. Once you exhaust your HRA Fund, Traditional medical coverage begins after you satisfy your deductible.
High Deductible Health Plan (HDHP)	An HDHP is a plan with a deductible of at least $1,200 for individuals and $2,400 for families for 2010, adjusted each year for cost of living.
Premium Pass Through	The amount of money we contribute to your HSA on a monthly basis. In 2010, for each month you are eligible for an HSA premium pass through, we will contribute to your HSA $104.17 per month for Self Only and $208.33 per month for Self and Family.

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; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

Several provisions of the Affordable Care Act (ACA) affect the eligibility of family members under the FEHB Program effective January 1, 2011.

Children	Coverage
Between ages 22 and 26	Children between the ages of 22 and 26 are covered under their parent's Self and Family enrollment up to age 26.
Married Children	Married children (but NOT their spouse or their own children) are covered up to age 26. This is true even if the child is currently under age 22.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are eligible for coverage up to age 26.
Stepchildren	Stepchildren do not need to live with the enrollee in a parent–child relationship to be eligible for coverage up to age 26.
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.
Foster Children	Foster children are eligible for coverage up to age 26.

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

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 or stepchildren 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 when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 26 turns 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.

- **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 2011 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 2010 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. Three Federal Programs complement FEHB benefits

Important information

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

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

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

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

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

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

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

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

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

Dental Insurance

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

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

Vision Insurance

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

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/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.

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

Notes

Notes

Summary of benefits for the HDHP of Bluegrass Family Health - 2011

Do not rely on this chart alone. All benefits 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.

In 2011, for each month you are eligible for the HSA, we will deposit $104.17 per month for Self Only enrollment or $208.33 per month for Self and Family enrollment to your HSA. You must satisfy your calendar year deductible by using your HSA or by paying out-of-pocket. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

For the Health Reimbursement Arrangement (HRA), for each month you are enrolled, we will credit $104.17 to your HRA Fund for Self Only and $208.33 for Self and Family. Once your calendar year deductible is satisfied, Traditional medical coverage begins.

The calendar year deductible applies to all benefits except In-network medical preventive care. Your in-network deductible is $2,500 for a Self Only enrollment and $5,000 for a Self and Family enrollment. Your out-of-network deductible is $5,000 for a Self Only enrollment and $10,000 for a Self and Family enrollment.

HDHP Benefits	You Pay	Page
In-network medical preventive care	Nothing at a participating provider	28
Medical services provided by physicians:		31
Diagnostic and treatment services provided in the office	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount	31
Services provided by a hospital:		43
• Inpatient	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount	43
• Outpatient	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount	44
Emergency benefits:	In-network or out-of-network: Nothing	46
Mental health and substance abuse treatment:	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount	48

HDHP Benefits	You Pay	Page
Prescription drugs:		50
• Retail pharmacy (up to a 30 day supply)	Tier I: $10 Copay Tier II: $20 Copay Tier III: $40 Copay	52
• Mail order (up to a 90 day supply)	Tier I: $20 Copay Tier II: $40 Copay Tier III: $80 Copay	52
Dental care:(Accidental injury benefit only)	No benefit	54
Vision care:(Limited benefit)	In-network: Nothing Out-of-network: 30% of our Plan allowance and any difference between our allowance and the billed amount	34
Special features: Flexible benefits option, NurseFirst, Special Delivery Maternity Program, Centers of Excellence		53
Protection against catastrophic costs (out-of-pocket maximum)**:**	In-network: Nothing after $5,000 Self Only or $7,500 Self and Family enrollment per year. Out-of-network: Nothing after $10,000 Self Only or $15,000 Self and Family enrollment per year. Some costs do not count toward this protection. Your deductible counts toward your out-of-pocket maximum.	72

2011 Rate Information for Bluegrass Family Health

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

Postal rates apply to career Postal Service employees. Most employees should refer to the Guide to Benefits *for Career* UnitedStates Postal Service Employees, RI 70-2, and to the rates shown below.

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

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

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
HDHP Option Self Only	KV1	$163.52	$54.50	$354.29	$118.09	$184.23	$33.79
HDHP Option Self and Family	KV2	$327.01	$109.00	$708.52	$236.17	$368.43	$67.58