Highmark Choice Company
Community Blue HMO

www.highmarkbcbs.com

1-866-283-4995

2016

Community Blue HMO
A Health Maintenance Organization

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See pages 4 and 8 for details.

IMPORTANT
- Rates: Back Cover
- Changes for 2016: Page 15
- Summary of benefits: Page 82

Serving: Western Pennsylvania

Enrollment in this plan is limited:

- You must live in our geographic service area to enroll.
- See page 14 for requirements.

Enrollment Codes for This Plan

NP(1) - Self Only
NP(2) - Self and Family
NP(3) - Self Plus One

Special Notice:
Keystone Health Plan West, Inc. will be changing its name for 2016 to Highmark Choice Company pending OPM approval.

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

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

Important Notice from Community Blue HMO about

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management (OPM) has determined that the Community Blue HMO 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. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug 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, Community Blue HMO, 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 Medicare Part D 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 will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) 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 800-772-1213 (TTY: 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: 877-486-2048).

Table of Contents

Introduction

This brochure describes the benefits of Highmark Choice Company's Community Blue HMO under our contract (CS 2948) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Member Services may be reached at 1-866-283-4995. Information can also be found on our website: highmarkbcbs.com. The address for Community Blue HMO is: Member Services, P.O. Box 226, Pittsburgh, PA 15230

Highmark Choice Company is an affiliate of Highmark Blue Cross Blue Shield, and a licensed controlled affiliate of the Blue Cross and Blue Shield Association. Highmark Blue Cross Blue Shield is an independent licensee of the Blue Cross and Blue Shield Association.

This brochure is the official statement of benefits. No verbal 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. If you enroll in Self Plus One coverage, you and one eligible family member that you designate when you enroll are entitled to these benefits.You do not have a right to benefits that were available before January 1, 2016, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2016, and changes are summarized in Section 2, page 15. Rates are shown at the end of this brochure.

Coverage under this plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

The ACA establishes a minimum value for the standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). The health coverage of this plan does meet the minimum value standard for the benefits the plan provides.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means Highmark Choice Company or Community Blue HMO.
- 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.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Periodically review your claims history for accuracy to ensure we have not been billed for services that you did not receive.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 1-866-283-4995 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

OR go to www.opm.gov/oig www.opm.gov/our-inspector-general/hotline-toreport-

fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.You can also write to:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC 20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
  - Your child age 26 or over (unless he/she is disabled and incapable of self-support prior to age 26).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage or enrolling in the plan when you are no longer eligible.
- 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 by your provider for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

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

1. Ask questions if you have doubts or concerns.

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

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

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines and dosage that you take, including non-prescription (over-the-counter) medicines and nutritional supplements.
- Tell your doctor and pharmacist about any drug, food, and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist 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. Note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

3. Get the results of any test or procedure.

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

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

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

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

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

Patient Safety Links

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

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

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

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

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

Never Events

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

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

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 Community Blue HMO preferred providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

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.
Minimum essential coverage (MEC)	Coverage under this plan qualifies as minimum essential coverage (MEC) and satifies the ACA's individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.
Minimum value standard	Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.
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 that 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 brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you: • When you may change your enrollment; • How you can cover your family members; • What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire; • What happens when your enrollment ends; • When the next Open Season for enrollment begins. We don’t determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.
Types of coverage available for you and your family	Self Only coverage is for you alone. Self Plus One coverage is an enrollment that covers you and one eligible family member.Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support. Newborns are covered from birth and must be enrolled within 31 days after their birth. If you have a Self Only enrollment, you may change to a Self and Family or Self Plus One 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 Plus One or 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 Plus One or Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

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

If you have a qualifying life event (QLE) – such as marriage, divorce, or the birth of a child – outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and one eligible family member as described in the chart below.

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

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

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self Plus One or 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 Plus One or 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 Plus One or Self and Family coverage, as appropriate, 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 Plus One or Self and Family, as appropriate, 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 Plus One or Self and Family, as appropriate, 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. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. 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. **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 2016 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 2015 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

Follow these procedures.

When FEHB coverage ends

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

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

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

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

Upon divorce

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get information about your coverage choices. You can also visit OPM's website at http://www.opm.gov/healthcare-insurance/healthcare/plan-information/.

Temporary Continuation of Coverage (TCC)

If you leave Federal service or Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHBP coverage.

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 or Tribal 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.

In lieu of offering a non-FEHB plan for conversion purposes, we will assist you, as we would assist you in obtaining a plan conversion policy, in obtaining health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace. For assistance, call 1-866-283-4995 or visit www.highmarkbcbs.com.

Health Insurance Marketplace

If you would like to purchase health insurance through the Affordable Care Act's Health Insurance Marketplace, please visit **www.HealthCare.gov.** This is a website provided by the United States Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How this plan works

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Visit the website, www.highmarkbcbs.com and visit ***Find a Doctor*** to view the provider directory. Select the Community Blue HMO plan or network to find physicians who are part of this plan.

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

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

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

Under this Community Blue HMO plan, you select a Primary Care Provider (PCP) who will coordinate all of your care. Services include inpatient hospitalization, outpatient surgery, diagnostic testing, rehabilitation therapy, and other services as prescribed by your PCP.

You must satisfy a calendar year deductible of $250 per Self Only or $500 per Self Plus One or Self and Family. After you have satisfied the annual deductible, the plan pays 100% for covered surgical procedures and inpatient hospitalization. Please see section 5 for specific details on coverage.

You will have copayments for some covered office visits, urgent care centers and retail clinic visits, some therapy and rehabilitation services and prescription drugs. Please see section 5 for specific details on coverage.

Catastrophic Protection
This coverage affords you protection from catastrophic illness because there is a limit to your out-of-pocket costs for covered care. Your total out-of-pocket maximum for covered services, including deductibles and copayments, cannot exceed $6,550 for Self Only enrollment or $9,000 for Self Plus One or Self and Family enrollment.

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

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. We distribute our member rights and responsibilities statement to new members upon enrollment. You may also get information about us, our networks, providers and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you.

Members have the right to:

1. Receive information about Highmark Choice Company its products and services, its practitioners and providers and members' rights and responsibilities.
2. Be treated with respect and recognition of your dignity and right to privacy.
3. Participate with practitioners in decision making regarding your health care. This includes the right to be informed of your diagnosis and treatment plan in terms that you understand and participate in decisions about your care.
4. Have a candid discussion of appropriate and/or medically necessary treatment options for your condition(s), regardless of cost or benefit coverage. Highmark Choice Company does not restrict the information shared between practitioners and patients and has policies in place, directing practitioners to openly communicate information with their patients regarding all treatment options regardless of benefit coverage.

5. Voice a complaint or appeal about Highmark Choice Company or the care provided, and receive a reply within a reasonable period of time.
6. Make recommendations regarding our Members' Rights and Responsibilities policies.

Members have the responsibility to:

1. Supply to the extent possible, information that the organization needs in order to make care available to you, and that its practitioners and providers need in order to care for you.
2. Follow the plans and instructions for care that you have agreed on with your practitioners.
3. Communicate openly with the physician you choose. Ask questions and make sure you understand the explanations and instructions you are given, and participate in developing mutually agreed upon treatment goals. Develop a relationship with your doctor based on trust and cooperation.

If you have any questions, please call Member Services at 1-866-283-4995, or write to Member Services, P.O. Box 226, Pittsburgh, PA 15230. You may also visit our website at www.highmarkbcbs.com.

Highmark Choice Company is affiliated with Highmark, which is:

- An insurance company with more than 75 years experience
- Offering a not-for-profit HMO
- Compliant with federal and state licensing requirements

How We Protect Your Right to Confidentiality

We have established policies and procedures to protect the privacy of our members' protected health information ("PHI") in all forms, including PHI given verbally, from unauthorized or improper use. It's all part of safeguarding the confidentiality of your PHI.

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

To protect your privacy, we do not discuss PHI outside of our offices. We verify your identity before we discuss PHI with you over the phone. As permitted by law, we may use or disclose protected health information for treatment, payment and health care operations, such as: claims management, routine audits, coordination of care, quality assessment and measurement, case management, utilization review, performance measurement, customer service, credentialing, medical review and underwriting. With the use of measurement data, we are able to manage members' health care needs, even targeting certain individuals for health improvement and disease management programs.

- If we ever use your protected health information for non-routine uses, we will ask you to give us your permission by signing a special authorization form, except with regard to court orders and subpoenas.
- You have the right to access the information your doctor keeps in your medical records; just ask your network physician.

To protect the use of data we maintain we require our employees to sign statements in which they agree to protect your confidentiality. We use passwords to limit computer access to your PHI, and include confidentiality language in our contracts with vendors and other health care providers. We even inspect the privacy of examination rooms when we conduct on-site visits to physicians' offices.

Our Privacy Department reviews and approves policies regarding the handling of confidential information.

Service Area

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

Our service area includes the following Pennsylvania counties: Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Clarion, Clearfield, Crawford, Elk, Erie, Fayette, Greene, Huntingdon, Indiana, Jefferson, Lawrence, McKean, Mercer, Pottern, Somerset, Venango, Warren, Washington and Westmoreland.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. Other urgent or follow-up care can be obtained through the country's largest network of providers, through the Blue Cross and Blue Shield Association.

Urgent care is an unexpected illness or injury that cannot wait until you return home. You do not need to contact your PCP or network specialist for the initial urgent care visit. However, any follow up care must be coordinated through your PCP or network specialist before receiving services.

Follow-up care consists of ongoing services started before you leave home that you must continue while traveling. Follow-up care must be coordinated with your PCP or network specialist prior to traveling.

To receive out-of-area urgent or follow-up care, members should call the BlueCard Provider Access number at 1-800-810-BLUE. When you call, you will be given the names of Blue Cross and/or Blue Shield participating physicians in the area where you are traveling. You can also find a provider online at www.bcbs.com at the BlueCard Doctor and Hospital Finder website. Along with the BlueCard Program for urgent and follow-up care, you can use the service of BlueCard Worldwide to locate providers outside the U.S. Should you receive care out of the country, call your PCP when you return home to report your care.

To file for reimbursement, save your medical receipts and call a Member Service representative who will assist you with your claims filing.

Long-term travelers, separated families or students living out of the service area for 90 days or more, can become guest members in the area’s local Blue Cross and/or Blue Shield HMO if one is available. This service can be especially valuable for members who have ongoing health needs that require regular care while they are away, or for college students living away from home. More information on this Guest Membership program is available from Community Blue HMO Member Service.

Section 2. Changes for 2016

There are changes in the description for the specific plan in 2016. There have been changes in other parts of this brochure. Also, we edited and clarified language throughout the brochure; these do not change benefits.

(Effective Sept. 15, 2015, Keystone Health Plan West has changed its name to Highmark Choice Company. Highmark Choice Company is offering the Community Blue HMO plan for 2016.)

Do not rely only on these descriptions. This section is not an official statement of benefits. For that, go to Section 5, Plan Benefits Overview.

Program Wide Changes

- Changes to Community Blue HMO Plan for 2016:
- Hearing Aids -- The plan will add a $2,500 per calendar year benefit maximum for children up to the age of 22, and a $2,500 three-year benefit maximum for adults over age 22.
- Private Duty Nursing -- Covered at 100% after deductible; a limit of 240 hours per member per benefit period has been added.
- Prescription Drugs -- Adding a fourth tier to cover specialty medications (See section 5f).
- Home Health Care -- Adding a 90 day visit limit per member per contract year.

Highlights of Community Blue HMO Plan

- The Plan covers office visits, therapy and rehabilitation services, hospital and medical/surgical services, including maternity, usually at 100% after deductible is met. Specifics as described in Section 5, Benefits should be used as the official coverage statement.
- Please note that you or a family member can use the services, including behavioral health and well-woman care, of any network physician or specialist without a referral and receive the maximum coverage under your benefit program. Your personal physician can help you select an appropriate specialist and work closely with that specialist when the need arises. In addition, primary care providers or their covering physicians are on call 24/7.
- Deductible for the calendar year is $250 for Self and $500 for Self and Family.
- Copayments are required for visits to urgent care centers, retail clinics and physician offices, along with therapy and rehabilitation sessions. There are limits to the number of therapy sessions permitted.
- Calendar year deductible, coinsurance, and copayments now apply to maximum out-of-pocket.
- Your total out-of-pocket maximum for a calendar year is $4,500 per Self and $9,000 per Self and Family.
- Mental Health/ Substance Abuse inpatient and outpatient treatment is covered at 100% after deductible is met.
- Preventive services coverage follows the federal guidelines. They are listed on the Highmark Preventive Schedule. Gender, age and frequency limits may apply. See page 26 for details.
- There is no maximum on durable medical equipment, orthotics and prosthetic devices. These are covered at 100% after deductible is met.
- Skilled Nursing Facility care is limited to 100 days per benefit period, and paid at 100% after deductible is met. Home health care, hospice care and private duty nursing are covered at 100% after deductible is met. There is a limit of 240 hours per member per benefit period for private duty nursing.
- The prescription drug formulary is an extensive list of Food and Drug Administration (FDA) approved prescription drugs selected for their quality, safety and effectiveness.It includes products in every major therapeutic category.The formulary was developed by the Highmark Pharmacy and Therapeutics Committee made up of clinical pharmacists and physicians.

- Your program includes coverage for both formulary and non-formulary drugs at the specific copayment or coinsurance amounts listed in Section 5.There is a fourth tier for specialty medications.
- Under the hard mandatory generic provision, you are responsible for the payment differential when a generic drug is available and you or your physician choose to purchase the brand-name medication. You will pay the brand-name copayment as well as the difference in cost between the brand name and the generic medication.

Section 3. How you get care

Identification cards

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

You can also access a Virtual ID online, through the member website at www.highmarkbcbs.com. You can email or fax this to a provider or show it on a mobile device at the provider facilitiy. You may also request replacement cards through our website.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-866-283-4995. You can also write Member Services, P.O. Box 226, Pittsburgh, PA 15230.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance.

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is found under ***Find a Doctor*** on our website at www.highmarkbcbs.com. You can also view board certification, hospital affiliation or other professional qualifications. Type in your zip code and choose the Community Blue HMO plan and type of professional. Click on the physician's name to view credentials and hospital affiliation. Or call Member Services at 1-866-283-4995.

Network physicians provide care 24 hours a day, seven days a week. Outside normal office hours, they provide care by themselves or through a covering physician.

- We provide benefits for the services of covered professional providers, as required by Section 2706(a) of the Public Health Service Act (PHSA). Coverage of practitioners is not determined by your state's designation as a medically underserved area (MUA).
- Covered professional providers are medical practitioners who are licensed to perform covered services in a certain state.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also under ***Find a Doctor*** on our website at www.highmarkbcbs.com.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician (PCP) within 30 days of enrolling. Contact the PCP to make sure he or she is accepting new patients. This decision is important since your primary care physician provides or arranges for most of your health care. You can complete a ***PCP Change Form*** and mail it, or call Member Services to make a selection.

- **Primary care**

Your primary care physician (PCP) can be a general practitioner, family practitioner, internal medicine physician or pediatrician.

Your PCP must provide certain services, such as routine adult physical exams, routine pediatric physical exams and routine pediatric immunizations. For all other services, Community Blue HMO gives you the flexibility to go directly to any network provider without a referral from your PCP.

If you want to change primary care physicians or if your PCP leaves the Plan, call Member Services at 866-283-4995 and we will help you select a new one. You must pick a new PCP within 30 days.

You can use the services, including behavioral health and well-woman care, of any network physician or specialist without a referral and receive the maximum coverage under your benefit program. Your personal physician can help you select an appropriate specialist and work closely with that specialist when the need arises. In addition, primary care providers or their covering physicians are on call 24/7.

- **Specialty care**

You do not need a referral to go to a specialist for needed care.

However, you will want to discuss your options with your primary care physician, who may be able to suggest a specific specialist.

- **How to get your physicians professional qualifications**

To view board certification information, hospital affiliation or other professional qualifications of your PCP or network specialist, visit your member website at www.highmarkbcbs.com. and click on "Find a Doctor". Type in your zip code and choose the type of professional. Click on the physician's name to view credentials and hospital affiliation. Or call Member Services at 1-866-283-4995.

- **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.

You can use the services, including behavioral health and well-woman care, of any network physician or specialist without a referral and receive the maximum coverage under your benefit program. Your personal physician can help you select an appropriate specialist and work closely with that specialist when the need arises.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call Member Service at 1-866-283-4995. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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

- you are discharged, not merely moved to an alternative care center; or
- the day your benefits from your former plan run out.

- **Inpatient hospital admission**

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

- **Other services that need prior approval**

For certain services, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. Please review covered services in Section 5 to see if your PCP or specialists must obtain reauthorization before starting treatment.

Contact Member Service at 1-866-283-4995 for a complete listing of services that require precertification.

How to request precertification for admission or other services

First, your physician, your hospital, you, or your representative, must call us at 1-866-283-4995 before admission or services requiring precertification are rendered.

Next, provide the following information:

- enrollee’s name and plan identification number;

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

- **Non-urgent care claims**

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

- **Urgent care claims**

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

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

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 1-866-283-4995. You may also call OPM's Health Insurance 3 at 202-606-0737 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 1-866-283-4995. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

- **Concurrent care claims**

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 before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. 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.

- **Emergency inpatient admission**

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

- **Maternity care**

Female members have direct access to obstetrical and gynecological services. They may select a participating health care provider to obtain maternity and gynecological covered services including medically necessary and appropriate follow-up care and referrals for diagnostic testing relating to the maternity and gynecological care. Covered services must be within the scope of practice of the network, given by a participating health care provider.

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

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

- **Transitions and continuity of care**

  - If you are receiving medical care from a non-network provider when you enroll, you may continue with treatment for up to 60 days. This will allow you to receive services from your current specialist until we can make arrangements for you to see someone else.
  - If you have a chronic and disabling condition and lose access to your specialist, you may be able to continue seeing your specialist for up to 90 days. This could be because we:
    - terminate our contract with your specialist for other than cause; or
    - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
    - reduce our service area and you enroll in another FEHB plan.
  - If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, if it is related to delivery.

How to get approval for...

- **Your hospital stay**

  Your hospital care will be covered at a participating network hospital on an inpatient or outpatient basis or at an ambulatory surgical center. Admission or treatment must be authorized in advance by your primary care physician or specialists. Inpatient benefits are provided as long as your are receiving medical services by the hospital. You are not covered for custodial or convalescent care-taking.

- **How to preauthorize an admission**

  It is the responsibility of your admitting physician to obtain approval from the Plan for your inpatient hospital admission.

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

  All covered services must be received by a Plan participating provider or facility. Any service or care received outside of this Plan's network or service area, without approval from the Plan, will be paid by the member.

  We will only pay for emergency services. We will not pay for any other health care services received outside of our service area or network unless the service has received prior approval by the Plan.

- **Circumstances beyond our control**

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

If you disagree with our pre-service claim decision

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

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

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

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

  In the case of a pre-service claim. we have 30 days from the date we receive your written request for reconsideration to:

  1. Approve your hospital stay or, grant approval for a service, drug, or supply
  2. Ask you or your provider for more information
     - You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.
     - If we do not receive the information we will base our decision on the information we already have. We will write to you with our decision.

  3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

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

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

- **To file an appeal with OPM**

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

Section 4. Your costs for covered services

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

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.
Copayments	A copayment (or copay) is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services. In addition to a copay, you will need to satisfy a deductible for certain services before we begin to pay for those services. Example for this plan: When you see your primary care physician, you pay a $20 copayment per office visit, or if you see a specialist you pay a $40 copayment per office visit. If you visit an emergency room, you will pay a $125 copayment. This copayment is waived if you are admitted to the hospital.
Deductible	A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. Under a Self Only enrollment, the deductible is considered satisfied and benefits are payable for you when your covered expenses applied to the calendar year deductible for your enrollment reach $250. Under a Self Plus One enrollment, the deductible is considered satisfied and benefits are payable for you and one other eligible family member when the combined covered expenses applied to the calendar year deductible for your enrollment reach $500. Under a Self and Family enrollment, the deductible is $500. This is considered satisfied for all family members when the combined covered expenses for all family members reach $500. 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.
Coinsurance	Coinsurance is the percentage of an allowance that you must pay for your care. This Plan pays 100% of expenses after the deductible is met and after copayments are paid. You do not have to pay coinsurance.
Your catastrophic protection out-of-pocket maximum	After your out-of-pocket expenses, including any applicable deductibles, copayments and coinsurance, total $4,500 for Self Only, or $9,000 for Self Plus One or Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. The maximum annual limitation on cost sharing listed under Self Only of $4,500 applies to each individual, regardless of whether the individual is enrolled in Self Only or Self and Family. Example Scenario: Your plan has a $4,500 Self Only maximum out-of-pocket limit and a $9,000 Self Plus One and Self and Family maximum out-of-pocket limit. If you or one of your eligible family members has out-of-pocket qualified medical expenses of $4,500 or more for the calendar year, any remaining qualified medical expenses for that individual will be covered fully by your health plan. With a Self and Family enrollment out-of-pocket maximum of $9,000, a second family member, or an aggregate of other eligible family members, will continue to accrue out-of-pocket qualified medical expenses up to a maximum of $9,000 for the calendar year before their qualified medical expenses will begin to be covered in full.

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.

Section 5. Listing of Benefits

See page 15 for Benefit Plan Highlights. See page 82 for a Summary of Benefits.

Section 5. Plan Benefits Overview

This Plan's benefits are described in this section, Section 5. It is divided into subsections.

Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information, contact us at 1-866-283-4995 or www.highmarkbcbs.com.

This Plan offers the following features:

- $20 office visit copayment; $20 retail clinic visit copayment; $40 specialist office and virtual visit copayment; $60 urgent care center visit copayment; and $125 emergency room visit copayment.
- Annual deductible of $250 per Self Only, $500 per Self Plus One or $500 per Self and Family applies.
- As detailed in this section, Section 5, generally services are covered at 100%, after deductible is met and copayments are paid.

How We Determine if a Technology or Drug is Experimental
In this plan, we use these criteria to determine if a medical procedure or medical experts are constantly searching for and testing new equipment, drugs and methods for treating health conditions. In turn, health care organizations like Highmark must evaluate these technologies and drugs to determine if they are covered by your plan. We believe that decisions for evaluating new technologies, new applications of existing technologies, new drugs and devices should be made by medical professionals. But we also honor decisions made by regulatory bodies, such as the Centers for Medicare and Medicaid Services (CMS).

For Medicare Advantage plans, CMS requires them to following National Coverage Determinations (NCDs) and Local Coverage Determination (LCDs). Sometimes NCDs or LCDs disagree with the health plan's decision. If the service is being provided to a Medicare Advantage plan member, the health plan must abide by the regulations and guidance of the NCDs or LCDs.

For services that do not fall under NCD or LCD regulations, a panel of more than 400 medical professionals works with our nationally recognized Medical Affairs Committee to review new technologies and new applications of existing technologies for medical and behavioral health procedures and devices. To stay current and patient-responsive, these reviews are ongoing and all encompassing. They consider factors such as product efficiency, safety and effectiveness. If the technology passes the review process, the Medical Affairs Committee recommends that it be considered an acceptable medical practice and a covered benefit.

Technology that does not pass the review is usually considered "experimental/investigative" and not covered by the health plan. However, it may be re-evaluated in the future.

A similar process is followed for evaluating new drugs. The Pharmacy and Therapeutics (P&T) Committee assesses new drugs based on national and international data, research that is currently underway and expert opinion from leading clinicians. The P&T Committee consists of at least one Highmark-employed pharmacist and/or medical director, five board-certified, actively practicing network physicians and two Doctors of Pharmacy currently providing clinical pharmacy services within the Highmark Medicare Advantage service area. At the committee's discretion, advice, support and consultation may also be sought from physician subcommittees in the following specialties: cardiology, dermatology, endocrinology, ematology/oncology, obstetrics/gynecology, ophthalmology, psychiatry, infectious disease, neurology, astroenterology and urology. Issues that are addressed during the review process include clinical efficacy, unique value, safety, patient compliance, local physician and specialist input and pharmacoeconomic impact. After the review is complete, the P&T Committee makes recommendations.

We recognize that situations may occur when you choose to pursue experimental or investigative treatment. If you are concerned that a service you will receive may be considered experimental or investigations, you, the hospital and/or the professional provider may contact the toll-free Member Service/TTY number on the back of your member identification card to determine if the service will be covered.

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:

- 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 for your care. You can use the services, including behavioral health and well-woman care, of any network physician or specialist without a referral and receive the maximum coverage under your benefit program. Your personal physician can help you select an appropriate specialist and work closely with that specialist when the need arises. In addition, primary care providers or their covering physicians are on call 24/7.
- The calendar year deductible is $250 for Self Only enrollment or $500 for Self Plus One or $500 per Self and Family. The calendar year deductible applies to certain benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.

Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with Medicare and other coverage*.

Benefit Description	You Pay
We added notes to show you when the calendar year deductible applies to benefits in this Section.	
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion • At home • In a virtual visit	$20 per primary care physician (PCP) office visit $40 per Specialist (SCP) office visit or virtual visit
• Injection or infusion of select injectible drugs that are part of the medical benefit. Note: A list of these drugs can be provided through Member Service at 1-866-283-4995.	Covered at 100% after deductible is met.
Professional services of physicians or health care providers • In an Urgent Care Center • In a Retail Clinic	$20 copayment for retail clinic visit $60 copayment for urgent care center visit
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Pathology • Lab work • Allergy testing of percutaneous, intracutaneous and patch tests. • X-rays, radiology, ultrasound and nuclear medicine • CAT scans, MRI or PET scans • Ultrasound • Electrocardiogram and EEG	Covered at 100% after deductible is met.

Benefit Description	You Pay
Preventive care, adult	
Routine physicals every 1 to 2 years for adults ages 19-49 and every 12 months for adults 50 and older. These include routine screenings such as: • Blood pressure • Pulmonary function test • Colorectal cancer screenings, including: - Fecal occult blood test - Sigmoidoscopy screening - Colonoscopy screening Starting at age 20, adults should get total blood cholesterol screenings every 5 years, or more often if you are at risk for cardiovascular disease. Note: Preventive services are listed on the Highmark Preventive Schedule. Gender age and frequency limits may apply.	Nothing
Well woman care; including, but not limited to: • Routine Pap test annually • Annual pelvic and clinicl breast exam • Annual counseling for sexually transmitted infections • Annual counseling and screening for human immune-deficiency virus • Contraceptive methods and counseling • Screening and counseling for interpersonal and domestic violence Members may receive treatment from a PCP, network gynecologist or network nurse-midwife. Preventive services are limited to those listed on the Highmark Preventive Schedule. Gender age and frequency limits may apply.	Nothing
Routine mammogram (with or without clinical breast examination) • An initial baseline mammogram for women between 35 and 40 years of age • An annual routine mammogram for women 40 years of age or older • A mammogram for women regardless of age when prescribed by the PCP or specialist Benefits for mammographic examinations are payable only if performed by a mammography service provider who is properly certified by the Pennsylvania Department of Health in accordance with the Mammography Quality Assurance Act of 1992.	Nothing

Preventive care, adult - continued on next page

Benefit Description	You Pay
Preventive care, adult (cont.)	
Routine immunizations, as recommended by your doctor and endorsed by the Centers for Disease Control and Prevention. Preventive services are listed on the Highmark Preventive Schedule. Gender age and frequency limits may apply.	Nothing
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	
Not covered: *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel. Immunizations for foreign travel or employment.* *Prostate Specific Antigen (PSA) is not covered as a routine preventive test.*	*All charges.*
Preventive care, children	
• Childhood immunizations provided by the PCP. • Limited to those immunizations recommended by the Pennsylvania Department of Health, that conform with the standards of the Advisory Committee on Immunization Practices of the CDC and the U.S. Department of Health and Human Services. • Additional immunizations available for children under age 21 based on state mandates. Preventive services are listed on the Highmark Preventive Schedule. Gender age and frequency limits may apply.	Nothing.
• Well-child care for routine examinations,diagnostic services and immunizations (through age 18) Examinations, such as: • Vision screenings through age 18 to determine the need for vision correction • Hearing screenings through age 18 to determine the need for hearing correction • Exams on the day of immunizations (through age 18) Preventive services are listed on the Highmark Preventive Schedule. Gender age and frequency limits may apply.	Nothing
Note: A complete list of preventive care services recommended under the U.S. Preventive Services Task Force is available online at http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.	

Benefit Description	You Pay
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal and obstetrical care by an obstetrician, nurse-midwife or PCP credentialed for obstetrical care • Screening for gestational diabetes for pregnant women between 24-28 weeks gestation or first prenatal visit for women at a high risk. • Other medically necessary tests such as sonogram (ultrasound), amniocentesis, lab tests and fetal non-stress test. • Delivery of your baby and care for both of you in the hospital under inpatient care. • One home health care visit within 48 hours of discharge when discharge occurs prior to: - 48 hours of inpatient care following a normal vaginal delivery - 96 hours following a caesarean delivery - Visit includes parent education, assistance and training in bottle and breast-feeding, infant screening and any needed tests and assessments. - Home health visit must be authorized by the PCP or OB/GYN or nurse-midwife.Postnatal care - a six-week check-up after delivery Note: Here are some things to keep in mind: • You do not need to submit a pre-authorization for your normal delivery. See Section 5c 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 if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self Plus One or Self and Family enrollment. • This includes routine nursery care, prematurity services, preventive health care services, injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. • Surgical benefits, not maternity benefits, apply to circumcision. We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). (Note: calendar year deductible applies.)	$20 primary care physician or $40 specialist copayment if office visit is required to receive services. Inpatient care is covered at 100% after deductible is met.

Maternity care - continued on next page

Benefit Description	You Pay
Maternity care (cont.)	
Enteral Formulae Benefits are provided for Enteral Formulae, when administered on an outpatient basis, either orally or through a tube, primarily for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria. This coverage does not include normal food products used in the dietary management of rare hereditary genetic metabolic disorders. Benefits for such Enteral Formulae are exempt from any applicable deductible requirements. Additional coverage for Enteral Formulae is provided when administered on an outpatient basis, when medically necessary and appropriate for the member's medical condition, when considered to be the member's sole source of nutrition, and: • When provided through a feeding tube (nasogastric, gastrostomy, jejunostomy, etc.) and used instead of regular shelf food or regular infant formulas; or, when provided orally, as one of the following types of defined formula with: - Hydrolyzed (pre-digested) protein or amino acids - Specialized content for special metabolic needs - Modular components or - Standardized nutrients. Coverage for Enteral Formulae will continue as long as the formulae represents at least 50% of the member's daily caloric requirement. *Not covered:* • *Blenderized food, baby food, or regular shelf food when used with an enteral system* • *Milk or soy based infant formulae with intact proteins* • *Any formulae, when used for the convenience of the Member or their family members* • *Nutritional supplements or any other substance utilized for the sole purpose of weight loss or gain, or for caloric supplementation, limitation or maintenance;* • *Semisynthetic intact protein/protein isolates, natural intact protein/protein isolates, and intact protein/protein isolates, when provided orally.* • *Normal food products used in the dietary management of rare hereditary genetic metabolic disorders.*	Covered at 100%

Maternity care - continued on next page

Benefit Description	You Pay
Maternity care (cont.)	
Breastfeeding support, supplies and counseling for each birth are covered through Baby Blueprints, our maternity education program. Baby Blueprints childbirth preparedness classes prepare parents for the birth of their baby, breastfeeding, and infant care.	Nothing
Family planning	
Contraceptive methods and counseling: patient education and coverage for all FDA-approved contraceptive methods and sterilization procedures, as prescribed. Correction of a physical or medical problem, diagnosis or counseling.	Covered at 100% after deductible is met.
A range of voluntary family planning services, limited to: • Voluntary sterilization, such a tubal ligation under Women's Preventive care. See Surgical procedures, Section 5b. • Injectable contraceptive drugs (injection only) • Intrauterine devices (IUD) insertion • Diaphragm fitting Note: We cover oral contraceptives under the prescription drug benefit.	Covered at 100% after deductible is met.
Not covered: • *Voluntary vasectomy* • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges.*
Infertility services	
Infertility counseling, testing and treatment, such as: • Artificial insemination: - intracervical insemination (ICI) - intrauterine insemination (IUI) • Fertility drugs (oral and self injectable pharmacy, all other medical)	Covered at 100% after deductible is met.
Assisted fertilization procedures are not covered. These include: • *Assisted reproductive technology (ART) procedures:* - *in vitro fertilization* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* - *intravaginal insemination (IVI)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges.*

Benefit Description	You Pay
Allergy care	
• Testing and treatment	Covered at 100% after deductible is met.
• Allergy extracts and injections • Allergy serum	Covered at 100% after deductible is met.
Treatment therapies	
• Chemotherapy, infusion and radiation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (I.V.) or Infusion Therapy – home I.V. and antibiotic therapy • Growth hormone therapy (GHT) Note: Benefits are provided for selected GHT, intravenous or infusion therapy drugs (and other Specialty Drugs) when sold by an exclusive specialty pharmacy provider. Contact Member Services at 1-866-283-4995 for a list of these drugs, the limitations and cost sharing provisions, or visit www.highmarkbcbs.com. See section 5f.	Covered at 100% after deductible is met.
Implanted devices (medical and contraceptive)	
• Drug delivery	Covered at 100% after deductible is met.
• Contraceptives	Covered at 100% after deductible is met.
Physical and occupational therapies	
20 visits per therapy per benefit year, for: • Physical medicine therapy • Occupational therapy • Spinal manipulations Note: You are limited to a combined total of 60 calendar days for in hospital treatment, per course of treatment, for the same condition, beginning on the date of the rehabilitation admission.	$40 copayment for outpatient services, per visit. No copayment if hospital inpatient. Covered at 100% after deductible is met.
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction.	Covered at 100% after deductible is met.
• Respiratory/ pulmonary rehabilitation or therapy	Covered at 100% after deductible is met.
Not covered: • *Long-term rehabilitative (maintenance) therapy* • *Exercise programs* • *Biofeedback*	*All charges.*

Benefit Description	You Pay
Speech therapy	
You are limited to 20 visits per benefit year, for the services of a qualified speech therapist. You are limited to a combined total of 60 calendar days for in hospital treatment, per course of treatment, for the same condition, beginning on the date of the rehabilitation admission.	$40 copayment for outpatient services. If services are received as a hospital inpatient, covered at 100% after deductible, with no copayment.
Hearing services (testing, treatment, and supplies)	
For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an MD, DO, or audiologist. Benefits are provided for routine hearing screening when performed by the PCP. For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.* Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants. See Section 5a for Orthotics and prosthetic devices.	Hearing aids covered at 100% after deductible is met. There is a $2,500 per calendar year benefit maximum for children up to the age of 22. There is a $2,500 benefit maximum over three years for adults over the age of 22.
Not covered: • *Hearing services not described in the previous section.*	*All charges.*
Vision services (testing, treatment, and supplies)	
• Diagnostic vision exams by the primary care physician (PCP) to determine if there is a need for vision correction.	Covered at 100% after deductible is met.
• Diabetic eye exams	Covered at 100% after deductible is met.
Not covered: • *Eyeglasses, contact lenses, and after age 17, testing and examinations for them except as shown above* • *Fitting, repair or replacement of eyeglasses/contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery.*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	Covered at 100% after deductible is met.
Not covered: • Routine nail trimming • Treatment of bunions (except capsular or bone surgery), corns, calluses, fallen arches, flat feet, weak feet, chronic foot strain (except for diabetic conditions).	*All charges.*

Foot care - continued on next page

Benefit Description	You Pay
Foot care (cont.)	
	All charges.
Orthotics and prosthetic devices	
• Artificial limbs and eyes • Stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Hearing aids and testing to fit them. (For children, refer to Preventive care) • External components of cochlear implants and bone anchored hearing aids (BAHA) • Internal prosthetic devices, such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. Note: For information on the professional charges for the surgery to insert an implant, see Section 5b (surgical and anesthesia services). For information on the hospital and/or ambulatory surgery center benefits, see Section 5c.	Covered at 100% after deductible is met. For hearing aids there is a $2,500 per calendar year benefit maximum for children up to the age of 22. There is a $2,500 benefit maximum for hearing aids for three years for adults over the age of 22.
Externally worn breast prostheses and mastectomy bras, including necessary replacements following a mastectomy. Note: Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Internal prosthetic devices are paid as hospital benefits; see Section 5c for payment information. Insertion of the device is paid as surgery; see Section 5b for coverage of the surgery to insert the device.	Covered at 100% after deductible is met.
• Orthotic or orthopedic devices, rigid appliances or apparatus used to support, align or correct bone and muscle deformities such as leg braces. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Diabetic foot orthotics	Covered at 100% after deductible is met.
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics (except for diabetics), heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges.*

Orthotics and prosthetic devices - continued on next page

Benefit Description	You Pay
Orthotics and prosthetic devices (cont.)	
• *Prosthetic replacements provided less than five (5) years after the last one that was covered (for members over age 19)* • *Disposable supplies* • *Dental appliances of any sort, including but not limited to, bridges, braces and retainers, except those for non-dental treatment of TMJ* • *Sexual dysfunction devices, male or female* • *Replacement due to neglect* • *Wigs*	*All charges.*
Durable medical equipment (DME)	
We cover rental or purchase of durable medical equipment (DME), including repair and replacement due to normal wear and not neglect. Also medical supplies needed for the function of the DME that are medical in nature, not for comfort or convenience. Covered items include: • Oxygen • Dialysis equipment • Insulin pumps • Semi-electric hospital beds and related equipment • Manual wheelchairs • Crutches, canes and walkers • Portable bedside commodes • Apnea monitors Note: Your primary care physician can make a referral to a participating durable medical equipment provider or you can call 1-866-283-4995 to procure a list of participating durable medical equipment providers.	Covered at 100% after deductible is met.
Not covered: • *Motorized wheelchairs* • *Deluxe equipment of any sort, or equipment which has been determined by the Plan to be non-standard.* • *Disposable items such as incontinent pads, electrodes, ace bandages, elastic stockings, and dressings* • *Equipment which serves for comfort or convenience functions or is primarily for the convenience of a person caring for a member* • *Air conditioners* • *Humidifiers* • *Electric air cleaners* • *Exercise or fitness equipment* • *Elevators*	*All charges.*

Durable medical equipment (DME) - continued on next page

Benefit Description	You Pay
Durable medical equipment (DME) (cont.)	
• *Hot tubs* • *Hoyer lifts* • *Shower/bath bench* • *Special clothing of any type* • *Batteries* • *Access ramps* • *Pulse oximeters, over age 18* • *Replacement due to neglect*	*All charges.*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or other health care professional. It must be administered by Home Health Care Agency or a hospital program for Home Health Care. • There is a limit of 90 days of visits per member per contract year.	Covered at 100% after deductible is met.
• Therapy and rehabilitation services; • Medical and surgical supplies provided by the Home Health Care Agency or Hospital program for Home Health Care; • Oxygen and its administration; • Medical social service consultations; • Health aide services to a member who is receiving covered nursing services or therapy and rehabilitation services.	Covered at 100% after deductible is met.
Not covered: • Dietitian services, homemaker services, maintenance therapy, custodial care and food or home delivered meals. • Nursing care for the convenience of, the patient or family • Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative • Services provided by any non-home health provider	*All charges.*
Urinary supplies, such as urinary catheters, collection devices, insertion trays, are covered for permanent urinary incontinence or permanent urinary retention.	You are covered at 100% after deductible is met.

Benefit Description	You Pay
Chiropractic	
• Medically necessary chiropractic services to include new patient exams, adjunctive therapy, x-rays and clinical laboratory tests. • Maximum 20 visits per benefit year.	$40 copayment for outpatient services.
• Chiropractic appliances from a participating provider or supplier	Covered at 100% after deductible is met.
Not covered: • Services for exams or treatment for conditions other than those related to neuromusculoskeletal disorders • Acupuncture, massage therapy, hypnotherapy, holistic medicine, herbal treatments and naturopathic services • Hypnotherapy, thermography, behavior training • Sleep therapy and weight programs	All charges.
Diabetes Treatment and Management	
Services, supplies, equipment and education for diabetes when prescribed by a physician: 1. Blood glucose monitors, monitor supplies, syringes, injection aids and insulin infusion devices. 2. Diabetes education: Upon diagnosis of diabetes; and later when a significant change in symptoms or conditions occur. This would require a changes in a patient's self-management; or identifies a new medication or therapeutic process for diabetes.	Covered at 100% after deductible is met.
Alternative treatments	
Not covered: *Complementary alternative care services such as, but not limited to, acupuncture, massage therapy, hypnotherapy, holistic medicine, herbal treatments and naturopathic services.*	*All charges.*
Educational classes and programs	
Community Blue HMO offers case management and health management programs to members with complex medical conditions and chronic health conditions. A specially-trained nurse (Case Manager/Health Manager) contacts members with targeted health conditions (for example heart failure and pneumonia) after a hospital, rehabilitation, or skilled nursing home admission. Members are also contacted by a case manager/health manager if they have a history of increased inpatient, outpatient, and emergency department utilization. The purpose of all case manager/health manager contacts is to assess and identify areas of impact – including the use of community/social services, medication management, and/or coordination of care with primary and/or specialty provider services.	Nothing

Educational classes and programs - continued on next page

Benefit Description	You Pay
Educational classes and programs (cont.)	
Blues On Call Health Information and Support Blues On Call is a free, phone-based service that members can access 24 hours a day, seven days a week, simply by calling the toll-free telephone number on the back of their ID card, 1-888-BLUE-428. Representatives can help you make the right decisions about your health care. Blues On Call supports your relationship with your PCP and other treating physicians—it is not a substitute for your PCP or other physician's care. When you call, you will speak to a health coach (a specially trained registered nurse) who can answer questions you have about your health. For example, learn about a new medication or decide between outpatient therapy and rehabilitation services or surgery for recurring back pain. Blues On Call can help you understand the risks, benefits and alternatives, so you can work with your physician to make the best choice for you. You can also receive comprehensive care support for any medical condition, including chronic conditions; an immediate health care assessment for an illness or injury; educational audiotapes and videotapes on a wide range of care topics and information about preventive programs and services, which includes online lifestyle improvement programs, smoking cessation programs and health-related discounts.	Nothing
Wellness Rewards Programs 1. Wellness Profile – The Wellness Profile is a questionnaire about your health and lifestyle, surveying aspects such as blood pressure and exercise habits. It is designed to identify current and future health risks. When you complete the Wellness Profile, you receive a detailed health summary, personalized action plan and recommendations for health and wellness programs to improve your health. 2. Preventive Exam – You must receive a physical/ preventive exam between Jan. 1, 2016 and Sept. 30, 2016. You will automatically receive credit for this activity once we have processed the applicable claim. Credit is typically received within six weeks of the date of your exam. 3. Tobacco Attestation – You will be certifying that you are either tobacco free, have enrolled or will enroll in a tobacco cessation program. Call Member Services to learn about tobacco cessation resources available to you. See Section 5h for additional details about the 2016 Wellness Rewards Program offered with this plan.	Nothing.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange for your care.
- The calendar year deductible is $250 per Self, $500 per Self Plus One and $500 per Self and Family coverage. The calendar year deductible applies to certain benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.
- 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 services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5c for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION OF SOME SURGICAL PROCEDURES.** Please refer to the prior authorization information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification .

Benefit Description	You pay
We added notes to show you when the calendar year deductible applies to benefits in this Section.	
Surgical procedures	
For surgical treatment of disease, illness or injury for: • 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*)	Covered at 100% after deductible is met.
• Insertion of internal prosthetic devices. See 5a – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (e.g., tubal ligation - under Women's Preventive Health) • Treatment of burns • Ostomy supplies; supplies are covered only for members who have had a surgical procedure which resulted in the creation of a stoma (artificial opening in the body which remains after surgery is completed).	Covered at 100% after deductible is met.

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	
Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Covered at 100% after deductible is met.
Not covered: • *Bariatric surgery for obesity* • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*All charges*
Reconstructive surgery	
• Surgery to correct a 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, performed on an inpatient or outpaient basis, including: • surgery to produce a symmetrical appearance of breasts; • surgery to restore funtion, augmentation, mammoplasty, reduction mammoplasty and mastopexy • treatment of any physical complications, such as lymphedemas; • breast prostheses and mastectomy 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. Coverage is also provided for one home health care visit, as determined by the member's physician, received within 48 hours after discharge, if such discharge occurs within 48 hours after an admission for a mastectomy.	Covered at 100% after deductible is met.
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.*

Benefit Description	You pay
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • extraction of teeth in preparation for radiation therapy • accidental injury to the jaw or body parts next to it • correcting a non-dental condition, which impairs function of teeth or jaw • treatment for tumors and cysts in the jaw, cheeks, lips, tongue, and mouth • orthodontic treatment of congenital cleft palates • mandibular staple implant, provided the procedure is not done in preparation of the mouth for dentures; • mandibular frenectomy; and • extraction of impacted third molars when partially or totally covered by bone. Also covered as hospital inpatient services or in surgical center.	Covered at 100% after deductible is met.
Extraction of partially or totally bony impacted wisdom teeth (third molars).	Covered at 100% after deductible is met.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Orthognathic or prognatic surgery only to improve the appearance of a functioning structure*	*All charges.*
Organ/tissue transplants	
Services related to transplants of human organ bone tissue or blood stem cells are covered if it is provided from a donor to a human transplant recipient . 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. Solid organ transplants are limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung (single/bilateral) • Pancreas • Intestinal transplants - Isolated small intestine	Covered at 100% after deductible is met.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas - Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis.	Covered at 100% after deductible is met.
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)	Covered at 100% after deductible is met.
Blood or marrow stem cell transplants limited to the stages of the following diagnoses, as based on medical necessity and how well the physicians thinks the disease will respond to treatment. • Allogeneic transplants for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Acute myeloid leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed) - Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Marrow Failure and Related Disorders (i.e. Fanconi's, PNH, pure red cell aplasia) - Hemoglobinopathies - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis - Paroxysmal Nocturnal Hemoglobinuria - Myelodysplasia/Myelodysplastic Syndromes - Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) - Advanced Myeloproliferative Disorders (MPDs) • Autologous transplants for - Acute lymphocytic leukemia - Acute myleogeneous leukemia - Advanced Hodgkin's lymphoma with recurrence (relapsed)	Covered at 100% after deductible is met.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
- Advanced non-Hodgkin's lymphoma with recurrence (relapsed) - Neuroblastoma - Amyloidosis	Covered at 100% after deductible is met.
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed above are subject to medical necessity review by the Plan.	Covered at 100% after deductible is met.
Blood or marrow stem cell transplants for • Allogeneic transplants for - Phagocytic/Hemophagocytic deficiency disease (e.g., Wiskott-Aldrich syndrome) • Autologous transplants for - Multiple myeloma - Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors	Covered at 100% after deductible is met.
Blood or marrow stem cell transplant services: Autologous transplants for: • Breast cancer • Epithelial ovarian cancer • Childhood rhabdomyosarcoma • Advanced Ewing sarcoma • Advanced Childhood kidney cancers • Mantle Cell (Non-Hodgkin's lymphoma) • Agressive Non-Hodgkin's Lymphoma **Please Note: These services are typically not covered but may be covered for clinical trials only.**	Covered at 100% after deductible has been met (for clinical trials only).
National Transplant Program Transplants which are non-experimental or non-investigational are a covered benefit. Covered transplant services must be ordered by a plan specialist physician and approved by our medical director in advance of the transplant services. The transplant must be performed in Centers of Excellence specifically approved and designated by us to perform these procedures. A transplant is non-experimental and non-investigational when we have determined, in our sole discretion, that the medical community has generally accepted the procedure as appropriate treatment for your specific condition. Coverage for a transplant where you are the recipient includes coverage for the medical and surgical expenses of a live donor; to the extent that these services are not covered by another plan or program.	Covered at 100% after deductible is met. The maximum coverage for travel and lodging for the transplant recipient is $20,000 per benefit period, not to exceed $200 a day for each stay.

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	
We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members.	
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges.*
Anesthesia	
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center Benefits are provided for Anesthesia Services when performed in connection with Covered Services, except as provided in connection with the Oral Surgery Benefits described in this document.	Covered at 100% after deductible is met.
• Office visit	$40 specialist copayment.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- In this Section, the calendar year deductible applies to almost all benefits. We added "(No deductible)" to show when the calendar year deductible does not apply.
- The calendar year deductible is $250 per Self and $500 per Self Plus One or $500 per Self and Family enrollment.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with other coverage, including 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 5a or 5b.
- **Your physician must get preauthorization for hospital stays.** Please refer to Section 3.

Benefit Description	You pay
We added notes to show you when the calendar year deductible applies to benefits in this Section.	
Inpatient hospital	
Room and board, such as • Ward, semiprivate rooms • Intensive care or cardiac care units • General nursing care • Meals and special diets, including tube feeding (enteral formulae) when medically needed • Dialysis treatments • Services from medical professionals within the hospital • Private duty nursing *care (limited to 240 hours per member per benefit period)* *Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.*	Covered at 100% after deductible is met.
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory and pathology tests • ECG, EEG and other electronic diagnostic procedures or testing • X-rays, radiology, MRI, ultrasound and nuclear medicine • Blood, blood plasma, and other biologicals and the administration of these • Dressings, splints, casts, and sterile tray services	Covered at 100% after deductible is met.

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	
• Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services (see Oral Surgery for exceptions) • Allergy testing with percutaneous, intracutaneous and patch tests • Voluntary inpatient family planning and infertility services. - Correction of a physical or medical problem, diagnostic services, counseling - Sterilization procedures such as tubal ligation (Women's preventive service).	Covered at 100% after deductible is met.
Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Covered at 100% after deductible is met.
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and bed*	*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 • Blood, blood plasma, and other biologicals, storage and the administration of these • Pre-surgical testing • Dressings, 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.	Covered at 100% after deductible is met.

Benefit Description	You pay
Extended care benefits/Skilled nursing care facility benefits	
Extended care benefit: • Room and board • General nursing care There is a limit of 100 days per benefit period.	Covered at 100% after deductible is met.
Skilled Nursing Facility (SNF): Services available in a skilled nursing facility must be pre-authorized. There is a limit of 100 days per benefit period. • *Private nursing care is limited to 240 hours per member per benefit period.*	Covered at 100% after deductible is met.
The Pediatric Extended Care Services Benefit Services given by a pediatric extended care facility as part of a treatment plan including: • Skilled nursing services of an RN or LPN • Physical medicine, speech therapy, and occupational therapy services • Respiratory therapy, medical and surgical supplies • Acute health care support • Ongoing assessments of health status, growth and development. Covered for children eight years of age or under, under a PCP's treatment plan. Coverage ends after the child has recovered as much as possible for the condition. After that point, routine supportive care is not covered. Subject to availability within your area as these facilities may have limited enrollment.	Covered at 100 percent after deductible is met.
Not covered: • *Custodial, domiciliary or convalescent care* • *Treatment of substance abuse* • *When the patient has recovered from the condition (to the maximum level possible) and is only getting routine supportive care.*	*All charges*
Hospice care	
Hospital services and home health services for a member enrolled in hospice care. This includes supportive and palliative (pain relief) care. Respite care and family counseling related to the member's terminal condition are covered.	Covered at 100% after deductible is met.
Not covered: *Independent nursing, homemaker services*	*All charges.*

Benefit Description	You pay
Ambulance	
Local professional urgent/emergency ambulance service when medically necessary.Transportation by means of a specially designed and equipped vehicle used only for transporting the sick and injured: from a home, scene of an accident, or a medical emergency to a Hospital; between Hospitals; between a Hospital and a Skilled Nursing Facility; from a Hospital or Skilled Nursing Facility to a home; or from a home to a Professional Provider's office. In an emergency, Preauthorization is not required.	Covered at 100% after deductible is met.

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 calendar year deductible is $250 per Self and $500 per Self Plus One or $500 per Self and Family. The calendar year deductible applies to certain benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with other coverage, including Medicare*.

What is a medical emergency?

Emergency care is the initial treatment:

- For bodily injuries resulting from an accident.
- Following the sudden onset of a medical condition

In the case of a chronic condition, a sudden and unexpected medical event would be an emergency if it manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the member, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; or
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ part

Emergency care services are available 24 hours a day, 7 days a week. If you need emergency care services, proceed to the nearest emergency services provider.

Emergencies within our Service Area

Emergency services do not require preauthorization or a referral from your primary care physician (PCP). Emergency services outside of our service area are covered the same as within our service area.

All necessary costs for Emergency Care Services, including evaluation, testing, and stabilization will be paid within or outside the network service area.

Treatment for an occupational injury (covered under Workers' Compensation Law) is not covered.

Transportation and related emergency services provided by an ambulance service is part of the emergency care and is covered. If you use an ambulance to go to an emergency department for an injury or condition that is not an emergency, it will not be covered as an Emergency Care Service.

While it may be helpful to call your PCP, network specialist, or Blues On Call if you are unsure as to whether you need emergency services, this is not required for emergency care services. This is true both in and out of the Plan service area. After you receive emergency services, you should follow up with your PCP or a specialist for any additional treatment.

Benefit Description	You Pay
We added notes to show you when the calendar year deductible applies to benefits in this Section.	
Emergency within our service area	
Emergency care at a doctor's office	• $20 primary care physician office visit copayment • $40 physician specialist copayment
• Emergency care at an urgent care center or retail clinic	• $60 per visit at an urgent care center or • $20 per visit at a retail clinic
• Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the emergency department copayment if you are admitted to the hospital directly from the emergency room. Emergency department copayment is not waived if you are placed in observation status.	$125 per visit. If admitted, there is no copayment but deductible applies to authorized admission
These services are not covered under emegency care: • *Elective care or non-emergency care* • *Follow-up care recommended by plan providers that has not been authorized in advance by member's primary care physician or by non-plan providers that has not been approved by the Health Plan.*	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center or retail clinic • Emergency care as an outpatient at a hospital, including doctors' services • We waive the Emergency Room copay if you are admitted to the hospital directly from the emergency room	• $20 primary care physician office visit copayment • $40 specialist visit copayment • $60 per visit at an urgent care center • $20 per visit at a retail clinic
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *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 necessary, including air transport (LifeFlight). See Section 5c for non-emergency ambulance services.	Covered at 100% after deductible is met.

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

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9, *Coordinating benefits with other coverage, including with Medicare*.
- The calendar year deductible is $250 per Self, $500 per Self Plus One and $500 per Self and Family enrollment. The calendar year deductible applies to certain benefits in this section.

Behavioral Health Care

- Your Community Blue HMO coverage gives you the flexibility to go directly to any network mental health or substance abuse specialist for inpatient or outpatient services. The Community Blue provider network includes a wide range of mental health and substance abuse professional providers, so members can get the appropriate level of responsive, confidential care.
- For behavioral health, you can use the services of any network physician or specialist without a referral and receive the maximum coverage under your benefit program. Your personal physician can help you select an appropriate specialist and work closely with that specialist when the need arises. In addition, primary care providers (PCPs) or their covering physicians are on call 24/7.
- We encourage you to talk to your PCP about which type of care, therapy or counseling you may need. He or she may also be able to recommend a network mental health or substance abuse provider. The network specialist will obtain any preauthorization required under your Plan.
- For non-emergency services to be covered, however, you must choose a network provider. To locate a network provider, you can ask your PCP or other treating physician for a recommendation, click on ***Find a Doctor*** to search our online Provider Directory at www.highmarkbcbs.com, or call the Mental Health/Substance Abuse Member Service telephone number on your ID card.
- Services must be part of an approved treatment plan and pre-authorized. (Call the telephone number for Mental Health Care on the ID Card.) Services can be delivered on an inpatient or outpatient basis.
- **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.
- Emergency services do not require prior authorization. However, you or a family member will need to contact your primary care physician or the designated behavioral health vendor after receiving emergency services and before receiving and follow-up care. We may limit your benefits if you do not obtain a treatment plan. 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.

Benefits Description	You Pay
We added notes to show you when the calendar year deductible applies to benefits in this Section.	
Professional services	
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. • Services by licensed mental health professional such as psychiatrists, psychologists, clinical social workers, counselors, or marriage and family therapists. • Services include individual psychotherapy, group psychotherapy, psychological testing, family counseling and convulsive therapy treatment, including: - Diagnostic evaluation - Crisis intervention and stabilization for acute episodes - Medication evaluation and management (pharmacotherapy) - Psychological and neuropsychological testing necessary to determine treatment - Treatment and counseling (including individual or group therapy visits) - Diagnosis and treatment of alcoholism and drug abuse, including detoxification, treatment and counseling - Intensive outpatient treatment in a provider's office - Electroconvulsive therapy **Substance Abuse** Services must be preauthorized and delivered in a hospital or substance abuse treatment facility as an inpatient or outpatient. Services must be provided by a physician, psychologist, nurse, master level therapist or social worker. Services include rehabilitation, therapy, counseling, family counseling and intervention, psychiatric, psychological and medical laboratory tests, as well as drugs, medicines, equipment and supplies.	Covered at 100% after deductible is met.
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	Covered at 100% after deductible is met.

Benefits Description	You Pay
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, general nursing care, meals and special diets, and other hospital services	Covered at 100% after deductible is met.
Outpatient hospital or other covered facility	
Outpatient services provided and billed by a hospital or other covered facility • Services in approved treatment programs, such as partial hospitalization, half-way house, residential treatment, full-day hospitalization	Covered at 100% after deductible is met.
Not covered	
Not covered: *Services that are not part of a preauthorized approved treatment plan*	*All charges.*
Limitations	
We may limit your benefits if you do not obtain a treatment plan.	
Autism Spectrum Disorder	
Treatment for members under age 21 for autism spectrum disorders; autistic, Asperger's and Pervasive Development disorders. Services includes pharmacy, psychiatric and psychological, rehabilitative and therapeutic care.	Covered at 100% after deductible is met.
Pharmacy care	Copayment per outpatient prescription drug (See Section 5(f))
Psychiatric and Psychological Care: Direct or consultative services provided by a psychiatrist or psychologist.	Covered at 100% after deductible is met.
Habilitative/Rehabilitative Care: Services to help those with autism improve socially, in behavior or to prevent the loss of skills and functioning. These services and treatment programs, including applied behavioral analysis, must be provided by an autism service provider. Limited to 20 visits per therapy per benefit period.	$40 specialist copayment
Therapeutic Care: Includes services provided by speech pathologists, occupational therapists or physical therapists. Limited to 20 visits per therapy per benefit period.	$40 specialist copayment.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Members must make sure their physicians obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- There is no calendar year deductible for Prescription drug benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9, *Coordinating benefits with other coverage, including with Medicare.*

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

- **Who can write your prescription.** A licensed physician or dentist, and in states allowing it, a licensed or certified Physician Assistant, Nurse Practitioner and Psychologist, must prescribe your medication.
- **Where you can obtain them.** Your prescriptions are covered when purchased through a network pharmacy. You will need to show the pharmacist your Community Blue HMO member ID card. Some long-term maintenance drugs can also be obtained less expensively through the mail order program.
  - To locate a network pharmacy, go to www.highmarkbcbs.com and click on “Find a Doctor or Rx” or call the Member Service telephone number listed on the back of your ID card.You must fill the prescription at a plan participating pharmacy, or for maintenance medications by mail using a participating mail order pharmacy.
- **We use a formulary.** A select drug list, or formulary, is an extensive list of FDA-approved prescription drugs and selected over-the-counter medications and includes products in every major therapeutic category. Community Blue physicians have copies of the formulary. They can submit a request that you receive coverage for a medication that is not on the formulary. You can look up the formulary at www.highmarkbcbs.com, or you can call Member Services to find out.
- The purpose of our formulary is to optimize patient care through appropriate selection and use of drugs that ensure quality, cost-effective prescribing.
- **These are the dispensing limitations.** Prescription drugs obtained at a Premier network retail pharmacy will be dispensed for up to a 31, 60, or 90-day supply per prescription or refill. Prescribed maintenance medication can be ordered using our mail order participating pharmacy. You get a 90-day supply for a copayment equal to the 60-day retail supply. You'll also enjoy the convenience of having the medications delivered right to your home.
- **Generic vs. brand name drugs.** Under this program, you pay one copayment for generic drugs and a higher copayment for formulary brand name drugs. This is a "hard mandatory generic" prescription drug program. If a generic drug is available, it will be dispensed. If you or your physician specifies a brand name drug when a generic is available, you also pay the difference between the price of the brand and the generic.
- **Why use generic drugs?** Generic drugs have the same chemical composition and therapeutic effect as brand name. The cost is less expensive, which may reduce your out-of-pocket prescription drugs costs.
- Please note that use of a drug formulary, as referenced in this section, may result in restriction of drug availability. To obtain a prescription medication that is not included in the formulary, or to request prior authorization for a managed care prescription drug, your physician must complete the “Prescription Drug Medication Request Form” and return it to the Pharmacy Affairs Department for clinical review. The Pharmacy Affairs Department will mail a decision letter to you and your provider within two business days of receipt of the request. This information is also available on our website at www.highmarkbcbs.com. Log onto the member website and click the “Spending” tab. Select “Forms Library” and click “Prescription Drug Medication" to get the Medication Request Form.

- Most drug benefit programs also include clinical programs designed to ensure best practices in medication prescribing, dispensing and use to maximize the positive impact of the prescription drug benefit on patient health. Certain prescription drugs may require preauthorization from Community Blue HMO and/or must be obtained through an exclusive pharmacy provider. Additional information is available from our Member Service staff**.**
- **When you do have to file a claim.** Normally, you won't have to submit a claim to us for prescriptions. In the event you are required to make a payment in excess of your required prescription copayment at the time your prescription is filled, we will reimburse you by check. Simply request a claim form from our Member Service Team. Send us your receipt, including your Member ID Number as soon as possible. You must submit claims by December 31 in the year following the year in which the prescription was filled. Refer to *Section 7. Filing a claim for covered services.*

Benefit Description	You Pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Premier network pharmacy or through our mail order program: • Drugs and medicines prescribed by a licensed practitioner in connection with a covered service. Must be purchased at a participating pharmacy provider with a valid member ID card. • Specialty medications - as a fourth tier • Insulin • Plan approved diabetic supplies and pharmacological agents, or devices used to assist in insulin injection (injection aids) including insulin syringes and needles, blood glucose test strips (copay per box of 100 test strips at retail or mail order pharmacy) and lancets • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction are limited to 6 units per 30 days, only to male members 18 years or older. • Benefits are provided for injectable medication for the treatment of an injury or illness when provided by the PCP or other network specialist and administered in the physician's office Includes prescription drugs and over-the-counter drugs listed in the comprehensive formulary. The Pharmacy will dispense Generic Drugs in accordance with State and Federal laws unless a generic equivalent is not available. If the member will not accept a generic substitution when the generic equivalent is available, the member will be required to pay the difference between the price for a Brand Drug and any available generic equivalent. **Injectable and Infusion Specialty Drugs**	**Purchased at participating retail pharmacy** For a 31-day supply per prescription or refill: • $5 for generic copayment • $35 formulary brand copayment • $60 non-formulary brand copayment • $95 formulary specialty drugs • 25% up to a $200 maximum for non-formulary specialty drugs For a 60-day retail supply • $10 for generic copayment • $70 formulary brand copayment • $120 non-formulary brand copayment For a 90-day retail supply • $15 for generic copayment • $105 formulary brand copayment • $180 non-formulary brand copayment **Maintenance drugs through mail order are purchased in a 90-day supply for one copayment** $10 for generic copayment $70 formulary brand copayment $120 non-formulary brand copayment $190 formulary specialty drugs 25% up to a $400 maximum for non-formulary specialty drugs (If there is no generic equivalent available, you will still have to pay the brand name copay.)

Covered medications and supplies - continued on next page

Benefit Description	You Pay
Covered medications and supplies (cont.)	
Certain high-cost and/or limited-access pharmaceuticals, such as injectable and biologic products, require precertification and must be filled through our contracted Specialty Pharmacy network. Quantity limits often apply. For a complete list of products, please contact Member Services at 1-866-283-4995.	**Purchased at participating retail pharmacy** For a 31-day supply per prescription or refill: • $5 for generic copayment • $35 formulary brand copayment • $60 non-formulary brand copayment • $95 formulary specialty drugs • 25% up to a $200 maximum for non-formulary specialty drugs For a 60-day retail supply • $10 for generic copayment • $70 formulary brand copayment • $120 non-formulary brand copayment For a 90-day retail supply • $15 for generic copayment • $105 formulary brand copayment • $180 non-formulary brand copayment **Maintenance drugs through mail order are purchased in a 90-day supply for one copayment** $10 for generic copayment $70 formulary brand copayment $120 non-formulary brand copayment $190 formulary specialty drugs 25% up to a $400 maximum for non-formulary specialty drugs (If there is no generic equivalent available, you will still have to pay the brand name copay.)
• Women's contraceptive drugs and devices (such as depo provera, diaphragms, and contraceptive rings) Note: The "morning after pill" is an over-the-counter (OTC) emergency contraceptive drug. It's considered a preventive service under contraceptives, with no cost to the member if prescribed by a physician and purchased at a network pharmacy.	Nothing for generic and brands with no generic equivalent. If you or your physician want to purchase the brand name medication when a generic is available, you will pay the difference in cost between the brand-name and the generic.
Not covered: • *weight control drugs* • *human growth hormone*	*All charges.*

Covered medications and supplies - continued on next page

Benefit Description	You Pay
Covered medications and supplies (cont.)	
• *drugs and supplies which can be purchased without a prescription order unless specifically described here* • *drugs whose labeled indications are for cosmetic purposes only* • *injectable drugs that require administration and/or monitoring by a health care professional(covered under separate provision for Specialty Drugs, see above).* • *prescription drugs and over-the-counter drugs not listed in the closed formulary* • *OTC medicines (except prescription medications due to health care reform). Contact the Member Services at 1-866-283-4995 for a list.*	*All charges.*
Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the tobacco cessation benefit. (See Section 5a, *Educational Classes and Programs*).	Discounted prices through the tobacco cessation classes.

Section 5(g). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9, Coordinating benefits with other coverage.
- **T**he calendar year deductible is $250 per Self, $500 per Self Plus One and $500 per Self and Family. The calendar year deductible applies to certain benefits in this Section. We added notes throughout this brochure to show when the calendar year deductible applies.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5c, for inpatient hospital benefits. We do not cover dental procedures unless they are 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, *Coordinating benefits with other coverage, including with Medicare*.

Benefit Description	You Pay
We added notes to show you when the calendar year deductible applies to benefits in this Section.	
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 (not chewing or biting).	Covered at 100% after deductible is met.
Not covered: • *Implants, bridges, crowns and root canals even if caused by or related to trauma to sound natural teeth.*	*All charges*

Dental benefits

We have no other dental benefits.

Section 5(h). Special features -- online tools and wellness programs

Feature	Description
Blues On Call Health Line	Blues On Call is a 24-hour a day help line to help you make the right decisions about your health care. Blues On Call supports your relationship with your PCP and other treating physicians—it is not a substitute for your PCP or other physician's care. When you call, you will speak to a health coach (a specially trained registered nurse) who can answer questions you have about your health. You can learn about possible side effects from a new medication, or get help to decide between outpatient therapy, rehabilitation services and surgery for recurring back pain. Blues On Call can help you understand the risks, benefits and alternatives, so you can work with your physician to make the best choice for you. Call the toll-free telephone number on the back of your ID card, anytime, 1-888-BLUE-428. Blues On Call can also provide: • Comprehensive care support for any medical condition, including chronic conditions. • An immediate health care assessment for an illness or injury. • Educational audiotapes and videotapes on a wide range of care topics. • Information about preventive programs and services, which includes online lifestyle improvement programs, smoking cessation programs and health-related discounts.
Services for deaf and hearing impaired	Community Blue HMO has an access line for deaf and hearing-impaired members. This toll free number is on the back of your Member ID Card.
Blue Distinction Centers and Physicians .	Blue Distinction® is a designation awarded by the Blue Cross and Blue Shield Association (BCBSA) to hospitals that deliver superior results for high-risk, high-cost procedures such as transplants, cardiac surgeries, complex and rare cancers, bariatric surgery, and major joint replacements. Blue Distinction Centers and Blue Distinction Centers+ offer better quality and improved outcomes for patients and lower rates of complications and readmissions than their peers. Blue Distinction Centers+ are more cost-efficient than non-designated hospitals.
Travel benefit/services overseas	Along with the BlueCard Program for urgent and follow-up care, you can use the service of BlueCard Worldwide® to locate providers outside the U.S. by calling the same number, 1-800-810-BLUE. Should you receive care out of the country, call your PCP when you return home to inform him or her about your care. To file for reimbursement, save your medical receipts and call a Member Service representative who will assist you with your claims filing.
Online Health Tools and Information	Our website offers information with easy-to-use online tools and resources. You will need to register first to get a user name and password. Then you can log onto www.highmarkbcbs.com to take advantage of all these health tools: • At "Your Coverage" you can review your member information and benefits, get coverage information and request replacement identification cards. • At "Claims" and "Spending" you can view your claims; track your health care costs, and get information about the costs of medical services. • At "Health and Wellness" you can access your wellness and set goals for health improvement through the comprehensive self-health tool, complete the Wellness Profile, link to health care decision support, explore treatment options, and get information on lifestyle improvement and preventive health care recommendations. • At "Find a Doctor" you can access our provider directory which includes a wide range of information on doctors, hospitals and other providers.

	• At “Health and Wellness” you can also read articles, get information in the Health Encyclopedia, go “Inside the Human Body,” and find the latest information on surgeries and procedures.
2016 Wellness Rewards Program	You are eligible to receive a $250 dollar incentive if you complete this plan's 2016 Wellness Rewards Program between Jan. 1, 2016 and Sept. 30, 2016. You must complete these program requirements by Sept. 30, 2016, to be eligible for the reward. As a member, you must register at www.highmarkbcbs.com and get a user name and password to participate. Then log in and click on ***Rewards Program*** to learn more and start earning your rewards. 1. **Wellness Profile** – The Wellness Profile is a questionnaire about your health and lifestyle, surveying aspects such as blood pressure and exercise habits. It is designed to identify current and future health risks. When you complete the Wellness Profile, you receive a detailed health summary, personalized action plan and recommendations for health and wellness programs to improve your health. 2. **Preventive Exam –** You must receive a physical/preventive exam between Jan. 1, 2016 and Sept. 30, 2016. You will automatically receive credit for this activity once we have processed the applicable claim. Credit is typically received within six weeks of the date of your exam. 3. **Tobacco Attestation** – You will be certifying that you are either tobacco free, have enrolled or will enroll in a tobacco cessation program. Call Member Services to learn about tobacco cessation resources available to you.

Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, and you cannot file an FEHB disputed claim about them. Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

Health Related Discounts

Community Blue HMO offers members a wide variety of health-related discounts at hundreds of businesses, including sporting goods stores, health clubs, vision and hearing outlets, dental offices and much more. Member discounts are available for fitness center memberships, chiropractic services, massage therapy and acupuncture, health products, eye wear, eye exams, mail order contact lenses and laser vision correction. You will be able to see a list of these when you join the plan and register on the member website www.highmarkbcbs.com. More information on these "Members Only Extras and Discounts" can be found at http://discoverhighmark.com/individuals-families/discover/why-highmark.

Section 6. General Exclusions - services, drugs and supplies we do not cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services.*

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see e*mergency services/accidents*)
- Services, drugs, or supplies you receive while you are not enrolled in this Plan
- Services, drugs, or supplies not medically necessary
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice
- Experimental or investigational procedures, treatments, drugs or devices (see transplants)
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations
- Services, drugs, or supplies specifically for assisted fertilization
- Operations for cosmetic purposes only, unless resulting from an accident, birth defect or to correction functional impairment from illness or injury
- 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
- Extra care costs and research costs for clinical trials
- Complementary alternative care services such as acupuncture, massage therapy, hypnotherapy, holistic medicine, herbal treatments and naturopathic services
- Other care described as "not covered" within this document

Section 7. Filing a claim for covered services

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

If you receive a bill for a medical service provided by a hospital, specialist, radiologist, anesthesiologist or other provider, check it over carefully. Often these bills do not include correct insurance information or they were filed incorrectly by the provider. Call Community Blue HMO Member Service at the phone number back of your ID card and ask if they have received a claim for the service in question. Your Member Service representative will investigate the claim for you, answer any questions you may have about it, and keep you informed of its status.

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. For claims questions and assistance, contact Member Services.

Written notice must be given to Highmark Choice Company for Community Blue HMO within 20 days It must include all information to identify you and the services you received. You can call Member Service: 1-866-283-4995 or write us at Highmark Blue Shield, P.O. Box 3355, Pittsburgh, PA 15230. Please include:

- Your name, date of birth, address, phone number and ID number
- Name and address of the physician or facility
- Dates you received the services
- Diagnosis
- Type and charge or each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor– such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

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

Prescription drugs

Submit your claims to Member Services by calling 1-866-283-4995 or write to Highmark Blue Shield, P.O. Box 3355, Pittsburgh, PA 15230.

Other supplies or services

Submit your claims to Member Services at 1-866-283-4995 or by writing to Highmark Blue Shield, P.O. Box 3355, Pittsburgh, PA 15230.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. Proof of loss (that you paid for services and want to be reimbursed) must be submitted within 90 days after the charge in incurred. We will not accept documents later than 12 months after the service was delivered.

Post-service claims procedures

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

If we do not approve your claim, we will tel you the reasons why and describe the rights of the Member to file a complaint or grievance appeal. If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8.

Authorized representative

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

Notice requirements

Any notices denying benefit coverage, will have identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and instruct you in how to request the diagnosis and procedure codes.

How to obtain language assistance

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Information for Non-English-Speaking Members
Non-English-speaking members have access to clear benefits information. They can call the toll-free Member Service telephone number on the back of their ID card to be connected to a language services interpreter line. Member Service representatives are trained to make the connection.

Section 8. The disputed claims process

How to Resolve a Problem

Informal Dissatisfaction Resolution: In the event that you are dissatisfied with any aspect of your Community Blue HMO program, or you have any objection regarding Community Blue HMO participating health care providers, coverage, operations or management policies, please contact Member Services at 1-866-283-4995. The appropriate designated unit representative will review, research and respond to your inquiry as quickly as possible.

Member Complaint and Grievance Processes

If the informal dissatisfaction process is not successful and does not meet your needs, you have the right to have your objection reviewed through Highmark Choice Company Member Complaint and Grievance Processes. Call Member Services at 1-866-283-4995 for information about and assistance with the processes.

Process to Appeal Disputed Claims

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

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

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact Member Services at 1-866-283-4995 or by writing to Member Services, P.O. Box 226, Pittsburgh, PA 15230.

Reconsideration Made Separately from the Initial Decision

- Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim.
- We will not consider if this information was submitted in the initial benefit determination.
- If a medical judgment is required, we will consult with a health care professional experienced in the field of medicine in question, and who was not involved in making the initial decision.
- Our reconsideration will not take in account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.
- We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

Complaint and Grievance Process Participants

Community Blue HMO's complaint and grievance processes has two levels. You can contact the Pennsylvania Department of Health ("Department of Health") to complain that our administrative processes or time frames are making it difficult to use the complaint and grievance processes.

You can designate an authorized representative to participate in the complaint or grievance process on your behalf. Please notify us in writing of this decision. We reserve the right to determining whether an individual has been authorized to act on your behalf.

We will appoint a person from its Member Service department to assist you, at no charge, in preparing the complaint or grievance. This person will not have participated in any previous decisions to deny coverage for the issue in dispute.

Step	Description
1	Ask us in writing or by phone to reconsider our initial decision. You must: a) Write to us within six months from the date of our decision. b) Send your request to us at Highmark Blue Cross Blue Shield, Attention: Complaint Committee, P.O. Box 2717, Pittsburgh, PA 15230-2717 or the address shown on your Explanation of Benefits (EOB). If the reconsideration request is not urgent, it will not be accepted by telephone. 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. e) We will provide you, free of charge and in a timely manner, with any new or additional evidence in connection with your claim. We will provide this in advance of the date of our decision. We will give you enough time to respond to use before that date. You may respond to that new evidence or rationale at the OPM review stage described in Step 4.
2	Each complaint will be promptly investigated: • Within 30 days -- for a non-urgent care Pre-service Claim, • When the complaint involves an Urgent Care Claim, as an expedited review - taking no more than 72 hours from the time the request for an expedited internal review was received. • When the complaint involves a Post-service Claim, not to exceed 30 days. We still have 60 days to receive requested information. We will provide written notification of our decision, not to exceed 30 days from our receipt of the complaint. **Post Service Claim** In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or c) Ask you or your provider for more information You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	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, if we did not send you a decision within 30 days after we received the additional information. Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 1, 1900 E Street, NW, Washington, DC 20415-3610. Send OPM the following information:

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

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

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

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

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

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to file a lawsuit, 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 file a lawsuit 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 the number on the back of your Service Benefit Plan ID card. We will expedite 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.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating benefits with Medicare and other coverage

When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary 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' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit the NAIC website at http://www.NAIC.org.

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.

TRICARE and CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

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

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB 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

Our right to pursue and receive subrogation and reimbursement recoveries is a condition of, and a limitation on, the nature of benefits or benefit payments and on the provision of benefits under our coverage.

If you have received benefits or benefit payments as a result of an injury or illness and you or your representatives, heirs, administrators, successors, or assignees receive payment from any party that may be liable, a third party's insurance policies, your own insurance policies, or a workers' compensation program or policy, you must reimburse us out of that payment. Our right of reimbursement extends to any payment received by settlement, judgment, or otherwise.

We are entitled to reimbursement to the extent of the benefits we have paid or provided in connection with your injury or illness. However, we will cover the cost of treatment that exceeds the amount of the payment you received.

Reimbursement to us out of the payment shall take first priority (before any of the rights of any other parties are honored) and is not impacted by how the judgment, settlement, or other recovery is characterized, designated, or apportioned. Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine and is fully enforceable regardless of whether you are "made whole" or fully compensated for the full amount of damages claimed.

We may, at our option, choose to exercise our right of subrogation and pursue a recovery from any liable party as successor to your rights.

If you do pursue a claim or case related to your injury or illness, you must promptly notify us and cooperate with our reimbursement or subrogation efforts.

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, or by phone at 1-877-888-3337, (TTY 1-877-889-5680), 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

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

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. This plan covers these costs.
- 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.

When you have Medicare

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age;

- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. 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.
- For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. For more Information about this extra help, visit the Social Security Administration online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY: 1-800-325-0778).

- **Should I enroll in Medicare?**

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 (TTY: 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

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

- **The Original Medicare Plan (Part A or Part B)**

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

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

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

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

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 1-866-283-4995 or see our website at www.highmarkbcbs.com.

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

When Medicare Part A is primary, we will waive our:

- Inpatient hospital deductible and coinsurance

When Medicare Part B is primary, we will waive our:

- Calendar year deductible;
- Coinsurance for services and supplies provided by physicians and other covered health care professionals (inpatient and outpatient);
- Copayments for office visits

Note: We do not waive benefit limitations, such as the 60 visit limit for Physical, Occupational and Speech therapy. In addition, we do not waive any coinsurance or copayments for prescription drugs.

- **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 our Medicare Advantage plan: You may enroll in one of our Medicare Advantage plans and also remain enrolled in our FEHB plan. You must maintain your Medicare Part A and B insurance to remain in our Medicare Advantage plan. We will not waive any of our copayments, coinsurance or deductibles.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers). However, 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.

Add Chart to show how you pay when enrollee has Medicare. Plan Specific.

Please review the following table it illustrates your cost share if you are enrolled in Medicare Part B. Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

CUSTOMIZE WITH OUR COSTS FOR OUR PLAN

Benefit Description	**Member Cost without Medicare**	**Member Cost with Medicare Part B**
Deductible	$1,000	$0
Out of Pocket Maximum	$5,000 self only/$10,000 family	$5,000 self only/$10,000 family
Primary Care Physician	15% or $25	Plan will insert applicable member cost sharing
Specialist	15% or $40	XX
Inpatient Hospital	15% per admission	XX
Outpatient Hospital	15% or $150 per visit	XX
Rx	Tier 1 -$10 Tier 2 -$40 Tier 3 - $100 Tier 4 – Specialty (30 day supply) 10% or $250	Tier 1 -$10 Tier 2 -$40 Tier 3 - $100 Tier 4 – Specialty (30 day supply) 10% or $250
Rx – Mail Order (90 day supply)	2x retail copay	2x retail copay

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

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

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
- 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 are generally covered by clinical trials. This plan doesn't cover these costs.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See 22.

Copayment

A copayment is the specific, up-front dollar amount you pay for certain covered services. See 22.

Covered Services

Those medically necessary and appropriate services and supplies which are provided as part of your Community Blue HMO benefit program and described in this brochure.

Custodial Care

Services to assist individuals in the activities of daily living not requiring continuing attention of skilled, trained medical or paramedical personnel. Custodial care is not provided for therapeutic value in treating an illness or condition.

Deductible

A deductible is a specific dollar amount you or your dependents must pay for certain covered services each benefit period before Community Blue HMO begins to provide payment of benefits covered under your program. See12

Experimental or investigational service

Any treatment, equipment, drug, device or supply which is not determined by Community Blue HMO to be medically effective for the condition being treated. Some reasons would be:

- Does not have Federal Food and Drug Administration (FDA) approval for the relevant indication(s);
- Available scientific evidence does not permit conclusions on effect on health outcomes;
- Not proven to be as safe or as effective, does not improve health outcomes, or is not applicable outside the research setting.

If it is determined to be Experimental/Investigative at the time of service, it will not receive retroactive coverage (even if it is found to be in accordance with the above criteria at a later date). The fact that an experimental treatment is the only treatment for a particular condition will not result in coverage.

If you have a concern that a service you will receive may be experimental/investigational, you or the hospital and/or professional provider may contact Community Blue HMO Member Service to determine coverage.

Group health coverage The employer, union or trust through which the member is enrolled.

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

Maximum out-of-pocket The maximum out-of-pocket is the annual limit that a member or family unit will be required to pay for covered services. This limit includes deductible, coinsurance and copayments (medical and prescription). Non-covered services are not included in this limit.

Medical necessity Medical Necessity or Medically Necessary means covered services rendered by a health care provider that we determine to be appropriate for the symptoms and diagnosis or treatment of the member's condition, illness, disease or injury in accordance with current standards of medical practice and not primarily for the convenience of the Member or Member's health care provider.

Plan allowance Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Us/We Us and We refer to Highmark Choice Company or Community Blue HMO Health Plan.

- **Reimbursement** A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

- **Subrogation** A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

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 866-283-4995. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

You — You refers to the enrollee and each covered family member.

Section 11. Other Federal Programs

Please note, the following programs are not part of your FEHB benefits. They are separate Federal programs that complement your FEHB benefits and can potentially reduce your annual out-of-pocket expenses. These programs are offered independent of the FEHB Program and require you to enroll separately with no Government contribution.

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care/or health care expenses. The result can be a discount of 30% 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 $100. The maximum annual election for a health care flexible spending account (HCFSA) or a limited expense health care spending account (LEX HCFSA) is $2,500 per person or $5,000 per household.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, **physician prescribed** over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).
  FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.
- **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 tax dependents including adult children (through the end of the calendar year in which they turn 26).
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible non-medical day care expenses for your children 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 Empolyees Dental and Vision Insurance Program – *FEDVIP*

Important Information	The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment. FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.
Dental Insurance	All dental plans provide a comprehensive range of services, including: • Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays. • Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments. • Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures. • Class D (Orthodontic) services with up to a 12-month waiting period. Most FEDVIP dental plans cover adult orthodontia. Review your FEDVIP dental plan's brochure for information on this benefit.
Vision Insurance	All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.
Additional Information	You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/vision and www.opm.gov/insure/dental . These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.
How do I enroll?	You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 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: 800-843-3557) or visit www.ltcfeds.com .

Index

Summary of Benefits for Community Blue HMO - 2016

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

Community Blue HMO Benefits	You Pay	Page
Medical services provided by physicians:	• Primary Care Physician: $20 copay • Specialty Care Physician: $40 copay	26
Diagnostic and treatment services provided in the office	• Primary Care Physician: $20 copay • Specialty Care Physician: $40 copay	26
• Diagnostic and treatment services provided in a Retail Clinic	Retail Clinic: $20 copay	26
• Diagnostic and treatment services provided in an Urgent Care Center	Urgent Care Center: $60 copay	26
Services provided by a hospital:		46
• **Inpatient**	100% after deductible	46
• **Outpatient**	100% after deductible	47
Emergency benefits:		50
• **In-area**	$125 per visit; waived if admitted	50
• **Out-of-area**	$125 per visit; waived if admitted	50
Mental health and substance abuse treatment:	Covered at 100% after deductible is met.	52
Prescription drugs:		55
• Retail pharmacy	For 31-/60-/90-day retail supply $5/$10/$15 generic copayment $35/$70/$105 formulary brand copayment $60/$120/$180 non-formulary brand copayment $95 formulary specialty drugs 25% coinsurance, up to a $200 maximum for non-formulary specialty drugs	55

Community Blue HMO Benefits	You Pay	Page
• Maintenance drugs through mail order	Mail order 90-day Supply $10 generic copayment $70 formulary brand copayment $120 non-formulary brand copayment $190 formulary specialty drugs 25% coinsurance up to a $400 maximum for non-formulary specialty drugs	55
Dental care (related to accidental injury only)	100% after deductible	59
Vision care: refractive screening only.	Initial screening by PCP covered at 100% after deductible is met. $20 Primary Care Physician copayment if office visit is required to receive services.	33
Protection against catastrophic costs (out-of-pocket maximum):	$4,500 self only/$9,000 self plus one/ $9,000 self and family	22
Special features	24-hour nurse hotline, health care navigator hotline; Blue Distinction providers, discounts on wellness products and services, programs for health improvement and tobacco cessation.	60

2016 Rate Information for Community Blue HMO

For 2016 health premium information, please see: http://www.opm.gov/healthcare-insurance/indian-tribes/health-insurance/#url=Premiums or contact your tribe's Human Resources department.