

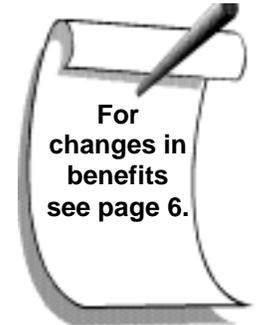
HEALTHGUARD

<http://www.hguard.com>

HealthGuard CEO

2002

A Health Maintenance Organization



Serving: Southeastern and Southcentral Pennsylvania

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 5 for requirements.



Enrollment codes for this Plan:

NQ1 Self Only

NQ2 Self and Family

Authorized for distribution by the:



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



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Table of Contents

Introduction	4
Plain Language.....	4
Inspector General Advisory	4
Section 1. Facts about this HMO plan.....	5
How we pay providers.....	5
Your Rights	5
Service Area	5
Section 2. How we change for 2002	6
Changes to this Plan	6
Section 3. How you get care	7
Identification cards.....	7
Where you get covered care	7
• Plan providers	7
• Plan facilities.....	7
What you must do to get covered care	7
• Primary care	7
• Specialty care	7
• Hospital care	8
Circumstances beyond our control	9
Services requiring our prior approval.....	9
Section 4. Your costs for covered services.....	10
• Copayments.....	10
Your out-of-pocket maximum.....	10
Section 5. Benefits	11
Overview	11
(a) Medical services and supplies provided by physicians and other health care professionals.....	12
(b) Surgical and anesthesia services provided by physicians and other health care professionals	22
(c) Services provided by a hospital or other facility, and ambulance services.....	25
(d) Emergency services/accidents	29
(e) Mental health and substance abuse benefits	32
(f) Prescription drug benefits	33
(g) Special features.....	35

(h) Dental benefits.....	36
(i) Non-FEHB benefits available to Plan members.....	37
Section 6. General exclusions -- things we don't cover.....	38
Section 7. Filing a claim for covered services.....	39
Section 8. The disputed claims process.....	40
Section 9. Coordinating benefits with other coverage.....	42
When you have...	
• Other health coverage	42
• Original Medicare	42
• Medicare Managed Care Plan	44
TRICARE/Workers' Compensation/Medicaid	45
Other Government agencies	45
When others are responsible for injuries	45
Section 10. Definitions of terms we use in this brochure.....	46
Section 11. FEHB facts	47
• No pre-existing condition limitation	47
• Where you get information about enrolling in the FEHB Program.....	47
• Types of coverage available for you and your family.....	47
• When benefits and premiums start	48
• Your medical and claims records are confidential	48
• When you retire.....	48
When you lose benefits	48
• When FEHB coverage ends	48
• Spouse equity coverage.....	48
• Temporary Continuation of Coverage (TCC)	48
• Converting to individual coverage	49
• Getting a Certificate of Group Health Plan Coverage.....	49
Long term care insurance is coming later in 2002	50
Index	52
Summary of benefits	53
Rates.....	Back cover

Introduction

HealthGuard
280 Granite Run Drive
Lancaster, PA 17601

This brochure describes the benefits of HealthGuard under our contract (CS 2232) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 6. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

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

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the Office of Personnel management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, D.C. 20415-3650.

Inspector General Advisory

Stop health care fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital 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 800/822-0350 and explain the situation.
- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE

202/418-3300

The United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street, NW, Room 6400

Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Section 1 – Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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 only pay 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.

How we pay providers

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

Your Rights

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

- HealthGuard has been incorporated since 1984, resulting in 17 years of operation.
- HealthGuard received an Excellent accreditation status from the National Committee for Quality Assurance (NCQA).

HealthGuard consists of an extensive network of hospitals, ambulatory surgical centers, highly qualified primary care physicians, highly qualified specialists, and various other ancillary providers.

If you want more information about us, call 800/822-0350, or write to HealthGuard, 280 Granite Run Drive, Lancaster, PA 17601. You may also contact us by fax at 717/581-4580 or visit our website at www.hguard.com.

Service Area

To enroll in this Plan, you must live or work in our Service Area. This is where our providers practice. Our service area is: Lancaster, York, Cumberland, Dauphin, Lebanon, and Berks counties in Pennsylvania.

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

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. HMO-USA is a network of Blue Cross Blue Shield physicians that participate with HealthGuard throughout the United States. Should you have an urgent, emergent need for a physician (non-life-threatening) which cannot wait to be treated until you return home, you call 1-800-4-HMO-USA. For temporary living arrangements outside of our service area, you can access HMO-USA through HealthGuard's Member Services 717-560-3353 or 800-822-0350. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2 - How we change for 2002

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

Changes to this Plan

- Your share of the non-Postal premium will increase by 7.8% for Self Only or 7.5% for Self and Family.
- You pay \$10 for generic, \$25 for preferred brand drugs and \$40 for non-preferred drugs. (Section 5(f))
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5 (a))
- We now cover routine screening for chlamydial infection. (Section 5(a))
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5 (a)).
- We now cover certain intestinal transplants. (Section 5 (b))
- We changed the address for sending disputed claims to OPM. (Section 8)

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 Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-822-0350.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments and you will not have to file claims.

- **Plan providers**

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

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

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. Your first step as a HealthGuard member will be to choose a Primary Care Physician from the HealthGuard network of providers.

- **Primary care**

Your primary care physician can be a Family Practice Physician, and Internist, or a Pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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

- **Specialty care**

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

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will work with the specialist and the plan to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause; or
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
 - reduce our service area and you enroll in another FEHB Plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-822-0350. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process pre-certification. Your physician must obtain pre-certification for the following services: Breast Reconstruction Mammoplasty, Cardiac Rehabilitation, Chiropractic, Cosmetic Procedures, Dental Procedures, Durable Medical Equipment, Infertility – diagnostics, drugs, treatments, etc., Out-of-Network referrals, Sclerotherapy, Sinus Surgery, TMJ issues, and UPPP (laser).

To obtain information on pre-authorization from HealthGuard, call the Member Services Department at 800-822-0350 or 717-560-3353 or send an email message to members@hguard.com.

Section 4 – Your costs for covered services

You must share the cost of some services. You are responsible for:

- **Copayments**

A co-payment is a fixed amount of money you pay to provider, facility, pharmacy, etc., when you receive services.

Example: When you see your primary care physician you pay a copayment of \$10 per office visit.

**Your catastrophic protection
out-of-pocket
maximum for deductibles,
coinsurance, and copayments**

We do not have an out-of-pocket maximum.

Section 5 – Benefits – OVERVIEW

(See page 6 for how our benefits changed this year and page 53 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in section 6: they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 800-822-0350 or at our website at www.hguard.com.

(a) Medical services and supplies provided by physicians and other health care professionals12-21

- Diagnostic and treatment services
- Lab, X-ray, and other diagnostic tests
- Preventive care, adult
- Preventive care, children
- Maternity care
- Family planning
- Infertility services
- Allergy care
- Treatment therapies
- Physical and occupational therapies
- Speech therapy
- Hearing services (testing, treatment, and supplies)
- Vision services (testing, treatment, and supplies)
- Foot care
- Orthopedic and prosthetic devices
- Durable medical equipment (DME)
- Home health services
- Chiropractic
- Alternative treatments
- Educational classes and programs

(b) Surgical and anesthesia services provided by physicians and other health care professionals22-24

- Surgical procedures
- Reconstructive surgery
- Oral and maxillofacial surgery
- Organ/tissue transplants
- Anesthesia

(c) Services provided by a hospital or other facility, and ambulance services25-28

- Inpatient hospital
- Outpatient hospital or ambulatory surgical center
- Extended care benefits/skilled nursing care facility benefits
- Hospice care
- Ambulance

(d) Emergency services/accidents.....29-31

- Medical emergency
- Ambulance

(e) Mental health and substance abuse benefits.....32

(f) Prescription drug benefits33-34

(g) Special features35

- Flexible Benefits Option
- Centers of Excellence
- Travel Benefit/Services Overseas

(h) Dental benefits36

(i) Non-FEHB benefits available to Plan members.....37

Summary of benefits53

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

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

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

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Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician’s office 	\$10 per office visit to your primary care physician \$20 per office visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion 	\$10 per office visit to your primary care physician \$20 per office visit to a specialist
At home	\$10 per visit from your primary care physician \$20 per visit from a specialist

Preventive care, children	You pay
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics 	\$10 per office visit
<ul style="list-style-type: none"> Well-child care charges for routine examinations, immunizations and care (up to age 22) Examinations, such as: <ul style="list-style-type: none"> Eye exams through age 17 to determine the need for vision correction. Ear exams through age 17 to determine the need for hearing correction Examinations done on the day of immunizations (up to age 22) 	\$10 per visit when performed in Primary Care doctor's office
Maternity care	You pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Prenatal care Delivery Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> You do not need to precertify your normal delivery; see page 9 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 and Family enrollment. We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	Nothing
<i>Not covered: Routine sonograms to determine fetal age, size or sex</i>	<i>All charges</i>

Family planning	You pay
<p>A broad range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$10 per office visit to your primary care physician \$20 per office visit to a specialist</p>
<p><i>Not covered: reversal of voluntary surgical sterilization, genetic counseling is excluded.</i></p>	<p><i>All charges</i></p>
Infertility services	You pay
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI) • Fertility drugs, injectable <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under prescription drug benefit.</p>	<p>\$10 per office visit \$20 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> - <i>in vitro fertilization</i> - <i>embryo transfer, gamete GIFT and zygote ZIFT</i> - <i>Zygote transfer</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<p><i>All charges</i></p>
Allergy care	You pay
<p>Testing and treatment</p>	<p>\$10 per office visit</p>
<p>Allergy injection</p>	<p>\$20 per office visit to a specialist</p>
<p>Allergy serum</p>	<p>Nothing</p>
<p><i>Not covered: provocative food testing and sublingual allergy desensitization</i></p>	<p><i>All charges</i></p>

Treatment therapies	You pay
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 24. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We will only cover GHT when we pre-certify the treatment. Call 800-447-0597 for pre-certification. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>\$10 per office visit to your primary care physician \$20 per office visit to a specialist</p>

Physical and occupational therapies	You pay
<ul style="list-style-type: none"> • 60 visits or 60 days whichever comes first, per condition for the services of each of the following: <ul style="list-style-type: none"> - qualified physical therapists and - occupational therapists. Note: We only cover therapy to restore bodily function when There has been a total or partial loss of bodily function due to illness or injury. • Cardiac Rehabilitation - a graded exercise program under continuous observation and with periodic monitoring of cardiac response when deemed Medically Necessary for patients with a high-risk medical condition defined by the HealthGuard Cardiac Rehabilitation policy. Covered Benefits are limited to eighteen (18) visits with a possibility of eighteen (18) additional visits if a medical reason exists for continued monitoring. 	<p>\$10 office visit copay \$10 per outpatient visit \$20 per office visit to a specialist Nothing per visit during covered inpatient admission</p>

Physical and occupational therapies continued on next page.

Physical and occupational therapies <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Treatment of developmental delay, apraxic disorders and other academic related problems, unless caused by injury or episodic illness;</i> • <i>Aquatic therapy;</i> • <i>Equestrian therapy;</i> • <i>Recreation therapy;</i> • <i>Work hardening;</i> • <i>Massage therapy;</i> • <i>Orthoptic therapy (visual therapy);</i> • <i>Music therapy;</i> • <i>Infant stimulation;</i> • <i>Patterning therapy (except for newborn children);</i> • <i>Cognitive therapy;</i> • <i>Multi-modality clinics;</i> • <i>Other therapies not within the scope of the definition of short-term rehabilitation therapy.</i> • <i>Therapy to maintain an already achieved level of function.</i> 	<p><i>All charges</i></p>
Speech therapy	You pay
<ul style="list-style-type: none"> • 60 visits per condition 	<p><i>Nothing</i></p>
Hearing services (testing, treatment, and supplies)	You pay
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury. • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	<p>\$10 per office visit to Primary Care Physician</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>all other hearing testing</i> • <i>hearing aids, testing and examinations for them</i> 	<p><i>All charges</i></p>

Vision services (testing, treatment, and supplies)	You pay
<ul style="list-style-type: none"> • community vision care benefit approved by OPM, if any • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	<p>\$10 per office visit</p> <p>\$20 per office visit to a specialist</p>
<ul style="list-style-type: none"> • Eye exam to determine the need for vision correction for children through age 17 (see preventive care children) 	<p>\$10 per office visit</p> <p>\$20 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Eyeglasses or contact lenses and, after age 17, examinations for them</i> • <i>Eye exercises and orthoptics</i> • <i>Radial keratotomy and other refractive surgery</i> 	<p><i>All charges</i></p>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$10 per office visit</p> <p>\$20 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<p><i>All charges</i></p>

Orthopedic and prosthetic devices	You pay
<ul style="list-style-type: none"> • Externally worn breast prostheses and surgical bras; including necessary replacement, following a mastectomy; • The purchase, fitting, necessary adjustment and repairs of Medically Necessary Orthotic Devices prescribed by a Plan PCP and authorized in advance by HealthGuard. • Custom molded foot Orthotics is limited to one pair per calendar year. • A replacement of an Orthotic Device is covered only if there has been a sufficient change in the Member's physical condition that makes the original device no longer functional. • The purchase, fitting, necessary adjustment, repairs and replacements of Prosthetic Devices that replace all or part of an absent body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body organ (excluding dental appliances) as a result of Illness or Injury or congenital defects. Such devices require a written prescription by a Plan Provider and must be authorized in advance by HealthGuard. Instruction and appropriate services required for the Member to properly use the item (such as attachment or insertion) are covered. Expenses incurred as a result of the misuse, negligence or loss or a prosthetic appliance are not covered. • Non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome, including orthopedic appliance. 	<p><i>Nothing</i></p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>orthopedic and corrective shoes</i> • <i>arch supports</i> • <i>heel pads and heel cups</i> • <i>lumbosacral supports</i> • <i>corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>prosthetic replacements provided less than 3 years after the last one we covered</i> • <i>Expenses incurred as a result of the misuse, negligence or loss or a prosthetic appliance.</i> 	<p><i>All charges</i></p>
Durable medical equipment (DME)	You pay
<p><i>Durable Medical Equipment</i> shall mean equipment which is primarily and customarily used to serve a medical purpose; can withstand repeated use; generally is not useful to a person in the absence of Illness or Injury; and is appropriate for use in the home. All requirements of the definition must be met before an item can be considered to be Durable Medical Equipment. (Examples include: wheelchairs and hospital beds)</p>	<p><i>Nothing</i></p>

Durable medical equipment (DME) continued on next page.

Durable medical equipment (<i>Continued</i>)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Motorized wheel chairs</i> 	<p><i>All charges</i></p>
Home health services	
<ul style="list-style-type: none"> • Home health care ordered by Plan Physician and provided by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Licensed Vocational Nurse (L.V.N.), or Home Health Aide. • Services include Oxygen Therapy, Intravenous Therapy, and Medications. <p>The following services and supplies for Home Health Care are covered when prescribed by the Plan PCP, determined to be Medically Necessary by HealthGuard, and provided by a Plan Home Health Care Agency. Pre-certification must be obtained from HealthGuard. HealthGuard shall not be required to provide benefits for Home Health Care services when HealthGuard determines the treatment setting is not appropriate, or when there is a more cost effective setting in which to provide appropriate care or member is not home bound. Home Health Care services include:</p> <ul style="list-style-type: none"> • Professional services of a registered nurse (R.N.) or licensed practical nurse provided that such nurse does not ordinarily reside in the Member's home or is not a member of the Member's immediate family. • Physical Therapy, Occupational Therapy, and Speech Therapy. • Medical and surgical supplies provided by the Home Health Agency. • Medical social service consultation. • Dietician services. • Home medical equipment. 	<p><i>Nothing</i></p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<p><i>All charges</i></p>

Chiropractic	You pay
<p>Chiropractic Care –for Medically Necessary treatment of acute sciatica, back or neck pain, provided by a chiropractor who is a Plan Provider upon a Referral by a Plan Primary Care Physician, for up to twenty (20) visits per calendar year.</p> <ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application. 	<p>\$10 per office visit</p> <p>\$20 per Specialist visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Naturopathic services</i> • <i>Hypnotherapy</i> • <i>Maintenance therapy for chronic conditions</i> 	<p><i>All charges</i></p>
Alternative treatments	
<p>Acupuncture – by a Plan Provider up to a maximum of thirty (30) visits per calendar year. Acupuncture will be covered for chronic pain syndrome when prescribed by a HealthGuard pain specialist as part of a comprehensive pain program provided by a plan MD or DO.</p> <p>Biofeedback Therapy –Medically Necessary biofeedback therapy for muscle re-education of specific muscle groups or for treating pathological muscle abnormalities of spasticity, when provided by a Plan Provider. If more conventional treatments are not successful, treatment for incapacitating muscle spasm or weakness is covered when part of a comprehensive pain management program provided by a Plan Provider.</p>	<p>\$10 Primary Care Physician office visit copay</p> <p>\$20 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>naturopathic services</i> • <i>hypnotherapy</i> • <i>maintenance therapy for chronic conditions</i> 	<p><i>All charges</i></p>
Educational classes and programs	
<p>Classes include:</p> <ul style="list-style-type: none"> • Weight Management • Smoking Cessation • Diabetes Management • Childbirth <p>Please contact HealthGuard Member Services department at 800-822-0350 for more information.</p>	<p>Nothing</p>

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

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

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

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Benefit Description	You pay
Surgical procedures	
<ul style="list-style-type: none"> • A comprehensive range of services, such as: • Operative procedures • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. <p>Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over</p>	Nothing
Voluntary sterilization Treatment of burns	\$10 office visit co-pay
Biopsy procedures	\$10 PCP; \$20 per office visit to a specialist
Endoscopy procedures Treatment of fractures, including casting	\$20 per office visit to a specialist
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.	
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care.</i> 	<i>All charge</i>

Constructive surgery	You pay
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> -the condition produced a major effect on the member’s appearance and -the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. 	Nothing
<ul style="list-style-type: none"> • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance on the other breast; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	See above
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<i>All charges</i>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate; or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts; and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • Surgical intervention of temporomandibular joint(TMJ) 	<p>\$10 per office visit</p> <p>\$20 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<i>All charges</i>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogenic (donor) bone marrow transplant • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas <p>Note: We cover related medical and hospital expenses of the donor only when we cover the recipient.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	<p><i>All charges</i></p>
Anesthesia	You pay
<p>Professional services provided in:</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	<p>Nothing</p>
<p>Professional services provided in:</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>\$10 per office visit \$20 per office visit to a specialist</p>

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

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Here are some important things to remember about these benefits:

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

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

Outpatient hospital or ambulatory surgical center	You pay
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	Nothing
<i>Not covered: blood and blood derivatives not replaced by the member</i>	<i>All charges</i>
Extended care benefits/skilled nursing care facility benefits	You pay
Some of HealthGuard’s Plan Hospitals provide sub-acute facility care.	Nothing
<p>Skilled nursing facility (SNF): Services and supplies, including room and board, provided during an admission at a Plan Skilled Nursing Facility are Covered Services for 180 days only if all of the following conditions are met:</p> <ul style="list-style-type: none"> • The member’s Plan PCP recommends the Skilled Nursing Facility admission; and • The admission is for recovery from an Illness or Injury upon release from a prior Hospital stay, or the admission is in place of a Hospital stay that would be required in the absence of these services or supplies; and • The Member is under the continuous care of his or her Plan PCP or a Plan Physician providing services at the direction of such Plan PCP; and • The Member’s Plan PCP certifies that he or she needs skilled nursing care twenty-four (24) hours a day; and • The Member’s admission is not for Custodial Care or respite care; and the request for admission is pre-certified by HealthGuard <p>In the event a Member elects to remain in the Skilled Nursing Facility after the date that the Member’s Plan PCP and/or HealthGuard has determined and notified the Member that the Member no longer meets the criteria for continued Inpatient confinement, the Member shall be fully responsible for payment for all services and supplies provided by the Skilled Nursing Facility, physicians and/or other Providers after such date of notification. HealthGuard shall not be financially responsible for any such service and supply provided after such date of notification.</p>	Nothing
<i>Not covered: custodial care</i>	<i>All charges</i>

Hospice care	
<p>Hospice shall mean an establishment which furnishes palliative care and supportive services only to Members who have a medical condition and prognosis of less than six (6) months to live and which is staffed and equipped to:</p> <ul style="list-style-type: none"> • Provide care either in the home or in a facility, or both, for persons who do not require the full services of a Hospital or Skilled Nursing Facility; and • Offer medical services under the direction of a physician and a continuous twenty-four (24) hour registered nursing staff; and • Provide directly or by arrangement, social psychological or spiritual services for the Member and his/her family. <p>Covered Services. Hospice care bereavement and pastoral counseling services for Member who has been determined to be terminally ill by the Member's Plan PCP are covered only if each service or supply is furnished by a Plan Provider within six (6) months from the date when the terminally ill Member entered the Hospice care program, is provided pursuant to a Referral by the Member's Plan PCP and is pre-certified by HealthGuard. Services may include home and Hospital visits by nurses and social workers, pain management and symptom control, instruction and supervision of a family Member, Inpatient care, counseling and emotional support; and other Home Health Care services. Hospice care benefits are limited to a Maximum of thirty (30) days of Inpatient care in a Plan Hospice facility and one hundred eighty (180) days of in-home care, per Member per lifetime.</p>	Nothing
<p><i>Not Covered:</i></p> <ul style="list-style-type: none"> • <i>funeral arrangements</i> • <i>financial or legal counseling</i> • <i>homemaker or caretaker services</i> • <i>any service not solely related to the care of the Member</i> • <i>Sitter or companion services for the Member or other Members of the family</i> • <i>Transportation</i> • <i>house cleaning</i> • <i>services and supplies provided during periods of remission</i> • <i>maintenance of the house</i> 	<i>All charges</i>

Ambulance	
<ul style="list-style-type: none"> • Covered Benefits are provided for ambulance service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the acutely sick and Injured from a Member's home or scene of the accident or Emergency to a Hospital. • To be covered, the transportation must be to the closest institution that can provide Covered Services appropriate to the Member's condition. If there is no Participating facility in the local area that can provide Covered Services appropriate to the Member's condition,, the transportation must be to the closest facility outside the local area that can provide the necessary service. • Covered Benefits are also available for Emergency Services actually provided by an advanced life support unit even though the unit does not provide transportation. <p>Special ground or air transportation will be covered when deemed Medically Necessary by HealthGuard.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Routine transportation between facilities and/or office sites.</i> 	<i>All Charges</i>

Section 5(d) - Emergency services/accidents

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- 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.

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What is a medical emergency?

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

What to do in case of emergency:

Availability. Covered Benefits are provided for Emergency Services and Urgent Care twenty-four (24) hours per day, seven (7) days per week, subject to the following conditions and limitations.

No Pre-Certification. Pre-Certification is not required for Emergency Services.

Plan Hospital. Urgent Care must be provided at a Plan Hospital, except in such instances where a Member's medical condition would be jeopardized if treatment is delayed or when the Member experiences symptoms requiring Urgent Care while outside of the Service Area.

Emergencies within our service area:

Professional and Hospital Services. Urgent Care and/or Emergency Services.

- Urgent Care must be arranged by the Member's Plan PCP and authorized in accordance with HealthGuard's policies and procedures. **FAILURE TO COMPLY WITH THIS SECTION MAY RESULT IN NON-PAYMENT OF SERVICES PROVIDED.**
- The Member may obtain Emergency Services from the closest Provider. Emergency Services do not require prior contact with the Member's Plan PCP. However, the Member or the Provider of the Emergency Services shall use their best efforts to contact the Member's Plan PCP and authorized care according to HealthGuard's policies and procedures.
- If care is Medically Necessary and appropriate, a Hospital emergency room visit will be covered. An emergency room Copayment is payable by a Member unless the Member has been referred to an emergency room by a Plan Primary Care Physician or by HealthGuard. Copayments will be waived if the Member is hospitalized directly from the emergency room.
- If a Member is admitted to a Plan Hospital for Inpatient Emergency Services, the Provider of Emergency Service must contact the Member's Plan PCP within forty-eight (48) hours or the next business day, whichever is later, unless it was not reasonable possible to do so. **FAILURE TO COMPLY MAY RESULT IN NON-PAYMENT OF SERVICES PROVIDED.**
- If contact is not made within the designated time frame(s), HealthGuard will only be financially responsible for services provided after the date of notification, provided the medical condition meets HealthGuard's Medically Necessity review criteria.

Emergencies outside our service area:

Professional and Hospital Services. A Member will be entitled to benefits for Urgent Care and/or Emergency Services received outside the Service Area provided: (1) delay in receipt of such services until the Member could access services at a Plan facility would jeopardize his/her life or health, and (2) the Member could not reasonably have been able to anticipate the need for such services prior to having to access care or prior to leaving the Service Area.

- Urgent Care should be arranged by the Member's Plan PCP and authorized in accordance with HealthGuard's policies and procedures. If contact with the Member's Plan PCP cannot be made prior to receiving the Urgent Care services, the Member must notify the Member's Plan PCP as soon as reasonably possible following the urgent care service.
- The Member may obtain Emergency Services from the closest Provider. Emergency Services do not require prior contact with the Member's Participating PCP. However, the Member or the Provider of the Emergency Services shall use their best efforts to contact the Member's Plan PCP within twenty-four (24) hours or treatment and released, unless it was not reasonable possible to do so. All follow-up services must be arranged by the Member's Plan and authorized according to HealthGuard's policies and procedures.
- If care was Medically Necessary and appropriate, a Hospital emergency room visit will be covered. An emergency room Copayment is payable by a Member unless the Member has been referred by a Plan Primary Care Physician or by HealthGuard. Copayments shall be waived if the Member is hospitalized directly from the emergency room.

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$25, waived if admitted
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>
Emergency outside our service area	You pay
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$25, waived if admitted
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>
Ambulance	You pay
<ul style="list-style-type: none"> • Covered Benefits are provided for ambulance service providing local transportation by means of a specially designed and equipped vehicle used only for transporting the acutely sick and Injured from a Member's home or scene of the accident or Emergency to a Hospital. • To be covered, the transportation must be to the closest institution that can provide Covered Services appropriate to the Member's condition. If there is no Plan facility in the local area that can provide Covered Services appropriate to the Member's condition,, the transportation must be to the closest facility outside the local area that can provide the necessary service. • Covered Benefits are also available for Emergency Services actually provided by an advanced life support unit even though the unit does not provide transportation. • Special ground or air transportation will be covered when deemed Medically Necessary by HealthGuard. Routine transportation between facilities and/or office sites are not covered. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Routine transportation between facilities and/or office sites</i> 	<i>All Charges</i>

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

Network Benefit

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

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

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

Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illness or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$20 per office visit</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>\$20 per (visit or test)</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>Nothing</p>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All charges</i></p>

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following authorization processes:
For access, please contact Magellan at 800-332-1024.

Limitation

We may limit your benefits if you do not obtain a treatment plan.

Section 5(f) – Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A licensed physician must write the prescription – or – A plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication.
- **We use a formulary.** HealthGuard has an open formulary with a preferred list of medications. A drug formulary is a listing of products that an organization such as a hospital or an HMO considers the preferred medications for patient use. HealthGuard’s formulary is for outpatient drug therapy. The products listed are considered to be the most effective in both health outcome and cost in each therapeutic category. The formulary is a guide for physicians for medication use. The Plan’s drug formulary is reviewed monthly by the Medical Policy and Technology Committee. The committee consists of the Plan’s Medical Director and ten community physicians who have direct input into the decisions of the committee. The committee’s goal is to develop appropriate utilization of prescription medication while maintaining cost controls. New drugs and therapies that become available, as well as existing drugs and therapies, are reviewed for safety, therapeutic value and cost. Based on these factors, drugs are added or deleted from the formulary.
- **These are the dispensing limitations.** The retail and mail order prescription drug benefit operates with the following quantities/limitations: Maximum Day Supply is 34 days; Maximum Unit Supply is 100 units; Mail Service – Maximum Day Supply is 90 days; Mail Service – Maximum Unit Supply is unlimited. Copayments for Generic Drugs are \$10 for a 34-day supply, \$25 for Preferred Brand for a 34-day supply and \$40 for Non-Preferred Brand Name Drugs for a 34-day supply. Prior authorizations are required for injectables (except for imitrex, insulin, lovenex). For those medications that exceed \$500 in cost your physician will need to establish medical necessity.
- A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you – and us – less than a name-brand drug.

- Here are some things to keep in mind about our prescription drug program:
 You now have a Three Tier Prescription Drug Program. The program is designed to help members access the medications that they need while aiding employers in controlling the rising costs of health care.
 What does this three tier benefit mean to me?
 If you have prescription drug coverage, it means you will continue to have coverage for the prescription drugs you need. However, you may notice a difference in what you pay at the pharmacy. With this benefit design, your out of pocket expense will vary depending on the tier in which your prescription drug falls. Our goal is to encourage you to choose value in your prescriptions. This Three Tier Prescription Drug Program offers you important advantages including:
 - Coverage for a wide range of medications
 - Protection for you if you need expensive medications
 - Opportunity for you to lower your out of pocket costs by using generic or preferred brand drugs whenever possible
- **When you have to file a claim.** Please call HealthGuard Member Services at 800-822-0350 to request a form to be sent to AdvancePCS (HealthGuard’s Prescription Benefit Manager).

Benefit Description	You pay
Covered medications and supplies	
Covered medications and accessories include: <ul style="list-style-type: none"> • Drugs for which a prescription is required by law • Oral and injectable contraceptive drugs; contraceptive diaphragms • Insulin, with a copay charge applied to each vial • Disposable needles and syringes needed to inject covered prescribed medication, including insulin • Glucose test strips for diabetics, when prescribed by a Plan doctor • Allergy serum • Intravenous fluids and medication for home use and Depo Provera are covered under Medical and Surgical Benefits. • Ostomy bags and wafers (365 per calendar year per member) • Oral fertility drugs • Growth hormone 	\$10 copayment for Preferred Generic Drugs per 34-day supply \$25 copayment for Brand Name Drugs per 34-day supply \$40 copayment for Non-preferred Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
<ul style="list-style-type: none"> • Drugs for sexual dysfunction (see Prior authorization above) 	
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> 	<i>All Charges</i>

Section 5(g). Special features

Feature	Description
Centers of excellence for transplants/heart surgery/etc	Centers of Excellence are any Hospital or facility designated by HealthGuard at which HealthGuard will authorize payment for covered transplant services and covered complex surgical procedures for Members.
Travel benefit/ services overseas	<p>Members who are approved by HealthGuard to receive Transplants from a transplantation center more than 150 miles from their home will be entitled to the following travel benefits provided if their residence is located within the HealthGuard Service Area:</p> <ul style="list-style-type: none">• Transportation, by the most appropriate means, for the Member from his or her home to the transplantation center at the time of transplant.• Transportation and temporary housing for the Member and one caregiver to accompany the Member for evaluation and pre- and post-transplantation care which must be delivered at the transplantation center. Lodging expense is limited to a Maximum of \$100.00 per day unless approved in advance by HealthGuard.• Food and other miscellaneous expenses are not reimbursable.• Total lifetime reimbursement for transplantation-related travel expenses is limited to \$10,000.00.

Section 5(h) – Dental benefits

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

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

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Description	You Pay
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.	\$10 office visit Copay \$20 office visit to a specialist
Dental Benefits	
We have no other dental benefits.	

Section 5(i) - 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 out-of-pocket maximums.

HealthGuard's Fitness Club Reimbursement Benefit.

We feel that it is important to encourage our members, ages 18 and above, to adopt a healthy lifestyle. Physical fitness has been shown to lower the risks of certain diseases, such as heart disease.

We wish to encourage those who have been in a program to continue with your program and for those who have not yet begun a program to get started. We strongly encourage you to see your physician before beginning any exercise program, especially if you have cardiovascular risk factors such as high blood pressure, high cholesterol, sedentary lifestyle, tobacco use or a family history of heart disease.

HealthGuard has designated specific Health and Fitness Clubs to participate in the Cardiovascular Disease Reduction Fitness Program. These clubs have met specific criteria that are essential to participate in this program.

There are several changes in the fitness requirements as outlined in the Question & Answer section to follow.

HOW DO I QUALIFY FOR THE NEW FITNESS REIMBURSEMENT PROGRAM?

- You must be a current HealthGuard member at the time of joining the health and fitness club and at the time of reimbursement.
- You must be eligible under your HealthGuard plan for the fitness reimbursement program.
- You must be a member of HealthGuard and a member of the HealthGuard Designated Health and Fitness Club for 12 consecutive months beginning in January, to submit an application.
- You must participate in the fitness program for a minimum of 104 visits.

Wellness Programs

As a Plan participant, you and all covered family members are eligible to participate in various programs that promote better health. The class program topics include weight management, diabetic education, heart/blood pressure, childbirth classes and cholesterol management. The Plan pays the full amount for the cost of each approved class. Member Services must be contacted in order to register for the approved classes. For more information on the various classes available, call Member Services at 717-560-3353 or toll-free at 800-822-0350.

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

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7 - Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment.

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, Hospital and Prescription Drug Benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 800-822-0350.

When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to: HealthGuard, 280 Granite Run Drive,
Lancaster, PA 17601

Deadline for filing your claim

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

When we need more information

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

Section 8 - The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization:

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: HealthGuard, 280 Granite Run Drive, Lancaster, PA 17601; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or arrange for the health care provider to give you the care); orWrite to you and maintain our denial -- go to step 4; orAsk you or your medical provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW Washington, D.C. 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none">A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;Copies of all letters you sent to us about the claim;Copies of all letters we sent to you about the claim; andYour daytime phone number and the best time to call. <p>Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.</p>

The Disputed Claims Process (Continued)

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

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

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

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

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

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

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

- (a) We haven't responded yet to your initial request for care or precertification/prior approval, then call us at 800-447-0597 and we will expedite our review; or
- (b) We denied your initial request for care or precertification/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You can call OPM's Health Benefits Contracts Division 3 at 202/606-0737 between 8 a.m. and 5 p.m. Eastern time.

Section 9 - Coordinating benefits with other coverage

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

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and 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 two 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. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B.

Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

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.

Some things are not covered under Original Medicare, like prescription drugs. 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.

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

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and ...	Then the primary payer is...	
	Original Medicare	This Plan
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when... a) The position is excluded from FEHB or b) the position is not excluded from FEHB (Ask your employing office which of these applies to you.)	✓	
		✓
4) 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),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and...		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and...		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or	✓	
		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

Claims process when you have the Original Medicare Plan –

You probably will never have to file a claim form when you have both our Plan and Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 800-822-0350.

We waive some costs when you have the Original Medicare Plan -- When Original Medicare is the primary payer, we will waive some out-of-pocket costs, as follows:

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

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan – a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

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

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

Suspended FEHB coverage to enroll in a Medicare managed care plan:

If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care 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 managed care plan’s service area.

If you do not enroll in Medicare Part A or Part B

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can’t get premium-free Part A, we will not ask you to enroll in it.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10 - Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 10.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care, including room and board, that a) does not require the skills of technical or professional personnel on a daily basis; b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of Skilled Nursing Facility care; or c) is at a level such that the Member has reached the maximum level of physical or mental function and such person is not likely to make further significant improvement. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, or using the toilet; changing dressings of non-infected, post operative or chronic conditions; preparation of special diets; supervision of medication which can be self-administered by the Member; general maintenance care of colostomy or ileostomy; residential care and adult day care; protective and supportive care including educational services, rest cures and convalescent care.
Experimental or investigational services	Procedures not in accordance with generally accepted medical practice are not covered. Prescription drugs and medications are not covered unless they are prescribed in accordance with the Food and Drug Administration guidelines.
Us/We	Us and we refer to HealthGuard
You	You refers to the enrollee and each covered family member.

Section 11 - FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

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

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

Types of coverage available for you and your family

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

When benefits and Premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. 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.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

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 (TCC).

When you lose benefits

- **When FEHB coverage ends**

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

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

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, *the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

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

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

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

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

- **Converting to individual coverage**

You may convert to an individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert)
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

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

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

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

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

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the “TCC and HIPAA” frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance is Coming Later in 2002

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG!*
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, in an assisted living facility, care in your home, adult day care, hospice care, and more. LTC insurance can supplement care provided by family members, reducing the burden you place on them.

I'm healthy. I won't need Long term care. Or will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. Many people now consider long term care insurance to be vital to their financial and retirement planning.

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed \$50,000. Home care for only three 8 – hour shifts a week can exceed \$20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "Not covered" blocks in sections 5(a) and 5 (c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out More about the Program NOW?

Our toll-free teleservice center will begin in med-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/lc.

Index

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

- Accidental injury 36
- Allergy tests 15
- Alternative treatment 21
- Allogenic (donor) bone marrow transplants 24
- Ambulance 25
- Anesthesia 24
- Autologous bone marrow transplant 16, 24
- B** biopsy 22
- Blood and blood plasma 25
- C** casts 25
- Changes for 2002 6
- Chemotherapy 16
- Childbirth 21
- Chiropractic 21
- Cholesterol tests 13, 37
- Claims 39
- Coinurance 5, 10
- Colorectal cancer screening 13
- Congenital anomalies 22, 23
- Contraceptive devices and drugs 15, 34
- Coordination of benefits 43
- D**eductible 5, 10
- Definitions 46
- Dental care 36
- Diagnostic services 13
- Disputed claims review 40
- Donor expenses (transplants) 24
- Dressings 25, 26
- Durable medical equipment (DME) 19
- Educational classes and programs 21
- Effective date of enrollment 46
- Emergency 29
- Experimental or investigational 38
- Eyeglasses 18
- F**amily planning 15
- Fecal occult blood test 13
- G**eneral Exclusions 38
- H**earing services 17
- Home health services 20
- Hospice care 27
- Home nursing care 20
- Hospital 23
- I**mmunizations 13, 14
- Infertility 15
- Inpatient Hospital Benefits 25
- Insulin 33, 34
- Laboratory and pathological services 13
- M**agnetic Resonance Imagings (MRIs) 13
- Mail Order Prescription Drugs 33
- Mammograms 13
- Maternity Benefits 14
- Medicaid 45
- Medically necessary 9, 12
- Medicare 42
- Members 5
- Mental Conditions/Substance Abuse Benefits 32
- Newborn care 14
- Non-FEHB Benefits 37
- Nurse
 - Licensed Practical Nurse 20
 - Nurse Anesthetist 25
 - Registered Nurse 20
- Nursery charges 14
- O**bstetrical care 14
- Occupational therapy 16
- Ocular injury 18
- Office visits 5
- Oral and maxillofacial surgery 11
- Orthopedic devices 19
- Ostomy and catheter supplies 34
- Out-of-pocket expenses 10
- Outpatient facility care 26
- Oxygen 20
- P**ap test 13
- Physical examination 5
- Physical therapy 16
- Physician 12, 22
- Precertification 22
- Preventive care, adult 13
- Preventive care, children 14
- Prescription drugs 33
- Preventive services 13, 14
- Prior approval 9
- Prostate cancer screening 13
- Prosthetic devices 19
- Psychologist 32
- Psychotherapy 32
- R**adiation therapy 16
- Renal dialysis 16
- Room and board 25
- Second surgical opinion 12
- Skilled nursing facility care 12, 24
- Smoking cessation 21
- Speech therapy 17
- Splints 25
- Sterilization procedures 15, 22
- Subrogation 45
- Substance abuse 32
- Surgery 22
 - Anesthesia 24
 - Oral 23
 - Outpatient 24
 - Reconstructive 23
- Syringes 34
- Temporary continuation of coverage 42
- Transplants 24
- Treatment therapies 16
- Vision services 18
- W**ell child care 14
- Wheelchairs 19
- Workers' compensation 45
- X**-rays 13

Summary of benefits for *HealthGuard* - 2002

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

Benefits	You Pay	Page
Medical services provided by physicians: <ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office 	Office visit copay: \$10 primary care; \$20 specialist	12
Services provided by a hospital: <ul style="list-style-type: none"> • Inpatient • Outpatient 	Nothing	25 26
Emergency benefits: <ul style="list-style-type: none"> • In-area • Out-of-area 	\$25 (waived if admitted to the hospital).... \$25 (waived if admitted to the hospital)....	31 31
Mental health and substance abuse treatment	Regular cost sharing.	32
Prescription drugs	\$10 Preferred Generic for 34-day supply \$25 Preferred Brand for 34-day supply \$40 Non-preferred Brand for 34-day supply	33
Dental Care	No Benefit	37
Vision Care	No benefit	18
Special Features		38
<ul style="list-style-type: none"> • Wellness Programs and Fitness Club Reimbursement 		

2002 Rate Information for HealthGuard

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

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

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

Type of Enrollment	Code	<i>Non-Postal Premium</i>				<i>Postal Premium</i>	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Location Information

High Option Self Only	NQ1	\$74.68	\$24.89	\$161.81	\$53.93	\$88.37	\$11.20
High Option Self & Family	NQ2	\$194.18	\$64.72	\$420.71	\$140.24	\$229.79	\$29.13