

# CIGNA HealthCare of California, Inc.



CIGNA HealthCare

<http://www.cigna.com/healthcare>

2002

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## A Health Maintenance Organization

Serving: Greater California



**Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 6 for requirements.**



*This Plan has commendable accreditation from the NCQA.  
See the 2002 Guide for more information on accreditation.*

### Enrollment codes for this Plan:

9T1 Self Only

9T2 Self and Family

Authorized for distribution by the:



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



RI 73-402

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## Introduction

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CIGNA HealthCare of California, Inc.  
400 North Brand Boulevard  
Glendale, California 91203

This brochure describes the benefits of CIGNA HealthCare of California, Inc. under our contract (CS 2841) 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 8. Rates are shown at the end of this brochure.

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## Plain Language

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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 CIGNA HealthCare of California, Inc.
- 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 others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let us know. Visit OPM's “Rate Us” feedback area at [www.opm.gov/insure](http://www.opm.gov/insure) or e-mail us at [fehwebcomments@opm.gov](mailto:fehwebcomments@opm.gov).

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## Inspector General Advisory

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### **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 1-800-CIGNA24 (1-800-244-6224) 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.

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## Section 1. Facts about this HMO plan

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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 or coinsurance. We compensate our participating providers in ways that are intended to emphasize preventive care, promote quality of care, and assure the most appropriate use of medical services. You can discuss with your provider how he is compensated by us. The methods we use to compensate participating providers are:

Discounted fee for service – payment for service is based on an agreed upon discounted amount for the services provided.

Capitation – Physicians, provider groups and physician/hospital organizations are paid a fixed amount at regular intervals for each Member assigned to the physician, provider group or physician/hospital organization, whether or not services are provided. This payment covers the physician and/or, where applicable, hospital or other services covered under the benefit plan. Medical groups and physician/hospital organizations may in turn compensate providers using a variety of methods.

Capitation offers health care providers a predictable income, encourages Physicians to keep people well through preventive care, eliminates the financial incentive to provide services that will not benefit the patient, and reduces paperwork.

Providers paid on a “capitated” basis may participate with us in a risk sharing arrangement. They agree upon a target amount for the cost of certain health care services, and they share all or some of the amount by which actual costs are over target. Provider services are monitored for appropriate utilization, accessibility, quality and Member satisfaction.

We may also work with third parties who administer payments to Participating Providers. Under these arrangements, we pay the third party a fixed monthly amount for these services. Providers are compensated by the third party for services provided to Healthplan participants from the fixed amount. The compensation varies based on overall utilization.

Salary – Physicians and other providers who are employed to work in our medical facilities are paid a salary. The compensation is based on a dollar amount, decided in advance each year, that is guaranteed regardless of the services provided. Physicians are eligible for any annual bonus based on quality of care, quality of service and appropriate use of Medical Services.

Bonuses and Incentives – Eligible Physicians may receive additional payments based on their performance. To determine who qualifies, we evaluate Physician performance using criteria that may include quality of care, quality of service, accountability and appropriate use of Medical Services.

Per Diem – A specific amount is paid to a hospital per day for all health care received. The payment may vary by type of service and length of stay.

Case Rate – A specific amount is paid for all the care received in the hospital for each standard service category as specified in our contract with the provider (e.g., for a normal maternity delivery).

## Who provides my health care?

We contract with a group of doctors and hospitals to provide your health care. You will select a primary care physician who supervises your total health care needs. You may see a Plan gynecologist for annual routine examination without a referral. However, if your primary care physician is affiliated with a medical group, you must see a Plan gynecologist in the same medical group.

## 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](http://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.

- CIGNA HealthCare of California is in compliance with all State and Federal licensing and certification requirements and has received its 3 year commendable certification by the National Committee on Quality Assurance (NCQA) in September 2000.
- CIGNA HealthCare of California is a Health Services Corporation licensed in the State of California since 1978.

If you want more information about us, call 1-800-CIGNA24 (1-800-244-6224), or write to CIGNA HealthCare of California, Inc., 400 North Brand Boulevard, Glendale, California 91203. You may also visit our website at [www.cigna.com/healthcare](http://www.cigna.com/healthcare).

## Service Area

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

### Northern California Area

Service area: Alameda, Butte, Contra Costa, El Dorado, Fresno, Glenn, King, Marin, Placer, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, and Yolo Counties. Merced County is only partially covered, the zip codes lists below describe the areas that are covered in these counties:

**Merced:** 95315, 95324

### Southern California Area

Service area: Los Angeles, Orange, San Luis Obispo, Santa Barbara, and Ventura counties. Kern, Riverside and San Bernardino counties are only partially covered, the zip code lists below describe the areas that are covered in these counties:

**Kern:** 93203, 93205, 93206, 98215, 93216, 93217, 93220, 93222, 93224, 93225, 93226, 93238, 93240, 93241, 93243, 93249, 93250, 93251, 93252, 93255, 93263, 93268, 93276, 93280, 93283, 93285, 93287, 93300, 93301, 93302, 93303, 93304, 93305, 93306, 93307, 93308, 93309, 93311, 93312, 93313, 93380-9, 93390, 93399, 93501-5, 93516, 93518, 93519, 93523, 93524, 93527, 93528, 93531, 93554, 93555, 93556, 93560, 93561, 93570, 93581, 93582, 93596

**Riverside:** 91718-20, 91752, 91760, 92220, 92223, 92230, 92282, 92320, 92379, 92500-9, 92513-23, 92530-2, 92551-7, 92562-4, 92567, 92570-2, 92589-93, 92595, 92599

**San Bernardino:** 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758, 91760-4, 91784-6, 91798, 92301, 92307-9, 92311-3, 92316, 92317, 92324, 92329, 92334-7, 92340, 92342, 92345-6, 92350, 92354, 92356-9, 92368-9, 92372-7, 92392-4, 92397, 92399, 92400-16, 92418, 92420, 92423-4, 92427

**San Diego Area**

Service area: San Diego County

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

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

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## Section 2. How we change for 2002

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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 changes not shown here is a clarification that does not change benefits.

### Program-wide changes

- We increased speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))

### Changes to this Plan

- Your share of the non-Postal premium will increase by 19.8% for Self Only or 19.8% for Self and Family.
- Urgent care copayment is now \$25 per visit instead of \$50 per visit.
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- We limit Durable Medical Equipment to a maximum of \$3,500 per member per contract year. You pay nothing.
- We now cover infertility treatment at 70% per procedure. You now pay 30% per procedure.
- There is no visit limit for outpatient rehabilitation services. You pay a \$20 copay per visit.
- We now cover cardiac and pulmonary rehabilitation under rehabilitation therapies. You pay a \$20 copay per visit.
- Under prescription drugs, you now pay \$15 for Preferred Brand name drugs and \$35 for non-Preferred Brand name drugs. There is no change for generic drugs.
- Under mail order prescription drugs, you now pay \$40 for Preferred Brand name drugs and \$100 for non-Preferred Brand name drugs. There is no change for generic drugs.
- The out-of-pocket maximum is now \$1,000 for Self Only enrollment and \$2,000 for Self and Family enrollment.

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## Section 3. How you get care

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### 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 1-800-CIGNA24 (1-800-244-6224).

### Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments and coinsurance, and you will not have to file claims unless you receive emergency services from a provider who does not have a contract with us.

- **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. When you enroll, you choose a Primary Care Physician (PCP). Each family member also chooses a PCP. Your PCP is your personal doctor and serves as your health care manager. If you do not select a PCP, we will assign one for you. If your PCP leaves our network, you will be able to choose a new PCP. You may voluntarily change your PCP for other reasons but not more than once in any calendar month. We reserve the right to determine the number of times during a year that you will be allowed to change your PCP. If you select a new PCP before the fifteenth day of the month, the designation will be effective on the first day of the month following your selection. If you select a new PCP on or after the fifteenth day of the month, the designation will be effective on the first day of the month following the next full month. For example, if you notify us on June 10, the change will be effect on July 1. If you notify us on June 15, the change will be effective on August 1.

Some Primary Care Physicians belong to provider organizations which usually refer you to a network of Specialty Care Physicians and Hospitals that are in the provider organization. Your choice of Primary Care Physician may affect the Hospital(s) and Specialty Care Physicians to which you may be referred. Therefore, you may not have access to every specialist or Participating Provider in your Service Area. Before you select a PCP, you should check to see if that PCP is associated with the specialist or facility you prefer to use.

- **Primary care**

Your primary care physician can be a general practitioner, family practitioner, internist or 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. You may see an OB/GYN for well-woman care or go to a hospital for emergency care without a referral. However, if your primary care physician is affiliated with a medical group, you must see a Plan gynecologist in the same medical group.

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 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 1-800-CIGNA24 (1-800-244-6224). 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.

A referral or Prior Authorization must be obtained prior to receiving services performed by any health care provider EXCEPT:

For services provided by

- Your Primary Care Physician;
- OB/GYN Services (If your primary care physician is affiliated with a medical group, you must see a Plan gynecologist in the same medical group); and
- Emergency Services or Urgently Needed Care.

A Referral must be obtained directly from your Primary Care Physician. Your Primary Care Physician must provide a referral if you receive services and benefits such as Specialty Care Physician services. If you receive services which require a referral without a referral from your Primary Care Physician, you will be obligated to pay for the unauthorized Services.

**We will not pay for unauthorized services.**

Certain benefits and services require Prior Authorization from us. Prior Authorization must always be obtained through your Plan Provider. If Prior Authorization is required from us, your Primary Care Physician or Specialty Care Physician will make arrangements with our Medical Director. Prior Authorization is required for the following types of benefits and services such as: Inpatient and Outpatient Hospital Services, Rehabilitative Therapy, Skilled Nursing Facility Services, Home Health Services, Second Surgical Opinions, Services provided by a Non-Plan Provider, Durable Medical Equipment and Prosthetic Devices.

If your coverage is terminated prior to the date of service, the service will not be covered, regardless of any Prior Authorization given by us or your Primary or Specialty Care Physician.

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## Section 4. Your costs for covered services

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

- **Copayments**

A copayment is a fixed amount of money you pay to the 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.

- **Deductible**

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. We do not have a deductible.

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

- **Coinsurance**

Coinsurance is the percentage of our negotiated fee that you must pay for your care.

Example: In our Plan, you pay 30% of our allowance for infertility services.

### **Your out-of-pocket maximum for copayments**

After your copayments total \$1,000 per person or \$2,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription drugs
- Dental services
- Mental Health/Substance Abuse
- External prosthetic appliances
- Infertility services

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

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## Section 5. Benefits – OVERVIEW

*(See page 9 for how our benefits changed this year and page 53 for a benefits summary.)*

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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 1-800-CIGNA24 (1-800-244-6224) or at our website at [www.cigna.com/healthcare](http://www.cigna.com/healthcare).

(a) Medical services and supplies provided by physicians and other health care professionals .....	15-21
• 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 professionals .....	22-24
• Surgical procedures	
• Reconstructive surgery	
• Oral and maxillofacial surgery	
• Organ/tissue transplants	
• Anesthesia	
(c) Services provided by a hospital or other facility, and ambulance services .....	25-27
• Inpatient hospital	
• Outpatient hospital or ambulatory surgical center	
• Extended care benefits/skilled nursing care facility benefits	
• Hospice care	
• Ambulance	
(d) Emergency services/accidents .....	28-29
• Medical emergency	
• Ambulance	
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## 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.
- We have no calendar year deductible.
- 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
<b>Diagnostic and treatment services</b>	
Professional services of physicians <ul style="list-style-type: none"> <li>• In physician’s office</li> <li>• In an urgent care center</li> <li>• During a hospital stay</li> <li>• In a skilled nursing facility</li> <li>• Office medical consultations</li> <li>• Second surgical opinion</li> </ul>	\$10 per office visit
<b>Lab, X-ray and other diagnostic tests</b>	
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Mammograms</li> <li>• CAT Scans/MRI</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul> <p><b>Note: You pay nothing for Lab, X-rays and other diagnostic tests, however a provider or facility copayment may apply. Refer to the provider/facility charges identified in this Section 5(c).</b></p>	Nothing

Preventive care, adult	You pay
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> <li>• Total Blood Cholesterol – once every three years</li> <li>• Colorectal Cancer Screening, including               <ul style="list-style-type: none"> <li>– Fecal occult blood test</li> <li>– Sigmoidoscopy, screening – every five years starting at age 50</li> </ul> </li> </ul> <p><b>Note: You pay nothing for routine screenings, however a provider or facility copayment may apply depending on where you receive the screening. Refer to the provider/facility charges identified in this Section 5(c).</b></p> <p>Prostate Specific Antigen (PSA test) – one annually for men age 40 and older</p> <p>Routine pap test</p> <p>Note: The office visit is covered if pap test is received on the same day; see <i>Diagnostic and treatment services</i>, above.</p> <p><b>Note: You pay nothing for routine tests, however a provider or facility copayment may apply depending on where you receive the test. Refer to the provider/facility charges identified in this Section 5(c).</b></p> <p>Routine mammogram –covered for women age 35 and older, as follows:</p> <ul style="list-style-type: none"> <li>• From age 35 through 39, one during this five year period</li> <li>• From age 40 through 64, one every calendar year</li> <li>• At age 65 and older, one every two consecutive calendar years</li> </ul> <p><b>Note: You pay nothing for routine mammograms, however a provider or facility copayment may apply depending on where you receive the mammogram. Refer to the provider/facility charges identified in this Section 5(c).</b></p>	Nothing
<p><i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i></p>	All charges
<p>Routine immunizations, limited to:</p> <ul style="list-style-type: none"> <li>• Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations)</li> <li>• Influenza/Pneumococcal vaccines, annually, age 65 and over</li> </ul>	Nothing
Preventive care, children	
<ul style="list-style-type: none"> <li>• Childhood immunizations and injections recommended by the American Academy of Pediatrics</li> <li>• Well-child care charges for routine examinations, immunizations and care (under age 22)</li> </ul> <p><b>Note: You pay nothing for childhood immunizations, however a provider or facility copayment may apply. Refer to the provider/facility charges identified in this Section 5(c).</b></p>	Nothing
<ul style="list-style-type: none"> <li>• Examinations, such as:               <ul style="list-style-type: none"> <li>– Eye exams through age 17 to determine the need for vision correction</li> <li>– Ear exams through age 17 to determine the need for hearing correction</li> <li>– Examinations done on the day of immunizations (under age 22)</li> </ul> </li> </ul> <p><b>Note: You pay nothing for childhood immunizations, however a provider or facility copayment may apply. Refer to the provider/facility charges identified in this Section 5(c).</b></p>	\$10 per office visit

Maternity care	You pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need to obtain prior authorization for your normal delivery; see page 12 for other circumstances, such as extended stays for you or your baby.</li> <li>• 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.</li> <li>• 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.</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5(c)) and Surgery benefits (Section 5(b)).</li> </ul>	<p>\$10 for the first office visit to confirm pregnancy; no copay for all pre-/post-delivery visits thereafter.</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex .</i></p>	<p><i>All charges</i></p>
Family planning	
<ul style="list-style-type: none"> <li>• Voluntary sterilization</li> </ul> <p><b>Note: You pay nothing for Voluntary sterilization, however a provider or facility copayment may apply. Refer to the provider/facility charges identified in this Section 5(c).</b></p>	<p>Nothing</p>
<ul style="list-style-type: none"> <li>• Surgically implanted contraceptives (such as Norplant)</li> <li>• Injectable contraceptive drugs (such as Depo provera)</li> <li>• Intrauterine devices (IUDs)</li> </ul> <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$10 per office visit</p>
<p><i>Not covered: reversal of voluntary surgical sterilization, genetic counseling.</i></p>	<p><i>All charges</i></p>
Infertility services	
<p>Diagnosis of infertility</p>	<p>\$20 per office visit</p>
<p>Treatment of infertility, such as:</p> <ul style="list-style-type: none"> <li>• Artificial insemination: <ul style="list-style-type: none"> <li>– <i>intravaginal insemination (IVI)</i></li> <li>– <i>intra-cervical insemination (ICI)</i></li> <li>– <i>intrauterine insemination (IUI)</i></li> </ul> </li> <li>• Fertility drugs</li> </ul> <p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.</p>	<p>30% per treatment/surgical procedure</p>

Infertility services (continued)	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> <li>– in vitro fertilization</li> <li>– embryo transfer, gamete GIFT and zygote ZIFT</li> <li>– Zygote transfer</li> </ul> </li> <li>• Services and supplies related to excluded ART procedures</li> <li>• Cost of donor sperm</li> <li>• Cost of donor eggs</li> </ul>	<p><i>All charges</i></p>
Allergy care	
<p>Testing and treatment Allergy injection</p>	<p>\$10 per office visit</p>
<p>Allergy serum</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Self-administered allergy injections</li> </ul>	<p><i>All charges</i></p>
Treatment therapies	
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 24.</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</li> <li>• Dialysis – Hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> <li>• Growth hormone therapy (GHT)</li> </ul> <p>Note: Growth hormone therapy is covered under the prescription drug benefit.</p> <p>Note: We will only cover GHT when your PCP has received our prior authorization – Prior approval must be received before you begin treatment; otherwise, we will only cover GHT services from the date your PCP receives prior authorization. If prior authorization is not received 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>	
Physical and occupational therapies	
<p>All medically necessary visits are covered if significant improvement can be expected. Services of each of the following are covered.</p> <ul style="list-style-type: none"> <li>– qualified physical therapists;</li> <li>– occupational therapists;</li> <li>– chiropractors; and</li> <li>– cardiac and pulmonary rehabilitation programs.</li> </ul> <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p>	<p>\$20 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• long-term rehabilitative therapy</li> <li>• exercise programs</li> </ul>	<p><i>All charges</i></p>

<b>Speech therapy</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>All medically necessary visits.</li> </ul>	\$20 per visit
<b>Hearing services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>Hearing testing for children through age 17 (see <i>Preventive care, children</i>)</li> </ul>	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>all other hearing testing</li> <li>hearing aids, testing and examinations for them</li> </ul>	<i>All charges</i>
<b>Vision services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>One eye refraction per year to provide a written lens prescription for eyeglasses.</li> <li>One pair of eyeglasses or contact lenses for treatment of keratoconus or post-cataract surgery</li> </ul> <p>Note: See Preventive care, children for eye exams for children.</p>	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Eyeglasses or contact lenses</li> <li>Eye exercises and orthoptics</li> <li>Radial keratotomy and other refractive surgery</li> </ul>	<i>All charges</i>
<b>Foot care</b>	
<p>Routine foot care when you are under active treatment for medical conditions such as diabetes; fungal infection of the nail beds, circulatory impairment; immunocompromised patients.</p> <p>See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>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</li> <li>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)</li> </ul>	<i>All charges</i>
<b>Orthopedic and prosthetic devices</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>Artificial limbs and eyes; hands or hooks.</li> </ul> <p>The maximum Plan allowance is \$1,000 per calendar year.</p>	You pay the first \$200 per calendar year.
<ul style="list-style-type: none"> <li>Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy.</li> <li>Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device.</li> </ul>	Nothing

*Orthopedic and prosthetic devices continued on next page.*

Orthopedic and prosthetic devices <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>orthopedic and corrective shoes</i></li> <li>• <i>arch supports</i></li> <li>• <i>foot orthotics and braces</i></li> <li>• <i>heel pads and heel cups</i></li> <li>• <i>lumbosacral supports</i></li> <li>• <i>corsets, trusses, elastic stockings, support hose, and other supportive devices</i></li> <li>• <i>prosthetic replacements due to wear and tear, loss, theft or destruction.</i></li> <li>• <i>Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</i></li> <li>• <i>biomechanical devices</i></li> <li>• <i>penile prosthetics</i></li> </ul>	<p><i>All charges</i></p>
Durable medical equipment (DME)	
<p>Initial rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician and received from a vendor approved by the Plan, such as:</p> <ul style="list-style-type: none"> <li>• oxygen tents;</li> <li>• dialysis equipment;</li> <li>• hospital beds;</li> <li>• wheelchairs (limited to the lowest cost alternative to satisfy medical necessity);</li> <li>• crutches;</li> <li>• walkers;</li> <li>• blood glucose monitors and blood glucose monitors for the legally blind;</li> <li>• insulin pumps and infusion devices;</li> <li>• respirators; and</li> <li>• oxygen tents.</li> </ul> <p>Note: Your PCP will prescribe and arrange for a participating health care provider to rent or sell you the durable medical equipment. We will not cover equipment received from a non-participating health care provider unless your PCP has received our prior authorization.</p>	<p>We limit coverage to \$3,500 per member per year. You pay nothing.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Hygienic or self-help items or equipment, or item or equipment that are primarily for comfort or convenience, such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;</i></li> <li>• <i>Environmental control equipment, such as air purifiers, humidifiers, and electrostatic machines;</i></li> <li>• <i>Institutional equipment such as air fluidized beds and diathermy machines;</i></li> <li>• <i>Consumable medical supplies including, but not limited to, bandages and other disposable supplies, skin preparations, test strips, ostomy supplies, surgical leggings, elastic stockings and wigs.</i></li> </ul>	<p><i>All charges</i></p>

<b>Home health services</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide.</li> <li>• Services include oxygen therapy, intravenous therapy and medications.</li> </ul>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>nursing care requested by, or for the convenience of, the patient or the patient's family;</i></li> <li>• <i>home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative;</i></li> <li>• <i>services primarily for rest, domiciliary or convalescent care.</i></li> </ul>	<i>All charges</i>
<b>Chiropractic</b>	
See Physical and occupational therapies under this Section, Chiropractic is part of Physical and occupational therapies.	Same as Physical and occupational therapies
<b>Alternative treatments</b>	
<i>No benefit</i>	<i>All charges</i>
<b>Educational classes and programs</b>	
<i>No benefit</i>	<i>All charges</i>

## 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.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- YOUR PLAN PROVIDER MUST GET PRIOR AUTHORIZATION OF SOME SURGICAL PROCEDURES. Please refer to the prior authorization information shown in Section 3 to be sure which services require prior authorization and identify which surgeries require prior authorization.

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Benefit Description	You pay
<b>Surgical procedures</b>	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see reconstructive surgery)</li> <li>• Surgical treatment of morbid obesity – a condition in which an individual weighs 200% of his or her normal weight according to the 1983 Metropolitan Life Insurance Company height-weight chart with a history of morbid obesity for at least 5 years and has complied with more conservative methods of weight loss</li> <li>• Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information</li> <li>• Voluntary sterilization</li> <li>• Treatment of burns</li> </ul> <p>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.</p>	Nothing

*Surgical procedures continued on next page.*

Surgical procedures <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care.</i></li> <li>• <i>Cosmetic therapy or surgery primarily for the purpose of altering appearance.</i></li> </ul>	<p><i>All charges</i></p>
<b>Reconstructive surgery</b>	
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>– the condition produced a major effect on the member’s appearance and</li> <li>– the condition can reasonably be expected to be corrected by such surgery.</li> </ul> </li> <li>• 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.</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> <li>– surgery to produce a symmetrical appearance on the other breast;</li> <li>– treatment of any physical complications, such as lymphedemas;</li> <li>– breast prostheses and surgical bras and replacements (see Prosthetic devices).</li> </ul> </li> </ul> <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>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <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></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>	<p><i>All charges</i></p>
<b>Oral and maxillofacial surgery</b>	
<p>Oral surgical procedures, with the prior approval of Plan Medical Director, such as:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures; and</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures.</li> </ul>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> <li>• <i>Other surgical procedures which have not received prior approval from the Plan Medical Director.</i></li> </ul>	<p><i>All charges</i></p>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Pancreas</li> <li>• Liver</li> <li>• Lung</li> <li>• Allogenic (donor) bone marrow transplants</li> <li>• 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</li> <li>• Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach and pancreas</li> <li>• National Transplant Program (NTP) please see Section 5(g), Special Features</li> </ul> <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's Medical Director in accordance with the Plan's protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i></li> <li>• <i>Implants of artificial organs</i></li> <li>• <i>Transplants not listed as covered</i></li> </ul>	<i>All charges</i>
Anesthesia	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> <li>• Hospital outpatient department</li> <li>• Skilled nursing facility</li> <li>• Ambulatory surgical center</li> <li>• Office</li> </ul>	Nothing

## 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.
- We have no calendar year deductible.
- 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 Section 5(a) or (b).
- **YOUR PRIMARY CARE PHYSICIAN MUST OBTAIN OUR PRIOR AUTHORIZATION FOR HOSPITAL STAYS, EXCEPT FOR EMERGENCIES.** Please refer to Section 3 to be sure which services require Prior Authorization.

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Benefit Description	You pay
<b>Inpatient hospital</b>	
Room and board, such as: <ul style="list-style-type: none"> <li>• ward, semiprivate, or intensive care accommodations;</li> <li>• general nursing care; and</li> <li>• meals and special diets.</li> </ul> Note: If you request a private room and 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"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Administration of blood, blood products and other biologicals</li> <li>• Blood or blood plasma</li> <li>• Dressings, splints, casts, and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics and anesthesia services</li> </ul>	Nothing
Not covered: <ul style="list-style-type: none"> <li>• Custodial care</li> <li>• Non-covered facilities, such as nursing homes and schools</li> <li>• Personal comfort items, such as telephone, television, barber services, guest meals and beds</li> <li>• Private nursing care</li> </ul>	<i>All charges</i>

<b>Outpatient hospital or ambulatory surgical center</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood products and other biologicals</li> <li>• Blood and blood plasma</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia services</li> </ul> <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>
<b>Extended care benefits/skilled nursing care facility benefits</b>	
<p>Benefits will be provided for up to 60 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. Covered services include:</p> <ul style="list-style-type: none"> <li>• Skilled and general nursing services</li> <li>• Physicians visits</li> <li>• Physiotherapy</li> <li>• X-rays</li> <li>• Administration of drugs, medications and fluids</li> </ul>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>personal comfort items, such as television and telephone</i></li> <li>• <i>custodial care, rest cures, domiciliary or convalescent care</i></li> </ul>	<i>All charges</i>

Hospice care	You pay
<p>Supportive and palliative care for a terminally ill member is covered. Services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six (6) months or less.</p> <p>Hospice care services include:</p> <ul style="list-style-type: none"> <li>• Inpatient care</li> <li>• outpatient care</li> <li>• physician services</li> <li>• psychologist, social worker or family counselor services for individual or family counseling</li> </ul>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Independent nursing</i></li> <li>• <i>homemaker services, including services and supplies that are primarily to aid you or your dependent in daily living</i></li> <li>• <i>services of a person who is a member of your family who normally resides in your house</i></li> <li>• <i>services or supplies not listed in the Hospice Care Program</i></li> <li>• <i>services for curative or life-prolonging procedures</i></li> <li>• <i>services for respite care</i></li> <li>• <i>nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals</i></li> <li>• <i>bereavement counseling</i></li> </ul>	<i>All charges</i>
Ambulance	
<ul style="list-style-type: none"> <li>• Local professional ambulance service when medically appropriate</li> </ul>	Nothing

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## 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.
- We have no calendar year deductible.
- 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.

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### What to do in case of emergency:

**Emergencies inside or outside our service area:** In the event of an emergency, get help immediately. Go to the nearest emergency room, the nearest hospital or call or ask someone to call 911 or your local emergency service, police or fire department for help. You do not need a referral from your PCP for emergency services, but you do need to call your PCP as soon as possible for further assistance and advice on follow-up care. If you require specialty care or a hospital admission, your PCP will coordinate it and handle the necessary authorizations for care or hospitalization. Participating providers are on call twenty-four (24) hours a day, seven (7) days a week, to assist you when you need emergency services.

If you receive Emergency services outside the service area, you must notify us as soon as reasonably possible. We may arrange to have you transferred to a participating provider for continuing or follow-up care if it is determined to be medically safe to do so.

Emergency services are defined as the medical, psychiatric, surgical, hospital and related health care services and testing, including ambulance service, which are required to treat a bodily injury or a serious illness which could reasonably be expected by a prudent layperson to result in serious medical complications, or in the case of a pregnant woman, serious jeopardy to the health of the woman or her unborn child, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include, but are not limited to, uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdoses of medication or poisoning, sudden paralysis or slurred speech, burns, cuts, and broken bones, or services required by you to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition within the capability of the facility.

Continuing or follow-up treatment, whether in or out of the service area, is not covered unless it is provided or arranged for by your PCP or upon prior authorization of our Medical Director.

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Benefit Description	You pay
<b>Emergency within our service area</b>	
<ul style="list-style-type: none"> <li>• Emergency care at a Plan doctor’s office</li> <li>• Emergency care at a Plan urgent care center</li> <li>• Emergency care as an outpatient or inpatient at a hospital, including doctors’ services</li> </ul> <p>Note: Urgent care center copay and emergency hospital care copay waived if admitted to hospital</p>	<p>\$10 per office visit  \$25 per office visit  \$50 per office visit</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>
<b>Emergency outside our service area</b>	
<ul style="list-style-type: none"> <li>• Emergency care at a doctor’s office</li> <li>• Emergency care at an urgent care center</li> <li>• Emergency care as an outpatient or inpatient at a hospital, including doctors’ services</li> </ul> <p>Note: Urgent care center copay and emergency hospital care copay waived if admitted to hospital</p>	<p>\$10 per office visit  \$25 per office visit  \$50 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Elective care or non-emergency care</i></li> <li>• <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> </ul>	<i>All charges</i>
<b>Ambulance</b>	
<p>Professional ambulance service when medically appropriate.  See 5(c) for non-emergency service.</p>	Nothing

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

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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.
- We have no calendar year deductible.
- 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.

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Benefit Description	You pay
<b>Mental health and substance abuse benefits</b>	
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.  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.	Your cost sharing responsibilities are no greater than for other illness or conditions.
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>• Medication management</li> </ul>	\$10 per office visit
<ul style="list-style-type: none"> <li>• Diagnostic tests</li> </ul>	Nothing
<ul style="list-style-type: none"> <li>• Services provided by a hospital or other facility</li> <li>• Services in approved alternative care settings such as partial hospitalization, facility based intensive outpatient treatment</li> </ul>	Nothing Nothing, however a provider copayment may apply.
<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>	<i>All charges</i>

*Mental health and substance abuse benefits continued on next page.*

## Mental health and substance abuse benefits *(continued)*

### **Preauthorization**

To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes:

Mental Health and Substance Abuse Services are provided by CIGNA Behavioral Health, Inc. You do not need a referral to receive these services. However, to obtain these services, you **must** call CIGNA Behavioral Health directly, their phone number can be found on your ID Card, to get more information or speak with someone about a specific problem. A representative is available to assist you twenty-four (24) hours a day, seven (7) days a week. The representative will provide you with a choice of providers in your area and will authorize an appropriate number of visits.

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## 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.
- We have no calendar year deductible.
- 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 plan physician or licensed dentist must write the prescription .
- **Where you can obtain them.** You may fill the prescription at a plan retail pharmacy, or by plan mail-order pharmacy. You must fill the prescription at a plan retail pharmacy. You may fill your maintenance medications by mail through a plan mail-order pharmacy.
- **We use a formulary.** A formulary is a listing of approved drug products. The drugs and medications included have been approved in accordance with parameters established by Healthplan. This list is subject to periodic review and is amended as required. Only those medications included on the formulary are covered.

**These are the dispensing limitations.** –

- Your copayment for generic retail prescription drugs that are on the formulary is \$5. Your copayment for name brand retail prescription drugs that are on the formulary but do not have a generic equivalent is \$15. Your copayment for name brand drugs that are on the formulary but do have a generic equivalent OR for drugs that are not on the formulary is \$35. Each prescription order or refill is limited to a consecutive thirty (30) day supply at a retail participating pharmacy, unless limited by the drug manufacturer’s packaging.
- Maintenance medications prescribed by Plan doctors may also be obtained through our mail order program. Your copayment for generic mail order prescription drugs that are on the formulary is \$10. Your copayment for name brand mail order drugs that are on the formulary but do not have a generic equivalent is \$40. Your copayment for name brand drugs that are on the formulary but do have a generic equivalent OR for drugs that are not on the formulary is \$100. Each prescription order or refill is limited to a consecutive ninety (90) day supply at a mail order participating pharmacy, unless limited by the manufacturer’s packaging.

**Each prescription order or refill is further limited to:**

- “generic” drugs unless a generic alternative does not exist or substitution is not permitted by state law.
- Coverage for prescription drugs are subject to a Copayment. In no event will the Copayment exceed the cost of the drug.

**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 prescription.

- **When you have to file a claim.** Please refer to Section 7 “Filing a claim for covered services”.

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*Prescription drug benefits begin on the next page.*

Benefit Description	You pay
<p><b>Covered medications and supplies</b></p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>.</li> <li>• Insulin</li> <li>• Disposable needles and syringes for the administration of covered medications</li> <li>• Drugs for sexual dysfunction (contact Plan for dose limits)</li> <li>• Oral and injectable contraceptive drugs and contraceptive devices (such as diaphragms)</li> <li>• Intravenous fluids and medications for home use.</li> <li>• Implanted time-release medications such as Norplant. Implanted time-release medications are covered under this Prescription drug section and the office visit is covered under Medical services and supplies, Section 5(a), Family planning. There is no charge when the device is implanted during a covered hospitalization.</li> <li>• Nutritional supplements (formulas) as medically necessary for the therapeutic treatment of phenylketonuria (PKU), branched-chain ketonuria, galactosemia and homocystinuria as administered under the direction of a Primary Care Physician</li> <li>• Diabetic supplies such as test strips</li> <li>• Oral agent for controlling blood sugar</li> </ul>	<p><b><u>Retail Pharmacy</u></b></p> <p>\$5 per generic formulary drug</p> <p>\$15 per name brand formulary drug</p> <p>\$35 per name brand formulary drug with generic equivalent OR per non-formulary drug</p> <p><b><u>Mail Order</u></b> <b>(Maintenance medications only)</b></p> <p>\$10 per generic formulary drug</p> <p>\$40 per name brand formulary drug</p> <p>\$100 per name brand formulary drug with generic equivalent OR per non-formulary drug</p> <p>Note: If there is no generic equivalent available, you will still have to pay the name brand copay</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs and supplies for cosmetic purposes</i></li> <li>• <i>Vitamins (except for prenatal vitamins), and fluoride products, nutrients and food supplements even if a physician prescribes or administers them</i></li> <li>• <i>Non-prescription medicines, over the counter drugs</i></li> <li>• <i>Drugs obtained from a non-Plan pharmacy except for out-of-area emergencies</i></li> <li>• <i>Medical supplies such as dressings and antiseptics</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Smoking cessation drugs and medications, including nicotine patches</i></li> <li>• <i>Diet pills or appetite suppressants (except when used in the treatment of morbid obesity)</i></li> <li>• <i>Replacement of drugs due to loss or theft</i></li> <li>• <i>Prescriptions more than one year from the original date of issue</i></li> <li>• <i>Injectable fertility drugs (see Infertility benefit under Medical and Surgical Benefits for limited coverage)</i></li> </ul>	<p><i>All charges</i></p>

## Section 5 (g). Special features

Feature	Description
<b>Flexible benefits option</b>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> <li>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.</li> <li>• Alternative benefits are subject to our ongoing review.</li> <li>• By approving an alternative benefit, we cannot guarantee you will get it in the future.</li> <li>• The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits.</li> <li>• Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</li> </ul>
<b>24 hour nurse line</b>	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-800-CIGNA24 (1-800-244-6224) and talk with a registered nurse who will discuss treatment options and answer your health questions.</p>
<b>Services for deaf and hearing impaired</b>	<p>Deaf/Hearing impaired individuals may access the member services department by calling their state relay line.</p>
<b>High risk pregnancies</b>	<p>Healthy Babies is a program that provides guidance and support to women from pre-pregnancy through post-partum care. This program is designed to promote better maternity care, reduce the number of premature births and educate expectant parents.</p>
<b>Centers of Excellence for transplants/heart surgery/etc.</b>	<p>CIGNA HealthCare members have access to the CIGNA Lifesource Organ Transplant Network<sup>®</sup> which is an organization of participating hospitals which provides organ transplant services. As part of the rigorous credentialing program, each hospital's transplant program is evaluated for patient outcome, as well as waiting period, housing arrangements, "patient friendly" environment and the availability of transportation, before it is included in the CIGNA Lifesource Organ Transplant Network<sup>®</sup>.</p>
<b>Travel benefit/ services overseas</b>	<p>We cover you for emergency services anywhere in the world.</p>

## Section 5 (h). Dental benefits

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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 dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when prior authorized by our Medical Director and a non-dental 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.
- We cover anesthesia for dental procedures only when (a) age 7 years and under; (b) developmentally disabled, regardless of age; or (c) health compromised and general anesthesia is Medically Necessary, regardless of age; AND prior authorized by the Plan Medical Director and a non-dental 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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<b>Accidental injury benefit</b>	<b>You pay</b>
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 per office visit
<b>Dental benefits</b>	
We have no other dental benefits.	

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## Section 5 (i). Non-FEHB benefits available to Plan members

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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.

### Guest Privileges

If you or a covered family member temporarily moves outside of the service area for at least 90 days, you may be eligible for the Plan's "guest privileges" program. The "guest privileges" program allows participants to enroll as "guests" in another CIGNA HealthCare site. This program is only available when you or your covered family member is temporarily relocating to an approved CIGNA guest site. Guest privileges is an ideal way to arrange for benefits in situations such as: a temporary job transfer/work assignments; college child attending school away from home, etc. **You should be aware that your FEHBP benefits will NOT follow you to the guest site.** You will be covered by the CIGNA HealthCare "guest privileges" program plan of benefits. Contact member services at 1-800-CIGNA24 (1-800-244-6224) for more information.

### CIGNA Dental Care

Health coverage for your mouth is available for FEHB program members at a very affordable cost. It is not necessary to have CIGNA Medical Care to purchase CIGNA Dental Care for yourself and your family.

- No deductibles
- No annual maximums
- No claim forms
- No charge for preventive services (oral exams, x-rays, routine cleanings, fluoride treatments)
- Low copayments required for other treatments (see Dental Fee Overview)
- Orthodontic coverage for both children and adults for treatment started after the effective date of your plan

For questions about enrollment, call Wright & Co. at 1-800-51DENTAL. For questions about the CIGNA Dental Care plan, call member services at 1-800-367-1037.

Members Choice allows you to select a different dental office for each covered member. To enroll in CIGNA Dental Care, choose any network general dentist for yourself and each of your covered dependents from the CIGNA Dental Care Network Directory, or access the dental office locator by calling 1-800-367-1037.

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## Section 6. General exclusions — things we don't cover

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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 and we agree, as discussed under *Services Requiring Our Prior Approval* on page 12.**

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.

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## Section 7. Filing a claim for covered services

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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 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 1-800-CIGNA24 (1-800-244-6224).

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: Please refer to your ID card for the address to mail any claims.**

### **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.

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## Section 8. The disputed claims process

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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
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|----------|---|
| <b>1</b> | <p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none"><li>Write to us within 6 months from the date of our decision; and</li><li>Send your request to us at: CIGNA HealthCare of California, Inc., 400 North Brand Boulevard, Glendale, California 91203; and</li><li>Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li><li>Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li></ol>   |
| <b>2</b> | <p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none"><li>Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</li><li>Write to you and maintain our denial – go to step 4; or</li><li>Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.</li></ol>  |
| <b>3</b> | <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>   |
| <b>4</b> | <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"><li>90 days after the date of our letter upholding our initial decision; or</li><li>120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or</li><li>120 days after we asked for additional information.</li></ul> <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"><li>A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;</li><li>Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;</li><li>Copies of all letters you sent to us about the claim;</li><li>Copies of all letters we sent to you about the claim; and</li><li>Your daytime phone number and the best time to call.</li></ul> |

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## The disputed claims process *(continued)*

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Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

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

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 prior authorization. This is the only deadline that may not be extended.

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

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

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

- (a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-CIGNA24 (1-800-244-6224) and we will expedite our review; or
- (b) We denied your initial request for care or preauthorization/prior approval, then:
  - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
  - You can call OPM's Health Benefits Contracts Division III at 202-606-0737 between 8 a.m. and 5 p.m. eastern time.

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## Section 9. Coordinating benefits with other coverage

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### 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 health care expenses without regard to fault. This is called “double coverage.”

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

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

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

#### • What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age 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 a Medicare+Choice plan that 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. Your care must continue to be authorized by your Plan PCP, or recertified as required.

We will not waive any of our copayments or coinsurance.

**(Primary payer chart begins on next page.)**

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.

<b>Primary Payer Chart</b>		
<b>A. When either you – or your covered spouse – are age 65 or over and ...</b>	<b>Then the primary payer is...</b>	
	<b>Original Medicare</b>	<b>This Plan</b>
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>B. When you – or a covered family member – have Medicare based on end stage renal disease (ESRD) and...</b>		
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,	✓	
<b>C. When you or a covered family member have FEHB and...</b>		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or b) Are an active employee, 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 the Original Medicare Plan. Please note, if your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.
- 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 1-800-CIGNA24 (1-800-244-6224), or write to CIGNA HealthCare of California, Inc., 400 North Brand Boulevard, Glendale, California 91203. You may also visit our website at [www.cigna.com/healthcare](http://www.cigna.com/healthcare). In this case we do not waive any out-of-pocket costs.

• **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](http://www.medicare.gov).

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, coinsurance, or deductibles. 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.

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## Section 10. Definitions of terms we use in this brochure

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<b>Calendar year</b>	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.
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care. See page 13.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Deductible</b>	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. We have no deductible.
<b>Experimental or investigational services</b>	<p>Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the Independent Review Process for Experimental and Investigational Therapies (see “Section III. Agreement Provisions”) and the Healthplan Medical Director to be:</p> <ul style="list-style-type: none"><li>• not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopoeia Drug Information, The American Medical Association Drug Evaluations; or the American Hospital Formulary Service Drug Information) or in medical and scientific evidence. Medical and scientific evidence means:<ol style="list-style-type: none"><li>a. peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health’s National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), and MEDLARS database Health Services Technology Assessment Research (HSTAR);</li><li>b. medical journals recognized by the Secretary of Health and Human Services;</li><li>c. the following standard reference compendia: The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;</li><li>d. findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes; and</li><li>e. peer-reviewed abstracts accepted for presentation at major medical association meetings.</li></ol></li><li>• the subject of review or approval by an Institutional Review Board for the proposed use;</li><li>• the subject of an ongoing clinical trial that meets the definition of a phase I, II or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight ; or</li><li>• not demonstrated, through existing peer-reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.</li></ul>

**Medical necessity**

Medically necessary covered Services and Supplies are those Services and Supplies that are determined by our Medical Director to be:

- No more than required to meet your basic health needs; and
- consistent with the diagnosis of the condition for which they are required; and
- consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; and
- required for purposes other than the comfort and convenience of the patient or his Physician; and
- rendered in the least intensive setting that is appropriate for the delivery of health care; and
- of demonstrated medical value.

**Us/We**

Us and we refer to CIGNA HealthCare of California, Inc.

**You**

You refers to the enrollee and each covered family member.

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## Section 11. FEHB facts

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### 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](http://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 marry.

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 of Coverage (TCC).

## When you lose benefits

### • When FEHB coverage ends

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

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

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.

### • 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](http://www.opm.gov/insure). It explains what you have to do to enroll.

• **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

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

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

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

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

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

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site ([www.opm.gov/insure/health](http://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.

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## Long Term Care Insurance Is Coming Later in 2002!

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- 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, care in an assisted living facility, care in your home, adult day care, hospice care, and more. It 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 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 insurance 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 mid-2002. In the meantime, you can learn more about the program on our web site at [www.opm.gov/insure/ltc](http://www.opm.gov/insure/ltc).

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## Department of Defense/FEHB Demonstration Project

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### What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 open season for the year 2000. Open season enrollments will be effective January 1, 2002. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

### Who is eligible

DoD determines who is eligible to enroll in the FEHB Program. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

### The demonstration areas

- Dover AFB, DE
- Fort Knox, KY
- Dallas, TX
- New Orleans, LA
- Adair County, IA area
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA area

### When you can join

You may enroll under the FEHB/DoD Demonstration Project during the 2001 open season, November 12, 2001, through December 10, 2001. Your coverage will begin January 1, 2002. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877-DOD-FEHB (1-877-363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during open season. Your coverage will begin January 1, 2002. If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at [www.tricare.osd.mil/fehbp](http://www.tricare.osd.mil/fehbp). You can also view information about the demonstration project, including "The 2002 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at [www.opm.gov](http://www.opm.gov).

See Section 11, FEHB Facts; it explains temporary continuation of coverage (TCC). Under this DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a “member of family” under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

### **Other features**

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration Project.

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Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

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**NOTES:**

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## Summary of benefits for CIGNA HealthCare of California, Inc. – 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"> <li>• Diagnostic and treatment services provided in the office .....</li> </ul>	Office visit copay: \$10 primary care or specialist	15
Services provided by a hospital: <ul style="list-style-type: none"> <li>• Inpatient .....</li> <li>• Outpatient .....</li> </ul>	Nothing per admission Nothing	25 26
Emergency benefits: <ul style="list-style-type: none"> <li>• In-area .....</li> <li>• Out-of-area .....</li> </ul>	Office visit: \$10 per visit; \$25 per urgent care center visit or \$50 per hospital emergency care visit	28 28
Mental health and substance abuse treatment .....	Regular cost sharing.	30
Prescription drugs .....	<b>Retail Pharmacy:</b> \$5 per generic formulary; \$15 per name brand formulary; \$35 per name brand non-formulary.  <b>Mail Order:</b> <b>(Maintenance Medications only)</b> \$10 per generic formulary; \$40 per name brand formulary; \$100 per name brand non-formulary.  Note: If there is no generic equivalent available, you will still have to pay the brand name copay	32
Dental Care (Accidental injury benefit only) .....	You pay a \$10 office visit copay	35
Vision Care .....	One refraction annually, you pay a \$10 copay per visit.	19
Special features: Flexible benefits option; 24 hour nurse line; Services for deaf and hearing impaired; High risk pregnancies; Centers of Excellence for transplants/heart surgery/etc.; Travel benefit/ services overseas .....		34
Protection against catastrophic costs (your out-of-pocket maximum) .....	Nothing after \$1,000/Self Only or \$2,000/Self and Family enrollment per year. This copay maximum does not include Prescription drugs, Dental services, Mental Health/ Substance Abuse services, Prosthetics or Infertility services.	13

## 2002 Rate Information for CIGNA HealthCare of California, Inc.

**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	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

### Greater California

Self Only	9T1	\$87.48	\$29.16	\$189.54	\$63.18	\$103.52	\$13.12
Self and Family	9T2	\$192.46	\$64.15	\$416.99	\$139.00	\$227.74	\$28.87