

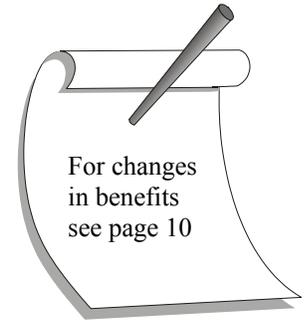


BlueCHOICE®

<http://www.bcbsmo.com>

2003

A Health Maintenance Organization



Serving: St. Louis, Central, and Southeast areas in Missouri and St. Clair and Madison counties in Illinois

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



This plan has excellent accreditation from the NCQA. See the *2003 Guide* for more information on accreditation.

Enrollment code:

- 9G1 Self Only**
- 9G2 Self and Family**

Authorized for distribution by the:



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





UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay Coles James".

Kay Coles James
Director



Notice of the Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.

- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice will be effective April 14, 2003.

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Rates Back cover

Blue Cross and Blue Shield of Missouri is the name RightCHOICE[®] Managed Care, Inc. (RIT) uses to do business in most of Missouri. In Missouri, RIT administers the FEHB program. HMO Missouri, Inc. does business as BlueCHOICE. RIT and HMO Missouri, Inc. are independent licensees of the Blue Cross and Blue Shield Association.

Introduction

This brochure describes the benefits of BlueCHOICE HMO under our contract (CS 2838) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by the Healthy Alliance Life Insurance Company. The address for administrative offices is:

BlueCHOICE
1831 Chestnut Street
St. Louis, Missouri 63103-2275

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on page 10. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; “we” means BlueCHOICE.
- 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 OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.

- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 800/932-4480 and explain the situation.
 - If we do not resolve the issue:

**CALL -- THE HEALTH CARE FRAUD HOTLINE
202-418-3300**

OR WRITE TO:
 The United States Office of Personnel Management
 Office of the Inspector General Fraud Hotline
 1900 E Street, NW, Room 6400
 Washington, DC 20415

- Do not maintain as a family member on your policy:
 - your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
 - You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory.

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 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, hospitals and other types of providers 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. We reimburse primary care physicians through capitation, which includes the majority of services the primary care physician renders. We compensate certain services, such as immunizations or cardiac diagnostic testing in the office as fee for service.

Who provides my health care?

This plan is an individual-practice Plan. All participating doctors practice in their own offices in the community. Unless it is an emergency, benefits are available only from doctors, hospitals and other health care providers that are in the BlueCHOICE network. The Plan arranges with doctors and hospitals to provide medical care for both the prevention of disease and the treatment of serious illness.

You must select a primary care doctor for each covered family member. Approximately 1,300 primary care physicians participate in BlueCHOICE. For most care, you must contact your primary care doctor for a referral or authorization before seeing any other doctor for specialty care or nonemergency hospital services. A wide variety of specialists are participating Plan doctors. Many are Board certified as indicated in the BlueCHOICE directory. If you need hospital care, your Plan primary doctor will admit you to a participating hospital where he/she has admitting privileges.

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 Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

About the plan and care management: Blue Cross and Blue Shield of Missouri has over 60 years of experience in the health insurance industry. We began as St. Louis Blue Cross in 1936. In 1945, Missouri Medical Service, commonly known as Blue Shield, began business in the St. Louis area. The two companies merged in 1986, forming Blue Cross and Blue Shield of Missouri, a not-for-profit health service corporation. In 1994, Blue Cross and Blue Shield of Missouri formed a new managed care company, Alliance Blue Cross Blue Shield.

Effective November 30, 2000, Blue Cross and Blue Shield of Missouri and its for-profit managed care subsidiary, Alliance Blue Cross Blue Shield, merged into a single, for-profit, publicly traded Delaware corporation. The insurance-related business that was part of the old Blue Cross and Blue Shield of Missouri has been transferred to and assumed by Healthy Alliance Life Insurance Co., a wholly owned subsidiary of Blue Cross and Blue Shield of Missouri, as part of the reorganization.

BlueCHOICE, the for-profit HMO subsidiary of Blue Cross and Blue Shield of Missouri, began operations in 1988.

Blue Cross and Blue Shield of Missouri, BlueCHOICE and Healthy Alliance Life Insurance Co. are independent licensees of the Blue Cross and Blue Shield Association.

On Jan. 31, 2002, RightCHOICE Managed Care Inc. and WellPoint Health Networks Inc. merged. WellPoint, which is based in Thousand Oaks, Calif., serves the health care needs of 12 million members and more than 45 million specialty members through Blue Cross of California, Blue Cross of Georgia, UNICARE and Blue Cross and Blue Shield of Missouri and its subsidiaries.

Utilization management services include:

- Precertifications of medical/surgical, mental health, rehabilitation, skilled nursing, outpatient and home health care
- Concurrent review of medical/surgical, mental health, rehabilitation, skilled nursing, outpatient and home health care
- Retrospective review
- Discharge planning
- Alternative care planning
- Individual case management
- Appeal for denial of payment due to lack of medical necessity
- Medical review

Our contracts with network providers require them to handle all certifications for BlueCHOICE members. You will not have to be concerned about managed care procedures as long as you receive care from network providers.

We offer special programs to help members with health conditions such as asthma, diabetes and high-risk pregnancy. These are voluntary programs to help members manage their particular health condition. These programs are explained in Section 5(g).

Accreditation status: BlueCHOICE is accredited by the National Committee for Quality Assurance (NCQA). The comprehensive review process evaluates how well a plan manages its benefits. The accreditation process evaluates more than 60 standards in the following six categories:

- quality management and improvement
- physician qualifications and evaluation
- members' rights and responsibilities
- preventive health services
- utilization management and
- medical records

Networks, providers and facilities: The BlueCHOICE network includes approximately 1,400 primary physicians, 4,000 specialists and 68 hospitals. Approximately 79 percent of network physicians are Board Certified and 85 percent are accepting new patients. The physician's Board status and whether or not he/she is accepting new patients are included in the BlueCHOICE provider directory.

We have established credentialing policies that require us to select and recredential physicians every three years, based on an evaluation of their experience and training, board certification and staff privileges at network hospitals. Our program goals are to support the development and maintenance of credentialing and recredentialing standards for our participating providers, review the qualifications of potential participating providers against established standards, and to reassess the qualifications and performance of our network providers.

Our credentialing criteria for network hospitals include accreditation by the Joint Committee on Accreditation of Health Care Organizations (JCAHO), Medicare certification, effective utilization management pricing, geographic location, scope of services and utilization experience.

If you want more information about us, call 1-800-932-4480, visit our website at www.bcbsmo.com, or write us at 471 Siemers, Cape Girardeau MO 63701. For the hearing impaired (TDD), call 1-800-822-1215.

Service Area

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

The *St. Louis Area*, including the *Missouri* counties of Crawford, Franklin, Gasconade, Jefferson, Lincoln, Montgomery, Pike, St. Charles, St. Francois, St. Louis (City and County), Ste. Genevieve, Warren and Washington; the *Central Missouri Area* counties of Audrain, Boone, Callaway, Camden, Chariton, Cole, Cooper, Howard, Macon, Maries, Miller, Moniteau, Monroe, Morgan, Osage, Phelps, Pulaski, and Randolph; the *Southwest Missouri Area* counties of Barry, Barton, Cedar, Christian, Dade, Dallas, Douglas, Greene, Hickory, Jasper, Laclede, Lawrence, McDonald, Newton, Ozark, Polk, Stone, Taney, Texas, Webster and Wright.

You may also enroll with us if you live in the Illinois counties of Madison or St. Clair.

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 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. As a BlueCHOICE member, you may have access to physician care through the BlueCard® Traditional network. This nationwide network is made up of 9,500 hospitals and 744,000 physicians that participate with Blue Cross and Blue Shield Plans across the country. Benefits are easy to use – a “suitcase” logo on members’ ID cards will identify them as BlueCard members. To locate a BlueCard provider outside the BlueCHOICE service area, members simply call the toll-free BlueCard Access number on their ID card (1-800-810-blue) or visit the **BlueCard Hospital and Doctor Finder** at www.BCBS.com. Members should contact their primary care physician just as they would if they were at home. The primary care physician will provide a non-network referral and coordinate care with the out-of-area provider as appropriate.

Section 2. How we change for 2003

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

Program-wide changes

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-Postal premium will increase by 13.8% for Self Only or 13.8% for Self and Family.
- The following counties will no longer be a part of our service area:
 - a) In Central Missouri: Adair, Linn, Putnam, Schuyler and Sullivan
 - b) In Southeast Missouri: Butler, Carter, Ripley and Wayne
- Copayments for prescription drug coverage will change to \$7 for generic, \$12 for preferred brand, and \$25 for nonpreferred brand, for up to a 30-day supply. Mail order is 2 times the retail cost, so that copayments will be \$14 for generic, \$24 for preferred brand and \$50 for nonpreferred brand, for up to a 90-day supply. (Section 5(f))
- We clarified that the organ/tissue transplant benefit covers "tandem" testicular and ovarian germ cell tumor autologous transplant treatment. (Section 5(b))
- Coverage for treatment received at an outpatient hospital or ambulatory surgical center will require a \$10 copayment. (Section 5(c))
- We clarified that medications and supplies are not covered for loss or theft, travel (except in emergencies) or special packaging for drugs in nursing homes. (Section 5(f))
- We clarified that we do not cover services, drugs or supplies received from immediate relatives or household members, such as a spouse, parent, child, brother or sister, by blood, marriage or adoption. (Section 6)
- On Jan. 31, 2002, RightCHOICE Managed Care Inc. and WellPoint Health Networks Inc. merged. WellPoint, which is based in Thousand Oaks, Calif., serves the health care needs of 12 million members and more than 45 million specialty members through Blue Cross of California, Blue Cross of Georgia, UNICARE and Blue Cross and Blue Shield of Missouri and its subsidiaries.
- Pharmacy services previously provided by Express Scripts, Inc., are now provided by WellPoint Pharmacy Management.
- We are developing a new mental health and substance abuse provider network. Updates will be provided in the first quarter of 2003.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-932-4480. You may also request replacement cards through our website at www.bcbsmo.com.

Where you get covered care

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

- **Plan providers**

Plan providers are primary care physicians, specialists 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 annually. The BlueCHOICE directory is also on our website, www.bcbsmo.com. The online directory is updated daily.

- **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 annually. 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.

Use the directory or website to select a physician convenient to you. Write the physician’s office code number in the space provided on your Provider Selection Card. You’ll find the office code number listed before each primary care physician’s name. See the Selection Card for instructions.

- **Primary care**

Your primary care physician can be a family or general practitioner, internist, pediatrician or geriatrician. 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. We will send you a new ID card with your new doctor’s name and phone number on the front.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without

additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see a network OB/GYN for any medically necessary OB/GYN care without a referral. And you may go to a network eye care provider for one routine vision exam each calendar year without a referral.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will 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.

If you think you have a mental health or substance abuse problem, we encourage you to see your primary care physician, who will coordinate your care. Your primary care physician may treat you or recommend that you call our mental health and substance abuse benefits manager.

If you do not wish to go through your primary care physician for care, you may call our mental health and substance abuse benefits manager directly at 1-800-965-2583. A trained professional will evaluate your needs and authorize your care.

- **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 1-800-932-4480. 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, is medically necessary, and follows generally accepted medical practice.

We call this review and approval process precertification and recertification. Your physician must obtain precertification before you can receive certain types of care, such as:

- Inpatient hospital care
- Outpatient hospital care
- Care in a freestanding surgery center or skilled nursing facility
- Home health care

Your physician must obtain recertification if your care needs to continue longer than originally certified.

Your BlueCHOICE primary care physician or specialist will handle all certification requirements for you. However, if you receive emergency care at a non-network facility, you will need to contact us for approval. Please see Section 5(d) for further information.

Section 4. Your costs for covered services

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**

We do not have a deductible.

•**Coinsurance**

We do not have coinsurance.

**Your catastrophic protection
out-of-pocket maximum
for copayments**

After you pay 100% of your annual premium in copayments for one family member (per person), or 100% of your annual premium for two or more family members (self and family), you do not have to make any further payments for certain services for the rest of the year. This is called a catastrophic limit. However, copayments for your prescription drugs and dental services do not count toward these limits and you must continue to make these payments.

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

Section 5. Benefits – OVERVIEW

(See page 10 for how our benefits changed this year and pages 66-67 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 1-800-932-4480 or at our website at www.bcbsmo.com.

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

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Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician's office • Office medical consultations • Second surgical opinion 	\$10 per office visit
Professional services of physicians <ul style="list-style-type: none"> • In an urgent care center • During a hospital stay • In a skilled nursing facility 	Nothing
At home	\$10 per visit
<i>Not covered:</i> <ul style="list-style-type: none"> • Care that is not medically necessary • Care that is investigational • Care from a non-network provider without prior approval from us 	<i>All charges.</i>

Diagnostic and treatment services -- Continued on next page

Diagnostic and treatment services <i>(Continued)</i>	You pay
<p>Lab, X-ray and other diagnostic tests</p> <p>Laboratory tests, such as:</p> <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG 	<ul style="list-style-type: none"> • Nothing if services are received during your office visit • \$10 copay applies to services received at outpatient facilities (Refer to Section 5(c))
<p>Preventive care, adult</p> <p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total blood cholesterol – once every three years* • Colorectal cancer screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50* <p>And other diagnostic tests as recommended by the American Cancer Society Guidelines</p> <ul style="list-style-type: none"> • Chlamydial infection • Routine Prostate Specific Antigen (PSA) test– one annually for men age 40 and older* • Routine Pap test – annual* <p>Note: The office visit is covered if the pap test is received on the same day; see <i>Diagnostic and treatment services</i>, above.</p>	<p>\$10 per office visit</p>

*or more frequently if recommended by your BlueCHOICE physician.

Preventive care, adult <i>(Continued)</i>	You pay
<ul style="list-style-type: none"> • Routine mammogram – once per calendar year or more frequently if recommended by a physician 	\$10 per visit
<p>Routine immunizations, limited to:</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – ages 19 and over is based on medical necessity • Influenza vaccines • Pneumococcal vaccines 	Nothing (\$10 office visit copay applies to any other covered services)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i> • <i>Immunizations for travel or occupational reasons.</i> 	<i>All charges.</i>
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing (\$10 office visit copay applies to any other covered services)
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (through age 22) • Examinations, such as: <ul style="list-style-type: none"> – Eye exams to determine the need for vision correction – Ear exams to determine the need for hearing correction – Newborn hearing screening, rescreening and initial amplification – Examinations done on the day of immunizations <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i> • <i>Immunizations for travel or occupational reasons.</i> 	\$10 per office visit

Treatment therapies	You pay
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 31.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Before administering any GHT treatment, your BlueCHOICE physician needs to obtain authorization by submitting a written request to our Provider Services Unit. Please check with your BlueCHOICE physician before receiving GHT treatment.</p> <p>We will not cover GHT or related services and supplies unless you have received prior authorization.</p> <p>Growth hormone is covered as a medical benefit.</p>	<p>Nothing</p> <p>\$10 per visit outpatient</p> <p>\$10 per visit outpatient</p> <p>Nothing</p> <p>Nothing</p>
<p><i>Not covered:</i></p> <p>Therapy that is not listed as covered in this booklet. For example, massage therapy or exercise conditioning.</p>	<p><i>All charges.</i></p>

Physical and occupational therapies	You pay
<ul style="list-style-type: none"> • 20 visits per calendar year for physical therapy and chiropractic care combined, and • 20 visits per calendar year for occupational therapy. <p>For the services of each of the following:</p> <ul style="list-style-type: none"> – qualified physical therapists and chiropractors, and – occupational therapists. <p>Note: We only cover physical and occupational therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation following, but not limited to, a heart transplant, bypass surgery or a myocardial infarction, is provided for one consecutive 12-week program per calendar year • Pulmonary rehabilitation for up to 14 sessions within 12 months and then one session every 3 months thereafter <p>Note: See Chiropractic care</p>	<p>\$10 per office visit</p> <p>\$10 per outpatient visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>long-term rehabilitative therapy</i> • <i>exercise programs</i> 	<p><i>All charges.</i></p>
Speech therapy	
<ul style="list-style-type: none"> • 20 visits per calendar year 	<p>\$10 per office visit</p>

Hearing services (testing, treatment, and supplies)	You pay
<ul style="list-style-type: none"> Routine hearing exams Newborn hearing, screening, rescreening and initial amplification 	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Hearing aids, testing and examinations for them, except for newborns 	<i>All charges.</i>
Vision services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> Routine eye exam (one per calendar year) Eyeglasses and contact lenses are reimbursed up to \$35 per 24-month period when received from a BlueCHOICE vision care provider. In addition, reduced-cost glasses or contact lenses are available from selected providers. 	\$10 per office visit
<ul style="list-style-type: none"> One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	\$10 per office visit
<ul style="list-style-type: none"> Eye exam to determine the need for vision correction for children (see Preventive care, children) Annual eye refractions 	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Eye exercises and orthoptics Radial keratotomy and other refractive surgery, including LASIK procedures 	<i>All charges.</i>
Foot care	
<ul style="list-style-type: none"> Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. <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"> Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery) 	<i>All charges.</i>

Durable medical equipment (DME)	You pay
<p>We cover the use of standard models of the durable medical equipment (DME) and medical supplies listed below when medically necessary to treat certain conditions.</p>	\$10 to \$200
<p>Your primary care physician or network specialist must give you a prescription for the equipment or supplies. You must obtain the equipment or supplies from a network DME provider.</p>	
<p>We only provide benefits up to our allowed amount for supplies and for basic models of equipment. If you want other than the basic model, you must pay your copay and any charges above the allowed amount for the basic equipment. We determine what is a basic model.</p>	
<p>Following is a list of covered equipment and medical supplies. The copay is shown at right.</p>	
Air flotation mattress and alternating pressure pump	\$ 10
Apnea monitor ⁽¹⁾	\$ 25
Bi-directional Positive Airway Pressure (BIPAP) apparatus ⁽¹⁾	\$ 50
Bili phototherapy system ⁽¹⁾	\$ 25
Blood glucose monitor ⁽¹⁾	\$ 25
Bone growth stimulator (electrical) ⁽²⁾	\$100
Canes	\$ 10
Commode (bedside)	\$ 10
Compression (anti-embolic) stockings (up to 2 pairs per calendar year)	\$ 25 (per pair)
Continuous Passive Motion (CPM) Devices	\$ 25
Continuous Positive Airway Pressure (CPAP) apparatus ⁽¹⁾	\$ 25
Replacement CPAP apparatus	\$ 25
Continuous Positive Airway Pressure (CPAP) humidifier	\$ 25
Crutches	\$ 10
Enteral feeding equipment	\$ 25
Enteral feeding supplies	\$ 10
Formulas for treatment of phenylketonuria or any inherited disease of amino and organic acids, one month supply per copayment	\$ 15
Hospital bed (electric)	\$ 50
Hospital bed (nonelectric)	\$ 25
Incontinence catheters and irrigation supplies, one month supply per copayment ⁽¹⁾	\$ 10
Insulin pump ⁽²⁾	\$100
Insulin pump supplies ⁽²⁾	\$ 25
Intermittent Positive Pressure Breathing Apparatus (IPPB) ⁽¹⁾	\$ 25
Lymphedema pumps/lymphedema sleeves	\$ 50
Mattress overlays	\$ 25
Medical and post-surgical dressings, irrigation supplies, and dressing tape, one month supply per copayment	\$ 10
Nebulizer compressor ⁽¹⁾	\$ 25
Neuromuscular Electronic Stimulator (NMES)	\$ 25
Ostomy supplies, all types, one month supply per copayment	\$ 10
Oxygen, one month supply per copayment	\$ 50
Patient lifts	\$ 25
Peak flow meters	\$ 10
Pulmoaids	\$ 10
Spacers for Metered Dose Inhalers (MDI)	\$ 10
Sphygmomanometer for gestational hypertension	\$ 25
Suction catheters, one month supply per copayment ⁽¹⁾	\$ 10

<p>Suction equipment \$ 25 Transcutaneous Electrical Nerve Stimulator (TENS) Units \$ 25 Traction devices \$ 25 Walkers \$ 10 Wheelchairs (electric) \$ 50 Wheelchairs (non-electric) \$ 25 Wheelchair gel pads \$ 10</p> <p>The maximum benefit for a medically necessary nonstandard wheelchair is \$2,000. The regular copay for a manual or electric wheelchair applies. ⁽²⁾</p> <p>ABI Vest, used to treat members with cystic fibrosis, is available for \$200 per month.</p> <p>⁽¹⁾ Includes initial provision of nonpharmaceutical medically necessary supplies.</p> <p>⁽²⁾ Subject to review by BlueCHOICE. To obtain more information, you may contact us at 1-800-932-4480.</p>	<p>\$ 25 \$ 25 \$ 25 \$ 10 \$ 50 \$ 25 \$ 10</p> <p>\$ 10</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Dialysis equipment (rental or purchase) • Equipment or supplies that are not listed as covered • Nonstandard models of equipment 	<p><i>All charges.</i></p> <p>Copay plus any charges above the allowed amount for the basic equipment.</p>
Home health services	
<ul style="list-style-type: none"> • 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. Your physician will periodically review the program for appropriateness and need. • Services include oxygen therapy, intravenous therapy and medications. 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family.</i> • <i>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<p><i>All charges.</i></p>

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

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

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

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Benefit Description	You pay
Surgical procedures	
<p>A comprehensive range of services, such as</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. 	<p>Nothing, unless services are received during an office visit, then the \$10 copay applies.</p>

Surgical procedures continued on next page.

Surgical procedures (Continued)	You pay
<ul style="list-style-type: none"> • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns <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>	<p>Nothing, unless services are received during an office visit, then the \$10 copay applies.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care.</i> 	<p><i>All charges.</i></p>
Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – the condition produced a major effect on the member’s appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – surgery to produce a symmetrical appearance on the other breast; – treatment of any physical complications, such as lymphedemas; – breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>Nothing, unless services are received during an office visit, then the \$10 copay applies.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges</i></p>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/pancreas • Liver • Lung: single –double • Pancreas • Allogeneic bone marrow transplant, if the treatment is part of a National Cancer Institute (NCI) phase III or IV trial, or the treatment is available elsewhere as part of a NCI phase III or IV trial. Donor screening tests and donor search expenses are also covered for allogeneic bone marrow transplants. • 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 single or tandem testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. <p>National Transplant Program (NTP): We are a member of the Blue Quality Centers for Transplants.</p> <p>Note: Autologous bone marrow or stem cell transplants after high-dose chemotherapy to treat breast cancer, and related care, must be received at St. Louis University Hospital/SLU Care.</p> <p>All care for transplants must be coordinated through BlueCHOICE in writing. The physician should send a letter to the BlueCHOICE Medical Director requesting precertification.</p> <p>If you live outside the St. Louis metropolitan area, we may cover up to \$10,000 in reasonable and necessary expenses for transportation, lodging and meals while you are away from home for the transplant. <i>This must be approved in advance by Case Management.</i></p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> • <i>Organ donation expenses unless this program is covering the organ transplantation.</i> 	<p><i>All charges</i></p>

Anesthesia	You pay
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) <p>General anesthesia for certain dental patients, limited to:</p> <ul style="list-style-type: none"> • Children through age 4 • Severely disabled people; and • People with medical or behavioral conditions that require hospitalization or general anesthesia for dental care. <p>The general anesthesia must be provided in a network hospital, network freestanding surgery center or dentist’s office. A primary care physician referral is required. The dental procedures themselves are not covered.</p>	<p>Nothing</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>Nothing</p> <p>\$10 per office visit</p>

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

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Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility, unless it is an emergency, (see Section 5(d)).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

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Benefit Description	You pay
<p>Inpatient hospital</p> <p>Room and board, such as</p> <ul style="list-style-type: none"> • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. <p>NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	<p>Nothing</p>

Inpatient hospital continued on next page.

Inpatient hospital <i>(Continued)</i>	You pay
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care</i> • <i>Non-covered facilities, such as nursing homes, schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and guest beds</i> • <i>Private nursing care</i> 	<i>All charges.</i>
Outpatient hospital or ambulatory surgical center	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>NOTE: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	\$10 copay

Extended care benefits/skilled nursing care facility benefits	You pay
<p>Extended care/skilled nursing facility (SNF):</p> <p>We cover treatment in a network skilled nursing facility for a condition that otherwise would require hospital confinement.</p> <p>You may transfer directly from the hospital. If you do not, your primary care physician must obtain advance approval from BlueCHOICE.</p> <p>We will cover the care only as long as it is medically necessary. We will notify you if we determine SNF care is no longer necessary. Then we will not cover any SNF charges after the date in the notice.</p> <p>We cover the following SNF services:</p> <ul style="list-style-type: none"> • Semiprivate room and board (We will cover a private room if BlueCHOICE agrees in advance that it is medically necessary. If not, you are responsible for any difference between the private room and the semiprivate room.) • General nursing care • Drugs, medications, biologicals, supplies, equipment and services ordered by the attending network physician with the primary care physician's prior authorization. 	Nothing
<i>Not covered: custodial care</i>	<i>All charges</i>
Hospice care	
<p>When a terminally ill member's life expectancy has reached six months or less, the member may benefit from hospice care. This care provides pain control and emotional support.</p> <p>Your primary care physician must obtain advance approval from BlueCHOICE. You must go to a network hospital or receive care from a network home health agency licensed to provide hospice care. The hospice provider will write a treatment plan for your signature. BlueCHOICE and your primary care physician must coordinate your care.</p> <p>We also cover inpatient hospice care for short-term pain control.</p>	Nothing
<i>Not covered: Independent nursing, homemaker services; bereavement services</i>	<i>All charges</i>
Ambulance	
<ul style="list-style-type: none"> • Local professional ambulance service when medically appropriate 	Nothing

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 and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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What is a medical emergency?

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

What to do in case of emergency:

Emergencies at network hospitals within our service area:

If possible, when an unexpected condition arises, call your primary care physician– unless you believe any delay would be harmful. This applies even if it's after office hours. Your primary care physician will tell you whether to go to the emergency room. Your primary care physician's number is listed on the front of your ID card.

If you need additional care after an emergency condition is stabilized, precertification is required. Your BlueCHOICE physician will handle this for you. We will make a decision about the care within 30 minutes after we receive all the necessary information.

When you need care right away but it is not an emergency, always call your primary care physician. Your primary care physician may have you come into the office for an urgent appointment. An urgent appointment is one scheduled with a physician for the same day or during hours not normally used for appointments.

Emergencies at non-network hospitals (inside or outside our service area):

If possible, when an unexpected condition arises, call your primary care physician unless you believe any delay would be harmful. This applies even if it's after office hours. Your primary care physician will tell you whether to go to the emergency room. Your primary care physician's number is listed on the front of your ID card.

If you receive emergency care before you call your primary care physician, you or a family member should notify your primary care physician as soon as possible. We encourage you to try to call within 24 hours. Your primary care physician's number is listed on the front of your ID card.

If you need additional care after an emergency condition is stabilized, precertification is required. We will make a decision about the care within 30 minutes after we receive all the necessary information.

If you are admitted as an inpatient to a non-network hospital as a result of an emergency, you, your doctor or a family member should call BlueCHOICE as soon as possible for precertification of the case. BlueCHOICE will cover your care until you are stabilized. Then you must transfer to a BlueCHOICE network hospital. The transfer must be coordinated through BlueCHOICE in advance.

BlueCHOICE will not provide benefits for continued care at a non-network hospital after you are stable enough to transfer.

When you need care right away but it is not an emergency, always call your primary care physician. Your primary care physician may have you come into the office for an urgent appointment. An urgent appointment is one scheduled with a physician for the same day or during hours not normally used for appointments.

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services • Hospital observation <p>If you need follow-up care after emergency treatment, call your primary care physician. If your primary care physician cannot provide the care, he or she will give you a written referral to a network specialist.</p> <p>If you are treated in the emergency room and then held for observation, only one copay will be charged.</p> <p><i>If you receive follow-up care without a written referral from your primary care physician, you must pay all charges.</i></p>	<p>\$10 per office visit</p> <p>\$10 per office visit</p> <p>\$50 at emergency room (waived if admitted)</p> <p>\$50 (waived if admitted)</p>
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>
Emergency outside our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services • Hospital observation <p>If you need follow-up care after emergency treatment, call your primary care physician. If your primary care physician cannot provide the care, he or she will give you a written referral to a network specialist.</p> <p>If you are treated in the emergency room and then held for observation, only one copay will be charged.</p>	<p>\$10 per office visit</p> <p>\$10 per office visit</p> <p>\$50 at emergency room (waived if admitted)</p> <p>\$50 (waived if admitted)</p>

<p>Emergency outside our area <i>(continued)</i></p> <p>After your condition is stabilized, you, the hospital, a family member or a friend must call us for approval of continued care.</p> <p>Benefits are available only until BlueCHOICE determines that your condition has improved enough for you to travel back to the BlueCHOICE service area.</p> <p><i>If you receive follow-up care without a written referral from your primary care physician, you must pay all charges.</i></p>	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> 	<p><i>All charges.</i></p>
<p>Ambulance</p>	
<p>Professional ambulance and air ambulance service when medically appropriate. Transportation by air ambulance must be approved in advance by BlueCHOICE.</p> <p>See Section 5(c) for non-emergency service.</p>	<p>Nothing</p>

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:

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

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Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Copayments are the same as for any other illness or condition.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$10 per office visit</p>

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits <i>(Continued)</i>	You pay
<ul style="list-style-type: none"> • Diagnostic tests 	\$10 per office visit or test
<ul style="list-style-type: none"> • Individual and group therapy for the treatment of smoking cessation 	Nothing
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	Nothing on inpatient basis; \$10 per visit for outpatient
<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 generally will not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All charges.</i>

Preauthorization

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

If you think you have a mental health or substance abuse problem, we encourage you to see your primary care physician. Your primary care physician may treat you or may recommend that you call our mental health and substance abuse benefits manager.

If you do not wish to go through your primary care physician for mental illness or substance abuse care, to receive benefits you must call our mental health and substance abuse benefits manager before you receive care. This number is 1-800-965-2583, and is also listed on your ID card.

Network providers will handle all authorizations for you. However, your benefits allow up to two visits each calendar year to diagnose and assess a mental health condition, in or out of network, without authorization.

Limitation

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

Section 5 (f). Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Some prescription drugs are covered only if your physician obtains prior authorization from us. In addition, coverage for some drugs is provided in limited quantities.
- 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 plan dentist must write the prescription, unless it is an emergency.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication.
- **Reimbursement for prescriptions purchased out-of-area will be covered up to the allowed amount after a \$25 copayment.**
- **Most maintenance drugs are available through mail order.** To find out if a certain maintenance drug is available by mail order, call 1-800-655-1936.
- **We use an incentive-based three-tier formulary.** A formulary is a list of preferred drugs chosen for use based upon their effectiveness, safety and cost. Drugs are prescribed by Plan doctors and dispensed in accordance with BlueCHOICE's drug formulary. Nonpreferred brand-name drugs will be covered when prescribed by a Plan doctor. The Plan must authorize a nonpreferred brand-name drug before it may be dispensed. It is the prescribing doctor's responsibility to obtain the Plan's authorization. You pay a \$7 copay per prescription unit or refill for generic drugs; \$12 for preferred brand-name drugs; and \$25 for nonpreferred brand-name drugs. When a generic drug is available but you or your physician request the brand-name drug, you pay the price difference between the generic and brand-name drug as well as the \$7 copay per prescription or refill *unless* your physician has obtained prior authorization for the brand-name drug. When the physician has obtained the prior authorization, you pay only the appropriate brand copay.
- **These are the dispensing limitations.** Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply for retail or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin); and are available at \$7 for generic; \$12 for preferred brand-name; and \$25 for nonpreferred brand-name.

Mail order prescription drugs are dispensed for up to a 90-day supply, and are available at \$14 for generic; \$24 for preferred brand-name; and \$50 for nonpreferred brand-name.
- **Why use generic drugs?** Generic drugs normally cost considerably less than brand-name drugs. So, the copayment you pay for generic drugs is also lower. The generic name of a drug is its chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand-name drugs must meet the same standards for safety, purity, strength and effectiveness. They are dispensed in the same dosage and taken in the same way.
- **When you have to file a claim.**
Follow the same procedures for filing a prescription drug claim found in Section 7.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
<p>Covered medications and supplies</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 and online program:</p> <ul style="list-style-type: none"> • 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>. • Drugs that under state law are dispensed only with a written prescription from a physician or other lawful provider. • Insulin • Disposable needles and syringes for the administration of covered medications, including insulin • Drugs for sexual dysfunction (See Limited Drug Benefits below) • FDA-approved prescription drugs and devices for birth control • Diabetic test strips, lancets • FDA-approved medications for the treatment of tobacco use <p>Please note:</p> <ul style="list-style-type: none"> • Most prescriptions are limited to a 30-day supply each time the prescription is filled. • Refills your doctor authorizes are covered for up to 12 months from the original prescription date. Then a new prescription is required. • Some prescription drugs are covered only if your physician obtains prior authorization from us. In addition, coverage for some drugs is provided in limited quantities. • Intravenous fluids and medication for home use are provided under home health services at no charge; and some injectable drugs are covered under Medical and Surgical Benefits. <p>Limited Drug Benefits Prescription benefits for the treatment of sexual dysfunction will only be available with prior authorization where sexual dysfunction is secondary to a medical condition and the medical history and work-up is documented. You must receive prior authorization before receiving any prescription for the treatment of sexual dysfunction. If approved, four prescribed treatments per month will be available and subject to the nonpreferred brand-name copayment.</p>	<p>Retail (up to a 30-day supply) \$7 generic \$12 preferred brand \$25 nonpreferred brand</p> <p>Mail order and online (up to a 90-day supply) \$14 generic \$24 preferred brand \$50 nonpreferred brand</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand-name copay.</p>

Covered medications and supplies <i>(continued)</i>	You pay
<p>Here are some things to keep in mind about our prescription drug program:</p> <ul style="list-style-type: none"> • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name-brand drug when a Federally approved generic drug is available, <i>whether or not your physician has specified Dispense as Written</i> for the name-brand drug, you have to pay the difference in cost between the name-brand drug and the generic, unless your physician has obtained prior authorization for the brand-name drug. • We have an incentive-based, three-tier formulary. If your physician believes a name-brand product is necessary or there is no generic available, your physician may prescribe a name-brand drug from a formulary list. This list of name-brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a copy of our Preferred Drug List, please call Client Services at 1-800-932-4480 or visit our website at www.bcbsmo.com. 	
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs for which there is a nonprescription equivalent available</i> • <i>Drugs obtained at a non-Plan pharmacy (except out-of-area emergencies)</i> • <i>Vitamins and nutritional substances that can be purchased without a prescription</i> • <i>Medical equipment, devices and supplies such as dressings and antiseptics</i> • <i>Drugs for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Test agents and devices</i> • <i>Appetite suppressants and other drugs for weight loss</i> • <i>Nonprescription medicines</i> • <i>Replacement drugs due to loss or theft</i> • <i>Travel (except for emergencies)</i> • <i>Special packaging for drugs in nursing homes</i> 	<p><i>All Charges</i></p>

Section 5 (g). Special features

Feature	Description
Flexible Benefits Option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf and hearing impaired	For the hearing impaired (TDD), call 1-800-822-1215.
Away From Home Care	<p>Through our BlueCard® program, BlueCHOICE offers its members medical care in emergency and urgent situations when traveling outside the service area.</p> <p>Also, members who are traveling for an extended time or who are on an extended work assignment in another city may be eligible to apply for a Guest Membership in a local Blue Cross and Blue Shield HMO. The Guest Membership also temporarily covers dependent children who are away at school or living in another city. For more information, see Section 1, page 9, or members can call Customer Service at the number listed on the back of their ID card.</p>
Blue Quality	National Transplant Program (NTP): We are a member of the Blue Quality Centers for Transplants.
RightSteps®	<p>This is a voluntary program that strives to help mothers-to-be avoid potential problems during pregnancy. Pregnant women who choose to participate are asked to complete a questionnaire within 20 weeks of becoming pregnant. An obstetrical registered nurse will then contact the member periodically to provide information on pregnancy and childbirth. We encourage the member to have early, regular prenatal care and to pay attention to her lifestyle behaviors. Mothers-to-be who participate in the program will also receive a nationally recognized book on pregnancy, childbirth and infant care; up to a \$40 reimbursement for the cost of a childbirth or parenting class; and a gift from us after the baby arrives.</p>
TakeCharge® Asthma Program	<p>Our goal is to help our members who have asthma manage their disease more successfully. Working with the patient's physician, we provide case management services to severe asthmatics through frequent phone calls, individual care plans, home health visits (as approved by the patient's doctor), durable medical equipment benefits and asthma educational material. Adults and children with mild or moderate asthma receive asthma educational materials as requested.</p>

Section 5 (g). Special features

<p>TakeCharge® Diabetes Program</p>	<p>This comprehensive care and disease management program is designed to support the health care needs of people with diabetes. The program is a complimentary, value-added service offered to members with diabetes to reinforce the diabetes treatment plan that has been designed by each member's physician. The member's doctor and other members of the diabetes management team also receive information about the program. This program provides newsletters, reminder cards and other important educational health information to members with diabetes throughout the year.</p>
<p>Cardiovascular Education Program</p>	<p>Through this member education program, we periodically send cardiovascular education materials to members who have cardiovascular disease. The heart-related educational brochures are intended to reinforce the physician's advice on understanding cardiovascular disease, risk factors and lifestyle modifications.</p>
<p>Note: Special programs such as <i>RightSteps®</i>, <i>TakeCharge® Asthma Program</i>, <i>TakeCharge® Diabetes Program</i> and the <i>Cardiovascular Education Program</i> are special programs that are available to members who have primary health coverage through BlueCHOICE.</p>	

Section 5 (h). Dental benefits

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists, which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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Dental Benefits

Service	You pay
<p>The following dental services are covered when provided by your participating Plan primary dentist:</p> <ul style="list-style-type: none"> • Office visit for oral examination, limited to two visits per calendar year • Oral prophylaxis (cleaning) as necessary, limited to two visits per calendar year • Topical application of fluorides is limited to two courses of treatment per calendar year, limited to children under age 18 • Oral hygiene instruction • Dietary advice and counseling • Consultations with Primary Dentist <p><i>Not Covered: Any procedures or services not listed.</i></p>	<p>\$ 5 per office visit</p>

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

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward the FEHB out-of-pocket maximum. Your medical program copay does not apply to these services. You must pay for the services or supplies when you receive them.

Wellness and Education Programs

Eat Smart: Learn to eat right and control your weight. You'll get \$75 if you achieve your weight loss goal through a participating facility.

Breathe Easy: Smoking cessation classes offered in cooperation with local health care providers teach you some helpful tips for kicking the habit. Earn \$50 for regular class attendance and for quitting smoking.

Physical Fitness: If you are 18 or older, we will reimburse you 25% (up to \$100) for a single membership and 50% of annual dues (up to \$200) for a family membership at the health club of your choice.

Self-Help Educational Information: Free literature is available on a variety of subjects, including stress, alcohol, drugs and cholesterol.

Discounted Services

Hearing Aids: Free hearing evaluations and savings on hearing aids are available through Accent Hearing Network providers and Southwest Hearing providers.

Vision Care: BlueCHOICE members may receive discounts on eye exams, lenses and frames by showing their ID card at a participating vision center. Members also can receive discounts off the regular retail price for all eye care accessories, including contact lens solutions and non-prescription sunglasses. Members can obtain discounted eye wear and eye care services through Access Eye Care network, Unity Health Eye Care network or Crown Optical.*

*Savings on LASIK surgery are available to members through Crown Optical. For more information, contact Crown at 1-800-232-4526.

Alternative Health Programs through American Specialty Health Networks: BlueCHOICE provides access to an alternative health care discount program through American Specialty Health Networks (ASHN). BlueCHOICE members can pay discounted fees when they see chiropractors, acupuncturists and massage therapists in ASHN's credentialed network. Members receive ASHN's toll-free telephone number to request provider directories and program brochures when they enroll.

In addition, members can access ASHN's national network of fitness clubs at the clubs' lowest membership rates. Additionally, members can try the fitness facilities at no charge for one full week.

Additional discounts are available for everything from educational videos to herbal supplements ordered through the Internet. Just go to www.bcsmo.com for additional information.

For more information on any of the special programs described on this page, call Client Services at 1-800-932-4480.

Note: We may receive payments from the providers of these discount programs to cover administrative and related costs associated with offering the programs and services to members. We do not select or recommend providers for the discount programs and do not recommend or prescribe the services or treatments provided. We encourage members to consult with their physician about any of these services or products.

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

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in the 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.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive from immediate relatives or household members, such as spouse, parent, child, brother or sister, by blood, marriage or adoption.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

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

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

Medical and hospital 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 1-800-932-4480.

How to file a claim:

- You can obtain claim forms by calling Client Services at 1-800-932-4480. The back of the claim form has complete filing instructions.
- You can use the same claim form to file a claim for all your health care benefits, except for prescription drugs.
- You may submit claims for more than one person in the same envelope. *However, you must submit a separate claim form for each person.* Attach each person's bill to the correct form.
- Complete the claim form fully and accurately. You must check "yes" or "no" for each question. If you do not answer a question, we may have to return your claim to you. This is also true if you do not provide additional information required.
- When you write in your identification number on the claim form, be sure to include the first three digits.
- We can only accept itemized bills. Each bill must show: the name of the patient; the name and address of the provider of care; a description of each service and the date provided; a diagnosis; and the charge for each service.
- Canceled checks and nonitemized bills that show only "balance due" or "for professional services rendered" are not sufficient.
- Include all bills for covered services not previously submitted.
- If you have paid the provider, mark each bill "paid."
- In some cases, we will pay you directly for covered services. In other cases, we will pay the provider.
- Please keep copies of the completed claim form and itemized bills.
- Send your claims to the address shown on the form.

Prescription drugs

Major chains and independent pharmacies belong to your pharmacy network. At these pharmacies, if you show your BlueCHOICE ID card, you should only be responsible for paying your share of the cost. The pharmacy should file your claim, and we will pay the pharmacy directly.

At a Non-Network Pharmacy: If you go to a non-network pharmacy in an urgent or emergency situation outside the BlueCHOICE service area, you are responsible for paying for your prescription at the time of service and then filing a claim. Your program will not provide benefits if you use a non-network pharmacy within the BlueCHOICE service area.

You can obtain a Prescription Drug Claim Form by calling Client Services at 1-800-932-4480.

You can file up to three prescriptions on each form. *Please do not use a regular health benefits claim form to file your prescription drug claim.* If you do, your claim may be denied.

- Please fill out a separate claim form for each person and pharmacy.
- Be sure to provide all the information requested for each prescription. You may need to have the pharmacy complete the form or get the information from the pharmacy.
- Then you or the pharmacist should fill out the pharmacy's name, address and National Association of Board of Pharmacy (NABP) number.
- On the completed form, *tape* your *original* itemized prescription drug receipt(s). Please do not send cash register receipts, canceled checks, bottle labels, copies of the original prescription drug receipts, or your own itemization of charges.
- The receipt(s) must show: the prescription number, the patient's name, the name of the drug, the quantity and unit dose, and the strength of the drug.
- Sign the claim form. Then mail it and your receipt(s) to the address shown on the form.

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
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| 1 | Ask us in writing to reconsider our initial decision. You must: <ul style="list-style-type: none">(a) Write to us within six months from the date of our decision; and(b) Send your request to us at: BlueCHOICE Grievance Unit
P.O. Box 66828
St. Louis, MO 63166-6828(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. |
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| 2 | We have 30 days from the date we receive your request to: <ul style="list-style-type: none">(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or(b) Write to you and maintain our denial -- go to step 4; or(c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request -- go to step 3. |
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| 3 | You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. |
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If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

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| 4 | If you do not agree with our decision, you may ask OPM to review it. |
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You must write to OPM within:

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

Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Health Benefits Contracts Division 2, 1900 E Street, NW, Washington, DC 20415-3620.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

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

The Disputed Claims process *(Continued)*

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

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

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

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

OPM may disclose the information it collects during the review process to support its 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 1-800-932-4480 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 it can give your claim expedited treatment too, or
 - You may call OPM's Health Benefits Contracts Division 2 at 202/606-3818 between 8 a.m. and 5 p.m. Eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member have coverage under 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. All programs together will not pay more than 100% of allowable expenses. The allowable expense is the maximum amount that a plan will pay for covered services. We will not pay more than our allowance.

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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

•The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. *Your care must continue to be authorized by your Plan PCP and you will still be responsible for the Plan’s copayments.*

•Filing a claim

When this Plan is primary and you have a claim for covered services that you must file yourself, please follow the claim filing instruction in Section 7.

Once you receive an Explanation of Benefits (EOB) from us, then file a claim for your Medicare benefits. *(For information on filing a Medicare claim, contact your Social Security office.)* *When Original Medicare is primary* you must submit your claims to Medicare first. The federal government requires most health care providers and suppliers to file your Medicare claims for you. So in most cases, you shouldn't need to file a claim to obtain your Medicare benefits.

Also, in most cases, *you* shouldn't need to file to receive the benefits of *this* program. If the services or supplies are covered by Medicare, the Medicare carrier will usually forward your medical claim to us. Then we will provide the benefits of this program automatically in most cases.

You should *not* submit a claim for benefits of this program if your Medicare Summary Notice (MSN) states, in part: "This information is being sent to your private insurer." This note means that the Medicare carrier is submitting your claim to us. Then we can provide the benefits of this program. If this note is on your MSN, please do *not* submit a claim to us. Also, please let your providers of care know that they should *not* submit your claim to us. When we receive duplicate claims, this increases costs.

Your MSN may not indicate that your claim has been referred to supplemental claims processing. In that case, you should file your own claim.

•To file your own claim

To file, send us a copy of your MSN. Include a completed claim form and copies of your itemized bills. Send the information to the address shown on the claim form.

You should also file a claim if you receive services or supplies that are not covered by Medicare but are covered by this program. Send a completed claim form and copies of your itemized bills to us.

(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.

Primary Payer Chart		
A. When either you—or your covered spouse—are age 65 or over and ...	Then the primary payer is...	
	Original Medicare	This Plan
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when... a) The position is excluded from FEHB, or b) The position is not excluded from FEHB (Ask your employing office which of these applies to you.)	✓	
		✓
4) Are a Federal judge who retired under Title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of Title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you—or a covered family member—have Medicare based on end stage renal disease (ESRD) and...		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and...		
1) Are eligible for Medicare based on disability, and a) Are an annuitant b) Are an active employee, or	✓	
		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

• **Medicare managed care plan**

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

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

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 **you will still be responsible for** copayments. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care plan's service area.

• **If you do not enroll in Medicare Part A or 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 & CHAMPVA

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

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Copayment A copayment is a fixed amount of money you pay when you receive covered services. See page 14.

Covered services Care we provide benefits for, as described in this brochure.

Custodial care Services that do not seek to cure, but are provided primarily for the convenience of the patient or his or her family, the maintenance of the patient, or to assist the patient in meeting his or her activities of daily living, rather than primarily for therapeutic value in the treatment of a Condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, eating, preparation of special diets, supervision over self-administration of medications not requiring constant attention of trained medical personnel, or acting as a companion or sitter. Custodial care that lasts 90 days or more is sometimes known as Long term care.

Note: BlueCHOICE will have the sole discretion to determine whether care is Custodial care. BlueCHOICE may consult with professional peer review committees or other appropriate sources for recommendations.

Experimental or investigational services

A drug, device or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.

An FDA-approved drug, device or biological product (for use other than its intended purpose and labeled indications), or medical treatment or procedure is experimental or investigational if

- 1) reliable evidence shows that it is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, or
- 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authorized medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

FDA-approved drugs, devices, or biological products used for their intended purpose and labeled indication and those that have received

FDA approval subject to postmarketing approval clinical trials, and devices classified by the FDA as “Category B Non-experimental/Investigational Devices” are not considered experimental or investigational.

Group health coverage

A health benefit plan that is offered to employees through their place of employment or to the membership of a sponsoring organization such as a union or association.

Medical necessity

We only cover care that is medically necessary. But we do not cover all medically necessary care. Even if the type of care is covered in general, the care is not covered if we determine it was not medically necessary in a specific case. BlueCHOICE must agree that care was medically necessary.

However, in some cases, you will not have to pay for care that was not medically necessary. In these cases, the provider is responsible. You do not need to pay if *all* of the following are true:

- You obtained the proper referral for the care.
- BlueCHOICE did not notify you in advance that the care was not medically necessary.
- The services would have been covered if they were medically necessary.

To be medically necessary, care must be provided to diagnose or treat a condition. Also, the type and level of care must be necessary and appropriate. We use current standards of medical practice to decide necessity and appropriateness. The type and level of care must not be more than what is necessary.

For example, surgery may not be medically necessary for your condition if your provider has not tried more conservative treatment. Also, inpatient care is not medically necessary if appropriate care is available on an outpatient basis.

Plan allowance

The maximum amount we will pay for covered services.

Us/We

Us and we refer to BlueCHOICE.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB) Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option,
- if you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- if you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot make any changes after retirement. Contact your employing office for further information.

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.

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. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a

divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/insure.

•Temporary Continuation of coverage (TCC)

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

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

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

•Converting to individual coverage

You may convert to a non-FEHB individual conversion 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 website (www.opm.gov/insure/health); refer to the “TCC and HIPAA” frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called “custodial care,” long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer’s disease.

You Can Also Apply Later, But...

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won’t receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 – act NOW so you won’t miss the abbreviated underwriting available to employees and their spouses, and the July 1 “age freeze!”

Find Out More – Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337)** (TDD for the hearing impaired: **1-800-843-3557**) or visiting www.ltcfeds.com to get more information and to request an application.

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

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Summary of benefits for BlueCHOICE – 2003

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

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office.....	Office visit copay: \$10	16
Services provided by a hospital:		
• Inpatient	Nothing	33
• Outpatient.....	\$10 copay	34
Emergency benefits:		
• In-area	\$ 50 per emergency room visit	37
• Out-of-area.....	\$ 50 per emergency room visit	37
Mental health and substance abuse treatment	Regular cost sharing	39
Prescription drugs.....	\$7 generic \$12 preferred brand name \$25 nonpreferred brand name	41
Mail order.....	\$14 generic \$24 preferred brand name \$50 nonpreferred brand name	
Dental Care.....	Preventive care only; \$5 copay	46
Vision Care.....	Routine eye exam (one per calendar year); \$10 per office visit. Eyeglasses and contact lenses are reimbursed up to \$35 per 24-month period when received from a BlueCHOICE vision care provider. In addition, reduced-cost glasses or contact lenses are available from selected providers.	23

<p>Special features:</p> <ul style="list-style-type: none"> • Flexible Benefits Option • Services for deaf and hearing impaired • Away From Home Care • Blue Quality • RightSteps® • TakeCharge® Asthma Program • TakeCharge® Diabetes Program • Cardiovascular Education Program 		44
<p>Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)</p>	<p>After you pay 100% of your annual premium in copayments for one family member (per person), or 100% of your annual premium for two or more family members (self and family), you do not have to make any further payments for certain services for the rest of the year. Some costs do not count toward this protection.</p>	14

2003 Rate Information for BlueCHOICE

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 a special FEHB guide is published 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
Self Only		\$104.71	\$34.90	\$226.87	\$75.62	\$123.90	\$15.71
Self and Family	9G2	\$226.70	\$75.56	\$491.18	\$163.72	\$268.26	\$34.00