



# SuperMed HMO

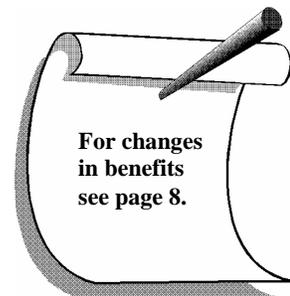
<http://www.MedMutual.com>

## 2005

### A Health Maintenance Organization

Serving: *Northeast Ohio*

**Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.**



*This Plan has an excellent accreditation from the NCQA. See the 2005 Guide for more information on accreditation.*

**Enrollment code for this Plan:**

**5M1 Self Only**

**5M2 Self and Family**



Authorized for distribution by the:



**United States  
Office of Personnel Management**

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

**RI 73-656**



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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

Welcome to the 2005 Open Season! By continuing to introduce pro-consumer health care ideas, the Office of Personnel Management (OPM) team has given you greater, cost effective choices. This year several national and local health plans are offering new options, strengthening the Federal Employees Health Benefits (FEHB) Program and highlighting once again its unique and distinctive market-oriented features. I remain firm in my belief that you, when fully informed as a Federal subscriber, are in the best position to make the decisions that meet your needs and those of your family. Plan brochures provide information to help subscribers make these fully informed decisions. Please take the time to review the plan's benefits, particularly Section 2, which explains plan changes.

Exciting new features this year give you additional opportunities to save and better manage your hard-earned dollars. For 2005, I am very pleased and enthusiastic about the new High Deductible Health Plans (HDHP) with a Health Savings Account (HSA) or Health Reimbursement Arrangement (HRA) component. This combination of health plan and savings vehicle provides a new opportunity to save and better manage your money. If an HDHP/HSA is not for you and you are not retired, I encourage you to consider a Flexible Spending Account (FSA) for health care. FSAs allow you to reduce your out-of-pocket health care costs by 20 to more than 40 percent by paying for certain health care expenses with tax-free dollars, instead of after-tax dollars.

Since prevention remains a major factor in the cost of health care, last year OPM launched the *HealthierFeds* campaign. Through this effort we are encouraging Federal team members to take greater responsibility for living a healthier lifestyle. The positive effect of a healthier life style brings dividends for you and reduces the demands and costs within the health care system. This campaign embraces four key "actions" that can lead to a healthy America: be physically active every day, eat a nutritious diet, seek out preventative screenings, and make healthy lifestyle choices. Be sure to visit *HealthierFeds* at [www.healthierfeds.opm.gov](http://www.healthierfeds.opm.gov) for more details on this important initiative. I also encourage you to visit the Department of Health and Human Services website on Wellness and Safety, [www.hhs.gov/safety/index.html](http://www.hhs.gov/safety/index.html), which complements and broadens healthier lifestyle resources. The site provides extensive information from health care experts and organizations to support your personal interest in staying healthy.

The FEHB Program offers the Federal team the widest array of cost-effective health care options and the information needed to make the best choice for you and your family. You will find comprehensive health plan information in this brochure, in the 2005 Guide to FEHB Plans, and on the OPM Website at [www.opm.gov/insure](http://www.opm.gov/insure). I hope you find these resources useful, and thank you once again for your service to the nation.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay C. 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 United States 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 health care 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](http://www.opm.gov/insure) on the Web. You may also call 202-606-0745 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  
United States 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 United States 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 are effective April 14, 2003.

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## Introduction

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This brochure describes the benefits of SuperMed HMO under our contract (CS 2759) with the Office Of Personnel Management (OPM), as authorized by the Federal Employee Health Benefit law. The address for SuperMed HMO's administrative office is:

Medical Mutual of Ohio, dba SuperMed HMO  
2060 East Ninth Street  
Cleveland, Ohio 44115-1355

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 for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2005, unless those benefits are also shown in this brochure

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2005, and changes are summarized on page 8. Rates are shown at the end of this brochure.

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## Plain Language

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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 SuperMed HMO.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean 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](http://www.opm.gov/insure) or e-mail OPM at [fehwebcomments@opm.gov](mailto:fehwebcomments@opm.gov). You may also write to OPM at the Office of Personnel Management, Insurance Services Program, Program Planning & Evaluation Group, 1900 E Street, NW Washington, DC 20415-3650.

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## Stop Health Care Fraud

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Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program (FEHB) 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 800/522-2066 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, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

## Preventing Medical Mistakes

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

1. **Ask questions if you have doubts or concerns.**
  - Ask questions and make sure you understand the answers.
  - Choose a doctor with whom you feel comfortable talking.
  - Take a relative or friend with you to help you ask questions and understand answers.
2. **Keep and bring a list of all the medicines you take.**

- Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
  - Tell them about any drug allergies you have.
  - Ask about side effects and what to avoid while taking the medicine.
  - Read the label when you get your medicine, including all warnings.
  - Make sure your medicine is what the doctor ordered and know how to use it.
  - Ask the pharmacist about your medicine if it looks different than you expected.
3. **Get the results of any test or procedure.**
- Ask when and how you will get the results of test or procedures.
  - Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
  - Call your doctor and ask for your results.
  - Ask what the results mean for your care.
4. **Talk to your doctor about which hospital is best for your health needs.**
- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
  - Be sure you understand the instructions you get about follow-up care when you leave the hospital.
5. **Make sure you understand what will happen if you need surgery.**
- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
  - Ask your doctor, "Who will manage my care when I am in the hospital?"
  - Ask your surgeon:
    - Exactly what will you be doing?
    - About how long will it take?
    - What will happen after surgery?
    - How can I expect to feel during recovery?
  - Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- [www.ahrq.gov/consumer/pathqpack.html](http://www.ahrq.gov/consumer/pathqpack.html). The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- [www.npsf.org](http://www.npsf.org). The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- [www.talkaboutrx.org/consumer.html](http://www.talkaboutrx.org/consumer.html). The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- [www.leapfroggroup.org](http://www.leapfroggroup.org). The Leapfrog Group is active in promoting safe practices in hospital care.
- [www.ahqa.org](http://www.ahqa.org). The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.
- [www.quic.gov/report](http://www.quic.gov/report). Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's healthcare delivery system.

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## Section 1. Facts about this HMO plan

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This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their 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, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments.

SuperMed HMO is a mixed model prepayment plan that provides care through a network of doctors, using groups of doctors, staff model arrangements, and IPA systems. Both primary care and specialist doctors are part of the network. Different members of the same family may select different centers or doctors.

### Your Rights

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

- Medical Mutual of Ohio is the oldest health insurance company in Ohio. SuperMed HMO has been in existence since January 1, 1992.
- SuperMed HMO has over 29,886 participating physicians.
- Medical Mutual of Ohio has been awarded three-year **Excellent** accreditation status for SuperMed HMO by the National Committee for Quality Assurance (NCQA), a leading independent evaluator of health plans.

If you want more information about us, call 800/522-2066, or write to SuperMed HMO, P.O. Box 6018, Cleveland, Ohio 44101, Attn: HMO Member Services. You may also contact us by fax at 216/687-2817 or visit our website at <http://www.MedMutual.com>.

## **Service Area**

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

Our service area is:

The Ohio counties of Ashtabula, Cuyahoga, Geauga, Lake, Lorain, Mahoning, Medina, Portage, Stark, Summit and Trumbull.

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 moves outside of our service area, you can enroll in another plan. If your dependants 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 moves, you do not have to wait until Open Season to change plans. Contact your employer or retirement office.

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## Section 2. How we change for 2005

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

### Program-wide changes

- In Section 9, we revised the **Medicare Primary Payer Chart** and updated the language regarding Medicare Advantage plans (formerly called Medicare + Choice plans).
- In Section 12, we revised the language regarding the Flexible Spending Account Program - *FSAFEDS* and the Federal Long Term Care Insurance Program.

### Changes to this Plan

- Your share of the non-Postal premium will increase by 99.2% for Self Only or 79.9% for Self and Family.
- The office visit copayment increased to \$15.00. The vision services copayment will not increase and will remain at \$10.00.
- The hospital emergency room copayment increased to \$75.00.
- We added a \$250 copayment per inpatient admission. The maximum is \$500/individual or \$1250/family per calendar year.
- Members who purchase a brand name prescription drug when a generic drug is available must pay the **GENERIC** copayment in addition to the cost difference between the generic drug and brand name drug
- Acupuncture is no longer covered.
- We added a third tier for non formulary brand name prescription drugs. Under the retail pharmacy benefit, the non formulary brand name copayment is \$30.00. Under the mail order pharmacy program, the non formulary brand name copayment is \$60.00.

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## Section 3. How you get care

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### Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800/522-2066 or write to us at Medical Mutual Of Ohio, 2060 E. 9<sup>th</sup> Street, Cleveland, OH 44115-1355. You may also request replacement cards through our website at <http://www.MedMutual.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 physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards. Both primary care and specialist doctors are part of the network. Different members of the same family may select different centers or doctors.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website. ([www.MedMutual.com](http://www.MedMutual.com))

#### • Plan facilities

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website. ([www.MedMutual.com](http://www.MedMutual.com))

### What you must do to get covered care

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when there has been a referral by a member’s primary care doctor.

#### • Primary care

Your primary care physician can be a physician, or group of physicians, trained in family or general practice, internal medicine, pediatrics or osteopathic medicine who has a contractual obligation with SuperMed HMO to provide the primary care services listed in this brochure. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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

## • Specialty care

Your primary care physician will refer you to a specialist for needed care. However, you may seek Plan provider care for Obstetrician/Gynecologist or vision provider without a referral. For mental conditions and substance abuse call SuperMed Behavioral Health Care Management Department at 800/258-3186.

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.

## • Hospital care

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800/522-2066. 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 92<sup>nd</sup> day after you become a member of this Plan, whichever happens first.

These provisions apply only to the hospital benefit of the hospitalized person; we

cover your other non-hospital care. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

**Circumstances beyond our control**

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

**Services requiring our prior approval**

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

We call this review and approval process precertification. Your physician must obtain approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care.

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## Section 4. Your costs for covered services

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

### **Copayments**

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

Example: You pay a copayment of \$15 per office visit or outpatient therapy session.

### **Deductible**

We do not have a deductible.

### **Coinsurance**

We do not have coinsurance.

### **Your catastrophic protection out-of-pocket maximum**

Your out-of-pocket expenses for benefits under this Plan are limited to the stated copayments required for a few benefits.

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## Section 5. Benefits – OVERVIEW

(See page 8 for how our benefits changed this year and page 58 for a benefits summary.)

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Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 800/522-2066 or at our Web site at [www.MedMutual.com](http://www.MedMutual.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.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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Benefit Description	You pay
<b>Diagnostic and treatment services</b>	<b>You pay</b>
Professional services of physicians <ul style="list-style-type: none"> <li>• In physician's office</li> <li>• In an urgent care center</li> <li>• Office medical consultations</li> <li>• Second surgical opinion (in office)</li> </ul>	\$15 per office visit
Professional services of physicians <ul style="list-style-type: none"> <li>• During a hospital stay</li> <li>• In a skilled nursing facility</li> </ul>	Nothing
Professional services of physicians <ul style="list-style-type: none"> <li>• At home</li> </ul>	Nothing

Lab, X-ray and other diagnostic tests	You pay
<p>Tests, such as:</p> <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine Mammograms</li> <li>• Cat Scans/MRI</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	<p>Nothing if you receive these services during your office visit. \$15 per office visit</p>
Preventive care, adult	You pay
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> <li>• Total Blood Cholesterol – once every three years</li> <li>• Colorectal Cancer Screening, including <ul style="list-style-type: none"> <li>– Fecal occult blood test</li> <li>– Sigmoidoscopy, screening – every five years starting at age 50</li> </ul> </li> <li>• Double contrasts</li> </ul>	<p>Nothing if you receive these services during your office visit. \$15 per office visit.</p>
<p>Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older</p>	<p>\$15 per office visit</p>
<p>Routine pap test</p> <p>Note: The office visit is covered if pap test is received on the same day; see <i>Diagnosis and Treatment</i>, above.</p>	<p>\$15 per office visit</p>

*Preventive care, adult – continued on next page*

Preventive care, adult ( <i>Continued</i> )	You pay
Routine mammogram –covered for women age 35 and older, as follows: <ul style="list-style-type: none"> <li>• From age 35 through 39, one during this five year period</li> <li>• From age 40 through 64, one every calendar year</li> <li>• At age 65 and older, one every two consecutive calendar years</li> </ul>	\$15 per office visit
Routine immunizations, limited to: <ul style="list-style-type: none"> <li>• Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under childhood immunizations)</li> <li>• Influenza vaccines, annually</li> <li>• Pneumococcal vaccine, age 65 and over</li> </ul>	\$15 per office visit
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>
Preventive care, children	You pay
<ul style="list-style-type: none"> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> </ul>	\$15 per office visit
<ul style="list-style-type: none"> <li>• Well-child care charges for routine examinations, immunizations and care (through age 22)</li> <li>• Examinations, such as:               <ul style="list-style-type: none"> <li>– Eye exams through age 17 to determine the need for vision correction.</li> <li>– Ear exams through age 17 to determine the need for hearing correction</li> <li>– Examinations done on the day of immunizations ( through age 22)</li> </ul> </li> </ul>	\$15 per office visit

Maternity care	You pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need to pre-certify your normal delivery.</li> <li>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.</li> <li>• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment.</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).</li> <li>• Circumcision is a surgical benefit, not a maternity benefit.</li> </ul>	<p>\$15 office visit copayment for initial visit only.</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex</i></p>	<p><i>All charges.</i></p>
Family planning	You pay
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (See Surgical procedures Section 5 (b))</li> <li>• Surgically implanted contraceptives</li> <li>• Injectable contraceptive drugs (such as Depo provera)</li> <li>• Intrauterine devices (IUDs)</li> <li>• Diaphragms</li> </ul> <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$15 per office visit</p>
<p><i>Not covered: reversal of voluntary surgical sterilization, genetic counseling,</i></p>	<p><i>All charges.</i></p>
Infertility services	You pay
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> <li>• Artificial insemination: <ul style="list-style-type: none"> <li>– intravaginal insemination (IVI)</li> <li>– intracervical insemination (ICI)</li> <li>– intrauterine insemination (IUI)</li> </ul> </li> </ul>	<p>\$15 per office visit</p>

*Infertility services – continued on next page*

Infertility services ( <i>Continued</i> )	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> <li>– <i>in vitro fertilization</i></li> <li>– <i>embryo transfer, gamete GIFT and zygote ZIFT</i></li> <li>– <i>Zygote transfer</i></li> </ul> </li> <li>• <i>Services and supplies related to excluded ART procedures</i></li> <li>• <i>Cost of donor sperm</i></li> <li>• <i>Cost of donor egg</i></li> </ul>	<p><i>All charges.</i></p>
Allergy care	You pay
<p>Testing and treatment Allergy injection</p>	<p>\$15 per office visit</p>
<p>Allergy serum</p>	<p>Nothing</p>
<p><i>Not covered: provocative food testing and sublingual allergy desensitization</i></p>	<p><i>All charges.</i></p>
Treatment therapies	You pay
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 26.</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</li> <li>• Dialysis – Hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> <li>• Growth hormone therapy (GHT)</li> </ul> <p>Note: Growth hormone is covered under the prescription drug benefit.</p>	<p>\$15 per office visit</p>

<b>Physical and occupational therapies</b>	<b>You pay</b>
<p>Physical therapy and occupational therapy –</p> <ul style="list-style-type: none"> <li>• For the greater of 20 visits or up to two months per condition per year, on an inpatient or outpatient basis, for each of the following: <ul style="list-style-type: none"> <li>– qualified physical therapists</li> <li>– occupational therapists and</li> </ul> </li> </ul> <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> <li>• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, provided at a Plan facility as prescribed by your primary care doctor.</li> </ul>	<p>\$15 copayment</p> <p>Nothing per visit during covered inpatient admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>long-term rehabilitative therapy</i></li> <li>• <i>exercise programs</i></li> </ul>	<p><i>All charges.</i></p>
<b>Speech therapy</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>• For the greater of 20 visits or up to two months per condition per year</li> </ul>	<p>\$15 per office visit</p> <p>Nothing per visit during covered inpatient admission.</p>
<b>Hearing services (testing, treatment, and supplies)</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>• Hearing evaluations</li> </ul>	<p>\$15 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>hearing aids, testing and examinations for hearing aids</i></li> </ul>	<p><i>All charges.</i></p>

Vision services (testing, treatment, and supplies)	You pay
<p>For medical and surgical benefits provided for the diagnosis and treatment of diseases of the eye, members must continue to be referred to a SuperMed HMO optometrist or ophthalmologist for care. In addition to these benefits, the Plan provides certain vision care benefits when received from Cole Network Managed Vision Providers:</p> <ul style="list-style-type: none"> <li>• One eye refraction, including lens prescription, every year.</li> <li>• Member is responsible for any difference in cost between an examination for glasses and an examination for contact lenses.</li> </ul>	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Corrective lenses or frames</i></li> <li>• <i>Eye exercises and orthoptics</i></li> <li>• <i>Sunglasses</i></li> </ul>	<i>All charges.</i>
Foot care	You pay
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	\$15 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i></li> <li>• <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i></li> </ul>	<i>All charges.</i>

Orthopedic and prosthetic devices	You pay
<ul style="list-style-type: none"> <li>• Orthopedic devices, such as braces; foot orthotics</li> <li>• Artificial limbs and eyes; stump hose</li> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy</li> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5© for payment information. See 5(b) for coverage of the surgery to insert the device.</li> <li>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</li> </ul>	Nothing.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• arch supports</li> <li>• heel pads and heel cups</li> <li>• trusses, elastic stockings, support hose, and other supportive devices</li> </ul>	<i>All charges.</i>
Durable medical equipment (DME)	You pay
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> <li>• hospital beds;</li> <li>• wheelchairs;</li> <li>• crutches;</li> <li>• walkers;</li> <li>• blood glucose monitors; and</li> <li>• insulin pumps.</li> </ul> <p>Note: Call us at 800/522-2066 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	Nothing.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Specially designed wheel chairs for use in sporting events</i></li> </ul>	<i>All charges.</i>

Home health services	You pay
<ul style="list-style-type: none"> <li>• Home health services of nurses and health aides, including intravenous fluids and medications, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need.</li> <li>• Services include oxygen therapy, intravenous therapy and medications.</li> </ul>	Nothing.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>nursing care requested by, or for the convenience of, the patient or the patient's family;</i></li> <li>• <i>services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.</i></li> <li>• <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i></li> </ul>	<i>All charges.</i>
Chiropractic	You pay
<ul style="list-style-type: none"> <li>• Manipulation of the spine and extremities</li> <li>• Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application</li> </ul>	\$15 copayment.
Alternative treatments	You pay
<ul style="list-style-type: none"> <li>• <i>No benefit</i></li> </ul> <p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>naturopathic services</i></li> <li>• <i>hypnotherapy</i></li> <li>• <i>biofeedback</i></li> </ul>	<i>All charges</i>
Educational classes and programs	You pay
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> <li>• Smoking cessation drugs and medication, including nicotine patches</li> <li>• Diabetes self-management</li> </ul>	\$15 per office visit

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Any costs associated with the facility charge (i.e. hospital, surgical center, etc.) are covered in Section 5 (c).
- Your physician must get precertification of some surgical procedures.

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Benefit Description	You pay
<b>Surgical procedures</b>	<b>You pay</b>
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see reconstructive surgery)</li> <li>• Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over</li> <li>• Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information.</li> </ul>	<p>\$15 per office visit; nothing for hospital visits</p>

*Surgical procedures- continued on next page*

<b>Surgical procedures (Continued)</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>• Voluntary sterilization (e.g. Tubal ligation, Vasectomy)</li> <li>• Treatment of burns</li> </ul> <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	\$15 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Surgery primarily for cosmetic purposes</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care.</i></li> </ul>	<i>All charges.</i>
<b>Reconstructive surgery</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>– the condition produced a major effect on the member’s appearance and</li> <li>– the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.</li> </ul>	\$15 per office visit

*Reconstructive surgery – continued on next page*

Reconstructive surgery ( <i>Continued</i> )	You pay
<ul style="list-style-type: none"> <li>• All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> <li>– surgery to produce a symmetrical appearance on the other breast;</li> <li>– treatment of any physical complications, such as lymphedemas;</li> <li>– breast prostheses and surgical bras and replacements (see Prosthetic devices)</li> </ul> </li> </ul> <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	\$15 per office visit.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i></li> <li>• <i>Surgeries related to sex transformation</i></li> </ul>	<i>All charges</i>
Oral and maxillofacial surgery	You pay
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures; and</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures.</li> <li>• Non-dental treatment of temporomandibular joint (TMJ) dysfunction syndrome</li> </ul>	\$15 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> <li>• <i>Dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome</i></li> </ul>	<i>All charges.</i>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Kidney/Pancreas</li> <li>• Liver</li> <li>• Lung: Single –Double</li> <li>• Pancreas</li> <li>• Allogeneic (donor) bone marrow transplants</li> <li>• Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors</li> <li>• Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas</li> <li>• National Transplant Program (NTP) – Ohio Department of Health and Ohio Organ Transplant Consortium</li> </ul> <p>Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols.</p> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i></li> <li>• <i>Implants of artificial organs</i></li> <li>• <i>Transplants not listed as covered</i></li> </ul>	<i>All charges</i>
Anesthesia	You pay
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> <li>• Hospital outpatient department</li> <li>• Skilled nursing facility</li> <li>• Ambulatory Surgical Center</li> <li>• Office</li> </ul>	Nothing

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

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**Here are some important things to remember about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- 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
<b>Inpatient hospital</b>	<b>You pay</b>
Room and board, such as <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations;</li> <li>• General nursing care; and</li> <li>• Meals and special diets.</li> </ul> NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$250 copayment per admission up to a maximum of \$500/individual, \$1250/family per calendar year.

*Inpatient hospital - continued on next page*

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

<b>Extended care benefits/skilled nursing care facility benefits</b>	<b>You pay</b>
<p>Extended care benefit:</p> <p>The Plan provides a comprehensive range of benefits for up to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. All necessary services are covered, including:</p> <ul style="list-style-type: none"> <li>• Bed, board and general nursing care</li> <li>• Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.</li> </ul>	<p>\$250 copayment per admission up to a maximum of \$500/individual, \$1250/family per calendar year.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Custodial care, rest cures, domiciliary or convalescent care</i></li> <li>• <i>Personal comfort items, such as telephone and television</i></li> </ul>	<p><i>All charges</i></p>
<b>Hospice care</b>	<b>You pay</b>
<p>Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, family counseling, and durable medical equipment; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.</p>	<p>Nothing</p>
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<p><i>All charges</i></p>
<b>Ambulance</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>• Local professional ambulance service when medically appropriate</li> </ul>	<p>Nothing</p>

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## Section 5(d) Emergency services/accidents

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

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

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### **What to do in case of emergency:**

If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room.

### **Emergencies within our service area:**

Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours, unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and Plan doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

The Plan pays reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

### **Emergencies outside our service area:**

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

The Plan pays reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers.

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Benefit Description	You pay
<b>Emergency within our service area</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office</li> </ul>	Nothing
<ul style="list-style-type: none"> <li>Emergency care at an urgent care center</li> </ul>	\$15 per office visit
<ul style="list-style-type: none"> <li>Emergency care as an outpatient at a hospital, including doctors' services.</li> </ul> <p>Note: If the emergency results in admission to a hospital, the emergency care copayment is waived.</p>	\$75 copayment per visit
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>
<b>Emergency outside our service area</b>	<b>You pay</b>
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office</li> </ul>	Nothing
<ul style="list-style-type: none"> <li>Emergency care at an urgent care center</li> </ul>	\$15 per office visit
<ul style="list-style-type: none"> <li>Emergency care as an outpatient or inpatient at a hospital, including doctors' services.</li> </ul> <p>Note: If the emergency results in admission to a hospital, the emergency care copayment is waived.</p>	\$75 copayment per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Elective care or non-emergency care</i></li> <li><i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li><i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> </ul>	<i>All charges.</i>
<b>Ambulance</b>	<b>You pay</b>
<p>Professional ambulance service when medically appropriate.</p> <ul style="list-style-type: none"> <li>Air ambulance when ordered or authorized by a Plan doctor</li> </ul> <p>See 5(c) for non-emergency service.</p>	Nothing

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

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

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure 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 benefit description below.

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Benefit Description	You pay
<b>Mental health and substance abuse benefits</b>	<b>You pay</b>
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illness or conditions.</p>
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> <li>• Medication management</li> </ul>	<p>\$15 per 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"> <li>Diagnostic tests</li> </ul>	Nothing
<ul style="list-style-type: none"> <li>Services provided by a hospital or other facility</li> <li>Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment</li> </ul>	\$250 copayment per admission up to a maximum of \$500/individual, \$1250/family per calendar year.
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All charges.</i>

**Preauthorization**

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

Call the SuperMed Behavioral Health Care Management Department at 800/258-3186. It is not necessary to obtain a referral from your primary care doctor.

**Limitation**

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

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## Section 5(f) Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

- **Who can write your prescription.** A plan or referral physician must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, except for out-of-area emergencies, or by mail for a maintenance medication.
- **We use a formulary.** Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. A formulary is a list of selected FDA approved, prescription medications reviewed by an independent Pharmacy and Therapeutics Committee brought together by Medco Health Solutions, Inc. These drugs are made by many different pharmaceutical manufacturers. To order a prescription drug brochure, call 800/417-1961.
- **Mail Order Program.** To receive mail order prescription drug benefits, you mail your prescription order and the prescription drug deductible amount which is specified below to a contracting mail order pharmacy. No benefits are payable if your prescription order is sent to a pharmacy other than a contracting mail order pharmacy. The contracting mail order pharmacy will fill your prescription order and send you up to a 90-day supply of the mail order prescription drug which your physician has prescribed. The contracting mail order pharmacy will dispense the medication and mail it to you within 72 hours. If the contracting mail order pharmacy fails to send you the mail order prescription drug within ten days after you mailed in your prescription order, you may call the contracting mail order pharmacy directly to determine the status of the prescription order.
- **These are the dispensing limitations.** Prescription drugs obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. Prescription drugs obtained by using the mail order prescription drug program will be dispensed for up to a 90-day supply.
- **A generic equivalent will be dispensed if it is available.** If you purchase a Brand Name Prescription Drug when a Federally approved Generic Drug is available, you will be required to pay any applicable Generic Prescription Drug Copayment plus the difference between the cost of the Generic Drug and the Brand Name Drug. You are still responsible for paying the difference between the cost of the Generic Drug and the Brand Name Drug, even if your Physician prescribes a brand name drug to be dispensed as written. When a generic substitution has proven to be ineffective in treating the patient, the member will be responsible for the Non-Formulary Brand Copay.
- If you are called to active duty or you are a member requiring medication during a national or other emergency, please call 1-800-522-2066 for assistance.

- **Why use generic drugs?** To reduce your out-of-pocket expenses! A generic drug is the chemical equivalent of a corresponding brand name drug. Generic drugs are less expensive than brand name drugs; therefore, you may reduce your out-of-pocket costs by choosing to use a generic drug.
- **When you have to file a claim.** You should contact Medco Health at 800/417-1961 for prescription drug claim forms. You should submit all claims to Paid Prescriptions, P.O. Box 2277, Lee Summit, MO 64063. Normally, when you use plan pharmacies, you will not have to file claims.

Benefit Description	You pay
<b>Covered medications and supplies</b>	<b>You pay</b>
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• Drugs for which a prescription is required by Federal Law</li> <li>• Insulin</li> <li>• Disposable needles and syringes for the administration of covered medications (<b>must be dispensed the same day as insulin</b>)</li> <li>• Drugs for sexual dysfunction (see prior authorization below)</li> <li>• Contraceptive drugs and devices</li> <li>• Smoking cessation drugs and medication, including nicotine patches</li> </ul> <p>Limited benefits:</p> <ul style="list-style-type: none"> <li>• Sexual dysfunction drugs have dispensing limitations. Contact the Plan for details.</li> </ul>	<p><b>30-day supply at a Plan pharmacy</b></p> <p>\$10 copayment per prescription or refill for generic drugs</p> <p>\$20 copayment per prescription or refill for formulary name brand drugs</p> <p>\$30 copayment per prescription or refill for non-formulary name brand drugs</p> <p><b><u>Mail Order</u></b></p> <p><b>Up to a 90-day supply through the mail order program</b></p> <p>\$20 copayment per prescription or refill for generic drugs</p> <p>\$40 copayment per prescription or refill for formulary name brand drugs</p> <p>\$60 copayment per prescription or refill for non-formulary name brand drugs</p>

*Covered medications and supplies -- continued on the next page*

Covered medications and supplies ( <i>continued</i> )	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs available without a prescription or for which there is a nonprescription equivalent available.</i></li> <li>• <i>Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies.</i></li> <li>• <i>Vitamins and nutritional substances that can be purchased without a prescription.</i></li> <li>• <i>Medical supplies such as dressings and antiseptics</i></li> <li>• <i>Fertility drugs</i></li> <li>• <i>Drugs for cosmetic purposes</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Diabetic supplies, except as specified, including glucose test tablets and test tape, Benedict's solution, or equivalent, and acetone test tablets</i></li> <li>• <i>Diet pills and appetite suppressants</i></li> </ul>	<p><i>All Charges</i></p>

## Section 5(g) Special features

Feature	Description
<b>Flexible benefits option</b>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> <li>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.</li> <li>• Alternative benefits are subject to our ongoing review.</li> <li>• By approving an alternative benefit, we cannot guarantee you will get it in the future.</li> <li>• The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits.</li> <li>• Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</li> </ul>
<b>Congestive Heart Failure (Heart Sense™)</b>	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-877-726-2715 and talk with a cardiac nurse disease manager who will set up a program of telephone and home visit(s) that will help you learn more about your condition and how to manage your symptoms.</p>
<b>Maternity Care (Baby Link®)</b>	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-866-833-BABY (2229) and talk with a maternity care nurse who can answer your questions and provide necessary information and additional resources that you may need concerning maternity care, during and after pregnancy.</p>
<b>Asthma (Breathe Easy®)</b>	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-888-224-6906 and talk with a specially trained respiratory nurse who will set up a program of telephone calls that will help you learn more about your breathing condition and how to manage your symptoms.</p>
<b>Chronic Obstructive Pulmonary Disease (Breathe Easy®)</b>	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-888-224-6906 and talk with a specially trained respiratory nurse who will set up a program of telephone calls that will help you learn more about your breathing condition (also known as COPD or emphysema) and how to manage your symptoms.</p>
<b>Diabetes (Diabetes Advantage™)</b>	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-800-861-4826 and talk with a Diabetes Care Coordinator who will set up a program of telephone calls that will help you learn more about your condition and how to manage your symptoms. You can also speak with a certified dietician and receive diabetes testing supplies at no out-of-pocket cost once you are enrolled in the program.</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.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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<b>Accidental injury benefit</b>	<b>You Pay</b>
Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. These services must be initiated within 90 days from the date of the accident. We do not cover services necessary because of injury as a result of chewing or biting.	Nothing.

<b>Dental benefits</b>
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We have no other dental benefits.

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

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services, drugs, or supplies you receive without charge while in active military service.

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## Section 7. Filing a claim for covered services

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

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

### **Medical 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 800/522-2066.

When you must file a claim -- such as for services you receive outside of the Plan's Service Area -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

**Submit your claims to:** SuperMed HMO, P.O. Box 6018, Cleveland, Ohio 44101, Attn: HMO Member Services. You may also contact us by fax at 216/687-2817, or visit our website <http://www.MedMutual.com>.

### **Prescription drugs**

**Submit your claims to:** Medco Health Solutions, Inc., P.O. Box 2277, Lee Summit, MO 64063.

### **Deadline for filing your claim**

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

### **When we need more information**

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

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## Section 8. The disputed claims process

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

Step	Description
<b>1</b>	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none"><li>Write to us within 6 months from the date of our decision; and</li><li>Send your request to us at: SuperMed HMO, P.O. Box 6018, Cleveland, Ohio 44101; and</li><li>Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li><li>Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li></ol>
<b>2</b>	<p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none"><li>Pay the claim (or arrange for the health care provider to give you the care); or</li><li>Write to you and maintain our denial -- go to step 4; or</li><li>Ask you or your medical provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.</li></ol>
<b>3</b>	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
<b>4</b>	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"><li>90 days after the date of our letter upholding our initial decision; or</li><li>120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or</li><li>120 days after we asked for additional information.</li></ul> <p>Write to OPM at: Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, D.C. 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"><li>A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;</li><li>Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;</li><li>Copies of all letters you sent to us about the claim;</li><li>Copies of all letters we sent to you about the claim; and</li><li>Your daytime phone number and the best time to call.</li></ul> <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>

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 their disputed claim decision. This information will become part of the court record.

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

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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800/522-2066 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
  - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
  - You may call OPM's Health Insurance Group 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

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## Section 9. Coordinating benefits with other coverage

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### When you have other health coverage

You must tell us if you 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.

If we pay second, we will determine our allowance. After the first plan pays, we will pay either what is left of our allowance or our regular benefit, whichever is less. We will not pay more than our allowance. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

### 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.

- **Should I enroll in Medicare?**

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

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

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

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

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, such as most prescription drugs (but coverage through private prescription drug plans will be available starting in 2006).

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. Your Plan PCP must continue to authorize your care.

**Claims process when you have the Original Medicare Plan --** You probably will never have to file a claim form when you have both our Plan and Medicare.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claims, call us at 800/522-2066, or visit our website at <http://www.MedMutual.com>.

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

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

<b>Primary Payer Chart</b>		
<b>A. When you - or your covered spouse - are age 65 or over and have Medicare and you...</b>	<b>The primary payer for the individual with Medicare is...</b>	
	<b>Medicare</b>	<b>This Plan</b>
1) Have FEHB coverage on your own as an active employee or through your spouse who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #1 above	✓	
4) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and... You have FEHB coverage on your own or through your spouse who is also an active employee You have FEHB coverage through your spouse who is an annuitant	✓	✓
5) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #1 above	✓	
6) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
7) 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	✓*	
<b>B. When you or a covered family member...</b>		
1) Have Medicare solely based on end stage renal disease (ESRD) and... • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30 – month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and... • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
• Medicare was the primary payer before eligibility due to ESRD	✓	
<b>C. When either you or a covered family member are eligible for Medicare solely due to disability and you</b>		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on you own as an annuitant or through a family member who is an annuitant	✓	
<b>D. Are covered under the FEHB Spouse Equity provision as a former spouse</b>		
	✓	

\* Workers' Compensation is primary for claims related to your condition under Workers' Compensation

- **Medicare Advantage**

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

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

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

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

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

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

### **TRICARE and CHAMPVA**

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

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

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

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<b>Calendar year</b>	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See page 12.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	Treatment or services that are mainly to help the patient with daily living activities. Custodial care that lasts 90 days or more is sometimes known as Long term care.
<b>Experimental or investigational services</b>	<p>A drug, device or medical treatment or procedure is experimental or investigational:</p> <ul style="list-style-type: none"><li>• If the drug or device does not have required Food and Drug Administration (FDA) approval.</li><li>• If reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I, II, III clinical trials or is under study to determine maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with the standard means of treatment or diagnosis.</li></ul>
<b>Group health coverage</b>	Health care coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies.
<b>Medical necessity</b>	<p>A service, supply or Prescription Drug that is required to diagnose or treat a Condition and which SuperMed HMO determines is:</p> <ul style="list-style-type: none"><li>• appropriate with regard to the standards of good medical practice;</li><li>• not primarily for your convenience or the convenience of a Provider; and</li><li>• the most appropriate supply or level of service which can be safely provided to you.</li></ul> <p>When applied to the care of an Inpatient, this means that your medical symptoms or condition requires that the services cannot be safely or adequately provided to you as an Outpatient. When applied to Prescription Drugs, this means the Prescription Drug is cost effective compared to alternative Prescription Drugs, which will produce comparable effective clinical results.</p>
<b>Plan allowance</b>	The amount a Contracting Institutional Provider or a Participating Professional Provider has agreed with SuperMed HMO to accept as payment in full for Covered Services.
<b>Us/We</b>	Us and we refer to SuperMed HMO.
<b>You</b>	You refers to the enrollee and each covered family member.

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## Section 11. FEHB facts

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### Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition that you had before you enrolled in this Plan solely because you had the condition before you enrolled.
- **Where you can get information about enrolling in the FEHB Program**

See [www.opm.gov/insure](http://www.opm.gov/insure). Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about your FEHB plan. These materials will 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 cancel your coverage, change to Self Only, or change to a plan that doesn’t serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of the first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2005 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan’s 2004 benefits until the effective date of your coverage with your new plan. Annuitants’ coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

- **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 (TCC), or a conversion policy (a non-FEHB individual policy).

- **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 family 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](http://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](http://www.opm.gov/insure). It explains what you have to do to enroll.
  
- **Converting to individual coverage**

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

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

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

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

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

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

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## Section 12. Two Federal Programs complement FEHB benefits

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### Important information

OPM wants to make sure you are aware of about new Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside tax-free money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** covers long term care costs not covered under the FEHB.

### The Federal Flexible Spending Account Program - *FSAFEDS*

#### • What is an FSA?

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. *By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%!!*

There are two types of FSAs offered by FSAFEDS:

#### Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have
- Eligible dependents for this account include anyone you claim on your Federal Income Tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal Income Tax return, even if you don't have self and family health benefits coverage. *Note:* The IRS has a broader definition than that of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum amount that can be allotted for the HCFSA is \$4,000. *Note:* The Federal workforce includes a number of employees married to each other. If each spouse/employee is eligible for FEHB coverage, both may enroll for a HCFSA up to the maximum of \$4,000 each (\$8,000 total). Both are covered under each other's HCFSA. The minimum annual amount is \$250.

#### Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you, and your spouse, if married, can work, look for work or attend school full-time.
- Qualifying dependents for this account include your dependant children under age 13, or any person of any age whom you claim as a dependant on your Federal Income Tax return (and who is mentally or physically incapable of self care).
- The maximum that can be allotted for the DCFSA is \$5,000 annually. The minimum amount is \$250. *Note:* The IRS limits contributions to a DCFSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive.

#### • Enroll during Open Season

You **must make an election** to enroll in an FSA during the 2005 FEHB Open Season. Even if you enrolled during 2004, you must make a new election to continue participating in 2005. Enrollment is easy!

- **Online:** visit [www.FSAFEDS.com](http://www.FSAFEDS.com) and click on **Enroll**.
- Telephone: call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (372-3337) Monday through Friday, from 9 a.m. until 9 p.m. Eastern Time. TTY: 1-800-952-0450.

**What is SHPS?**

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and will be responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

**Who is eligible to enroll?**

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB– you can choose to participate in either, or both, of the FSA’s. *However, if you enroll in a High Deductible Health Plan (HDHP) with a Health Savings Account (HSA), you are not eligible to participate in an HCFSA.*

Almost all Federal employees are eligible to enroll for a DCFSA. The only exception is intermittent (also called when actually employed [WAE]) employees expected to work less than 180 days during the year.

*Note:* FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers signed on to participate. Under IRS law, FSAs are not available to annuitants. In addition, the U.S. Postal Service and the Judicial Branch, among others, are Federal agencies that have their own plans with slightly different rules, but the advantages of having an FSA are the same regardless of the agency for which you work.

**• How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits an FSA provides, the IRS places strict guidelines on how the money can be used. Under current IRS tax rules, you are required to forfeit any money for which you did not incur an eligible expense under your FSA account(s) during the Plan Year. This is known as the “use-it-or-lose-it” rule. You will have until April 30, following the end of the Plan Year to submit claims for your eligible expenses incurred from January 1 through December 31. For example, if you enroll in FSAFEDS for the 2005 Plan Year, you will have until April 30, 2006 to submit claim for eligible expenses.

The **FSAFEDS Calculator** at [www.FSAFEDS.com](http://www.FSAFEDS.com) will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

**• What can my HCFSA pay for?**

Every FEHB plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 14 and detailed throughout this brochure. Your HCFSA will reimburse you when those costs are for qualified medical care that you, your spouse and/or your dependents receive that is NOT covered or reimbursed by this FEHB Plan or any other coverage that you have.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. The FSAFEDS Web site also has a comprehensive list of eligible expenses at [www.FSAFEDS.com/fsafeds/eligibleexpenses.asp](http://www.FSAFEDS.com/fsafeds/eligibleexpenses.asp). If you do not see your service or expense listed, please call an FSAFEDS Benefit Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

**• Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will be less. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

<b>Annual Tax Savings Example</b>	<b>With FSA</b>	<b>Without FSA</b>
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into an FSA:	\$2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$2,000
Your real spendable income is:	\$34,193	\$33,617
<b>Your tax savings:</b>	<b>\$576</b>	<b>-\$0-</b>

**Note:** This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon in which retirement system you are enrolled (CSRS or FERS), your state of residence, and your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424 - a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal Income Tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

- **Health care expenses**

The HCFSA is Federal Income Tax-free from the first dollar. In addition, you may be reimbursed from your HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal Income Tax return. Using the example shown above, only health care expenses exceeding \$3,750 (7.5% of \$75,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through a HCFSA is also exempt from FICA taxes. This exception is not available on your Federal Income Tax return.

- **Dependent care expenses**

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit [www.FSAFEDS.com](http://www.FSAFEDS.com) and download the Dependent Care Tax Credit Worksheet from the Quick Links box to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

Section 1127 of the National Defense Authorization Act (Public Law 108-136) requires agencies that offer FSAFEDS to employees to cover the administrative fee(s) on behalf of their employees. However, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the Plan Year, resulting in the forfeiture of funds remaining in your account (the IRS "use-it-or-lose-it" rule).

- **Contact us**

To learn more or to enroll, please visit the **FSAFEDS Web site** at [www.FSAFEDS.com](http://www.FSAFEDS.com), or contact SHPS directly via email or by phone. FSAFEDS Benefits Counselors are available Monday through Friday, from 9:00 a.m. until 9:00 p.m. Eastern Time.

- E-mail: [FSAFEDS@shps.net](mailto:FSAFEDS@shps.net)
- Telephone: 1-877-FSAFEDS (372-3337)
- TTY: 1-800-952-0450 (for hearing impaired individuals that would like to utilize a text messaging service)

## **The Federal Long Term Care Insurance Program**

- **It's important protection**

Why should you consider applying for coverage under the Federal Long Term Care Insurance Program (FLTCIP)?:

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself – or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you control over the type of care you receive and where you receive it. It can also help you remain independent, so you won't have to worry about being a burden to your loved ones.
- **It's to your advantage to apply sooner rather than later.** Long term care insurance is something you must apply for, and pass a medical screening (called underwriting) in order to be enrolled. Certain medical conditions will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a change in health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. If you marry, your new spouse will also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.

- **To find out more and to request an application**

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

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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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**NOTES:**

## Summary of benefits for the SuperMed HMO – 2005

- **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.
- We only cover routine vision examinations provided by Cole Network Managed Vision Providers.

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office.....	Office visit copayment: \$15	14
Services provided by a hospital:		
• Inpatient .....	\$250 copayment per admission up to a maximum of \$500/individual, \$1250/family per calendar year.	27
• Outpatient.....	Nothing for outpatient hospital or ambulatory surgical center	28
Emergency benefits:		
• In-area .....	\$75 per hospital emergency room visit, nothing per doctor's office visit for services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copayment is waived.	30
• Out-of-area.....	\$75 per hospital emergency room visit, nothing per doctor's office visit for services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copayment is waived.	30
Mental health and substance abuse treatment.....	\$15 copayment per visit	32
Prescription drugs.....	\$10 copayment for generic drugs \$20 copayment for name brand drugs <b>\$30 copayment for non-formulary drugs</b> \$20 copayment for generic drugs mail order \$40 copayment for name brand drugs mail order <b>\$60 copayment for non-formulary drugs</b>	34

Dental care.....	Accidental injury benefit; you pay nothing.	38
Vision Care.....	Every year, one refraction; \$10 copayment per office visit	20
Special features: Flexible Benefits Option; Heart Sense, Babylink, Breathe Easy, Diabetes Advantage		37
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum) .....	Your out-of-pocket expenses for benefits under this Plan are limited to the stated copayments for a few benefits.	12

## 2005 Rate Information for SuperMed HMO

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

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

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

		<i>Non-Postal Premium</i>				<i>Postal Premium</i>	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	5M1	131.08	\$92.95	\$284.01	\$201.39	\$154.74	\$69.29
Self & Family	5M2	\$298.23	\$274.83	\$646.17	\$595.46	\$352.08	\$220.98