

Community Health Plan

<http://www.mychp.com/>



2005

A Health Maintenance Organization

Serving: Northwest Missouri; Northeast Kansas

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

Enrollment code for this Plan:

IC1 Self Only

IC2 Self and Family

Special notice: This Plan is offered for the first time under the Federal Employees Health Benefits Program during the 2004 Open Season.

Authorized for distribution by the:



**United States
Office of Personnel Management**

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

RI 73-831



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 lifestyle 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 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, 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. 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 United States 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 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 19, 2003.

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Introduction

This brochure describes the benefits of Community Health Plan under our contract (CS 2890) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for Community Health Plan administrative offices is:

Community Health Plan
Heartland Health Business Plaza
137 North Belt Highway
St. Joseph, MO 64506

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

If you are enrolled in this plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits.

OPM negotiates benefits and rates with each plan annually. Rates are shown at the end of this brochure.

Plain Language

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

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means Community Health Plan.
- 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 or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

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

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

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

- 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 1-800-990-9247 (toll-free) or 816-271-1271 and explain the situation.

If we do not resolve the issue:

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

OR WRITE TO:

**United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC 20415-1100**

- Do not maintain as a family member on your policy:

Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or

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

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

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

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

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

Want more information on patient safety?

- 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 health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org/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. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- 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 health care delivery system.

Section 1. Facts about this HMO plan

This plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These plan providers coordinate your health care services. The plan is solely responsible for the selection of these providers in your area. Contact us for a copy of our most recent provider directory by calling 1-800-990-9247 (toll-free) or 816-271-1271.

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

When you receive services from plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments and coinsurance 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. You will only be responsible for your copayments or coinsurance.

Your Rights

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

- Community Health Plan is domiciled in Missouri, and licensed in Missouri and Kansas, providing services to Northwest Missouri and Northeast Kansas.
- We have been in business for 9 years.
- We are a non-profit organization that is subject to income tax.

If you want more information about us, call 1-800-990-9247 (toll-free) or 816-271-1271, or write to **Community Health Plan, Heartland Health Business Plaza, 137 North Belt Highway, St. Joseph, MO 64506**. You may also contact us by fax at 816-271-7976 or visit our website at www.mychp.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:

Missouri: Andrew, Atchison, Buchanan, Caldwell, Carroll, Clinton, Daviess, DeKalb, Gentry, Grundy, Harrison, Holt, Livingston, Mercer, Nodaway, Ray, and Worth counties.

Kansas: Atchison, Brown, and Doniphan counties.

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

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

Section 2. We are a new plan

This plan is new to the FEHB Program. We are being offered for the first time during the open enrollment season for 2005.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-990-9247 (toll-free) or 816-271-1271, or write to us at **Community Health Plan, Heartland Health Business Plaza, 137 North Belt Highway, St. Joseph, MO 64506**.

Where you get covered care

You get care from “plan providers” and “plan facilities.” You will only pay copayments and/or coinsurance, and you will not have to file claims.

- **Plan providers**

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

We list plan providers in the provider directory, which we update periodically. The list is also on our Web site.

- **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 Web site.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician (PCP). This decision is important since your primary care physician provides or arranges for most of your health care. Your PCP will refer you for any specialty care you might need. If you need help selecting a PCP for yourself or a family member, please request a provider directory, or call the plan at 1-800-990-9247 (toll-free) or 816-271-1271.

- **Primary care**

Your primary care physician (PCP) can be a Doctor of Medicine (MD) or Osteopathy (DO) who is in Family Practice, an Internist or a Pediatrician, or a Nurse Practitioner or Physician’s Assistant who is licensed to practice medicine in the State where he or she provides care to you and who has entered into a written contract with Community Health Plan, or on whose behalf a written contract with Community Health Plan has been made. Your PCP is responsible to provide, arrange and coordinate care for you while you are a member of Community Health Plan. Your PCP, therefore, 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 PCP will refer you to a specialist for needed care. When you receive a referral from your PCP, you can see the specialist for the approved number of visits. All referrals are done telephonically. You may only seek care for the appropriate number of visits. However, you may see a contracted chiropractor or contracted OB-GYN without a referral.

Here are some 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 PCP will work with you, your specialist, and the plan to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your PCP 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 PCP. Your PCP 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 PCP, 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 and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist other than for cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
 - Reduce our service area and you enroll in another FEHB plan, 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. Contact us, or if we drop out of the Program, contact your new plan.

- **Hospital care**

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

If you are in the hospital when your enrollment in our plan begins, call our Customer Service department immediately at 1-800-990-9247 (toll-free) or 816-271-1271. If you are new to the FEHB Program, we will arrange for you to receive care.

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

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. 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 PCP has authority to refer you for most services. For certain services, however, your PCP 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 *Prior Authorization*. **Your physician must obtain authorization for the following services:**

(List is subject to change)

All Inpatient Hospital Admissions including:

- Acute Rehabilitation
- *Skilled Nursing
- Partial Hospitalization and Intensive Outpatient treatment for Mental Illness and Chemical Dependency

Accident-Related Dental Services/Oral Surgery

All Organ Transplants

Durable Medical Equipment (DME) - All rental DME, and DME with purchase price of \$200 or greater

The Plan requires prior authorization for certain medications. Please contact the Plan for a listing of these medications.

Therapies: Physical, occupational, speech

Nutritional Counseling limited to 4 visits calendar year

External Counter Pulsation

Air Ambulance Transfers

Global OB Care

Home Health Care

Home Infusion

Pain Management (multi-modality pain management)

Cosmetic/Plastic Surgery

Reduction Mammoplasty/Reconstruction

CPT Category III codes (these are temporary codes that may not be a covered benefit)

Electro Convulsive Therapy (ECT): inpatient and outpatient

Neuropsychological Testing

Formula for Inborn Errors of Metabolism

Hyperbaric Chamber Therapy

PET scans

SPECT scans

Gamma Knife

Ossatron

Osteogenic stimulation (bone stimulator): invasive and noninvasive

Neurostimulator implantation

Outpatient surgeries:

- Tonsillectomy and/or Adenoidectomy

*May have benefit limitations

Section 4. Your costs for covered services

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

Copayments

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

Example: When you see your primary care physician, you pay a copayment of \$15 per office visit and when you are admitted to the hospital, you pay a copayment of \$100 per day up to four (4) days.

Coinsurance

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

Example: You pay 50% of our allowance for infertility services and 20% of our allowance for durable medical equipment.

Deductible

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

Your catastrophic protection out-of-pocket maximum

After your copayments and coinsurance total \$2,500 per person or \$5,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

- Outpatient prescription drugs

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

Section 5. Benefits – OVERVIEW

Note: This benefits section is divided into subsections. Please read the “Important things you should keep in mind” at the beginning of each subsection. Also read the General exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 1-800-990-9247 (toll-free) or 816-271-1271.

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

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan 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 |
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| Diagnostic and treatment services | |
| Professional services of physicians | \$15 copayment per visit to PCP or OB-GYN (non-maternity) \$30 copayment per visit to specialist |
| <ul style="list-style-type: none"> • In physician's office | |
| Professional services of physicians | \$30 per visit |
| <ul style="list-style-type: none"> • In an urgent care center • Office medical consultations • Second surgical opinion | |
| At home | \$15 primary care visit \$30 specialist visit |
| Lab, X-ray and other diagnostic tests | |
| Tests, such as: | \$15 primary care office visit \$30 specialist office visit |
| <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG | Note: No additional copayments apply to these services if ordered by a participating provider. |

| Preventive care, adult | You pay |
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| Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 – Double contrast barium enema – every five years starting at age 50 – Colonoscopy screen – every ten years starting at age 50. • Chlamydial infection | \$15 primary care office visit \$30 specialist office visit |
| Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older. | \$15 primary care office visit |
| Routine pap test Note: The office visit is covered if pap test is received on the same day; see <i>Diagnosis and Treatment</i> , above. | \$15 primary care office visit |
| Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years | \$15 primary care office visit \$30 specialist office visit |
| Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and older | \$15 primary care office visit |
| <i>Not covered:</i> <ul style="list-style-type: none"> • Examinations for or in connection with insurance, employment, entering school, extracurricular school activities, any recreational activities, marriage, or a court order. • Immunizations and medications required for travel and work-related activities. | <i>All charges.</i> |
| Preventive care, children | You pay |
| <ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics | \$15 primary care office visit |
| <ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> – Eye exams through age 17 to determine the need for vision correction – Ear exams through age 17 to determine the need for hearing correction – Examinations done on the day of immunizations (up to age 22) | \$15 primary care office visit \$30 specialist office visit |

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| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Examinations for or in connection with insurance, employment, entering school, extracurricular school activities, any recreational activities, marriage, or a court order.</i> • <i>Immunizations and medications required for travel and work-related activities.</i> | <p><i>All charges.</i></p> |
| <p>Maternity care</p> <p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to prior authorize your normal delivery (this is the responsibility of your physician); • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. (Surgical benefits, not maternity benefits, apply towards circumcision of the newborn; see page 23). • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). | <p>You pay</p> <p>One time \$30 copayment for all office visits during the entire pregnancy.</p> |
| <p><i>Not covered: Routine sonograms to determine fetal age, size or sex.</i></p> | <p><i>All charges.</i></p> |
| <p>Family planning</p> <p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5(b)) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo-Provera) • Intrauterine devices (IUDs) • Diaphragms <p>NOTE: We cover oral contraceptives under the prescription drug benefit.</p> | <p>You pay</p> <p>\$15 primary care office visit \$30 specialist office visit</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary surgical sterilization</i> • <i>Genetic counseling</i> • <i>Elective pregnancy termination</i> | <p><i>All charges.</i></p> |

| Infertility services | You pay |
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| <p>Diagnosis and treatment of infertility, with treatment limited to:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> – Intravaginal insemination (IVI) – Intracervical insemination (ICI) – Intrauterine insemination (IUI) | 50% coinsurance |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> – In vitro fertilization – Embryo transfer, Zygote transfer, Gamete Intrafallopian Transfer (GIFT), and Zygote Intrafallopian Transfer (ZIFT) • Services and supplies related to excluded ART procedures • Cost of donor sperm • Cost of donor egg • Fertility drugs | <i>All charges.</i> |
| Allergy care | You pay |
| <ul style="list-style-type: none"> • Testing and treatment • Allergy injections | <p>\$15 primary care office visit</p> <p>\$30 specialist office visit</p> |
| Allergy serum | Nothing |
| <i>Not covered: Provocative food testing and sublingual allergy desensitization</i> | <i>All charges.</i> |
| Treatment therapies | You pay |
| <ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 25.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: We will only cover GHT when we prior authorize the treatment for children under the age of 18. Call 1-800-990-9247 (toll-free) or 816-271-1271 for prior authorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p> | \$30 specialist office visit |
| <i>Not covered: Any unauthorized therapies or treatments.</i> | <i>All charges.</i> |

| Physical and occupational therapies | You pay |
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| Unlimited visits for services of the following: <ul style="list-style-type: none"> • Qualified physical therapists • Occupational therapists Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. <ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery, or a myocardial infarction Note: For all therapies, the actual number of visits depends upon prior authorization by the Plan | \$30 per visit |
| <i>Not covered:</i> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs • Enrollment in health clubs or athletic clubs | <i>All charges.</i> |
| Speech therapy | You pay |
| Unlimited visits for services of the following: <ul style="list-style-type: none"> • Speech therapist Note: The actual number of visits depends upon prior authorization by the Plan. | \$30 per visit |
| Hearing services (testing, treatment, and supplies) | You pay |
| <ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see Preventive care, children) | \$30 specialist office visit |
| <i>Not covered:</i> <ul style="list-style-type: none"> • All other hearing testing • Hearing aids, testing and examinations for them | <i>All charges.</i> |
| Vision services (testing, treatment, and supplies) | You pay |
| You are covered for medical vision services, such as glaucoma or cataracts. | \$30 specialist office visit |
| <ul style="list-style-type: none"> • Eye exam for evaluation of medical vision services | \$30 specialist office visit |
| <i>Not covered:</i> <ul style="list-style-type: none"> • Eye exercises and orthopedics, pleoptics • Radial keratotomy and other refractive surgery | <i>All charges.</i> |

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| <p>Foot care</p> <ul style="list-style-type: none"> • Routine foot care <p>You may receive services for routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See “Orthopedic and prosthetic devices” for information on podiatric shoe inserts.</p> <ul style="list-style-type: none"> • Non-routine Foot Care <p>Non-routine foot care is limited to the following:</p> <ul style="list-style-type: none"> – Nail debridement – Avulsion of the nail plate – Excision of the nail ingrown or outgrown – Evacuation of subungual hematoma – Bunionectomy – Excision of Planters Wart; and – Extensive foot debridement of ulcers or injury <p>Note: When you receive services from your primary care physician, no referral or authorization from Community Health Plan is necessary. Otherwise, a referral to a podiatrist is required.</p> | <p>\$15 primary care office visit \$30 specialist office visit</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above.</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery).</i> | <p><i>All charges.</i></p> |
| <p>Orthopedic and prosthetic devices</p> <ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose. • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. <p>Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery. See Section 5(b) for coverage of the surgery to insert the device.</p> <ul style="list-style-type: none"> • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) syndrome. | <p>You pay</p> <p>20% of plan allowance</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Orthopedic and corrective shoes</i> • <i>Arch supports</i> • <i>Foot orthotics</i> • <i>Heel pads and heel cups</i> • <i>Lumbosacral supports</i> • <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>Repair or replacement of prosthetic medical appliances except if required due to normal anatomical changes.</i> | <p><i>All charges.</i></p> |

| Durable medical equipment (DME) | You pay |
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| <p>The Plan provides benefits for durable medical equipment when prescribed for you by your participating provider, prior authorized by the Plan, and obtained from a participating physician or participating provider who is a durable medical equipment supplier.</p> <p>The Plan may, at its option, rent or purchase durable medical equipment. The Plan will authorize use of the equipment for a limited period of time. The Plan retains the right to possess the equipment and you agree to cooperate with the Plan in arrangements to take possession of equipment following your authorized use.</p> <p>You are covered for 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"> • Hospital beds • Non motorized wheelchairs • Crutches • Walkers • Insulin pumps | <p>20% of plan allowance</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Deluxe equipment, i.e. motorized wheel chairs and beds; except when the deluxe features are determined by the Plan to be necessary for your condition in order to allow you to operate the equipment.</i> • <i>Items not primarily and customarily for medical purposes or medical in nature or which are provided for your comfort and convenience.</i> • <i>Physician's equipment including, but not limited to, stethoscopes and blood pressure monitoring equipment.</i> • <i>Disposable supplies; except colostomy, ileostomy, cystostomy, gastrostomy and nephrostomy supplies.</i> • <i>Exercise equipment and self help equipment not primarily medical in nature including, but not limited to, sauna baths, whirlpool baths, chairs and elevators.</i> • <i>Supplies and equipment for household use including but not limited to air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses and water beds.</i> • <i>Replacement, repair or routine periodic maintenance of purchased durable medical equipment.</i> • <i>Items obtained from a provider that is not a participating provider, except for emergency services.</i> | <p><i>All charges.</i></p> |

| Home health services | You pay |
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| <ul style="list-style-type: none"> You may receive home health care ordered by a participating physician and provided by a participating home health provider. Care and services may be administered by a registered nurse (R.N.); licensed practical nurse (L.P.N.); home health aide; or physical, speech, or occupational therapist. Your care must be authorized by the plan in conjunction with a treatment plan. | \$30 per day |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Nursing care requested by, or for the convenience of, the member or the member's family;</i> <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> | <i>All charges.</i> |
| Chiropractic | You pay |
| <ul style="list-style-type: none"> 26 visit limit per calendar year Manipulation of the spine and extremities Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application | \$15 per office visit |
| <i>Not covered: Services received after 26 visits.</i> | <i>All charges.</i> |
| Alternative treatments | You pay |
| <p>No benefit.</p> <p>Note: See Section 5(i) "Non-FEHB benefits available to plan members", page 38 for details.</p> | <i>All charges.</i> |
| Educational classes and programs | You pay |
| Nutritional Counseling- 4 visits per year | \$10 per calendar year |
| <p>Smoking Cessation – Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs.</p> <p>Note: Combination of prescription drug copayments and office visit copayments must not exceed \$100 lifetime.</p> | <p>\$15 primary care office visit</p> <p>\$30 specialist office visit</p> |

| Disease Management Programs | You pay |
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| <p>Diabetes Connections is available to members with type 1 or type 2 diabetes. This program includes educational phone calls, mailings and guidelines for managing diabetes to help members stay in control of the disease so they can live healthy and productive lives. Interventions improve members' health and prevent, delay or reduce the severity of long-term complications.</p> <p>Cardiac Connections coordinates and combines all of the healthcare needs of members diagnosed with heart disease and congestive heart failure. This program highlights current guidelines for care and provides phone calls, mailings and cardiac management guidelines to help members stay in control of the disease and live healthy and productive lives.</p> <p>Asthma Connections provides interventions and includes a focus on children. The clinical staff provides the intervention that includes phone calls to members and their physicians, asthma care management, and member and provider education.</p> <p>COPD Connections is a program for members with airflow obstruction due to chronic bronchitis, emphysema or asthma. Using area clinicians and home pulmonary rehabilitation services, the COPD program delivers interventions, including phone calls to members and providers, care management, and member and provider education.</p> <p>Low Back Pain Connections provides low back pain interventions by the clinical staff through phone calls to members, back care material mailings, and member and provider education. This program helps members quickly regain their usual activity level, return to work earlier and prevent another occurrence of low back pain.</p> <p>CARE Connections is designed for members diagnosed with depression, hospitalized for depression or at high risk of being hospitalized, or need assistance in determining what type of behavioral health care they need. Behavioral health nurses provide support to members over the phone, send educational mailings and coordinate care between the health plan, the member and the member's providers regarding depression management.</p> <p>Wellness Benefit</p> <p>Community Health Plan will mail Health Risk Appraisals to each employee (18 years and older) within 30 days of their initial signing or renewal with Community Health Plan. After participating employees have returned the appraisal, an individual report that explains their results will be mailed to them.</p> | <p>Nothing</p> |

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

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

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

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| Benefit Description | You pay |
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| Surgical procedures | You pay |
| <p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity: a condition in which an individual weighs 100 pounds, or is 100%, over his or her normal weight according to current underwriting standards, and/or has a Body Mass Index (BMI) => 40. Eligible members must be 18 years of age and over, and must meet medical necessity according to Community Health Plan policy. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Newborn circumcision • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay hospital benefits for a pacemaker and surgery benefits for insertion of the pacemaker.</p> | <p>\$15 primary care office visit</p> <p>\$30 specialist office visit</p> <p>Nothing for surgery - \$100 outpatient copayment, or \$100 per day up to 4 days per inpatient admission</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care</i> • <i>Selective reduction for cosmetic purposes</i> | <p><i>All charges.</i></p> |

| Reconstructive surgery | You pay |
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| <ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – the condition produced a major effect on the member’s appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – surgery to produce a symmetrical appearance of breasts; – treatment of any physical complications, such as lymphedemas; – breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p> | <p>\$30 specialist office visit</p> <p>Nothing for surgery - \$100 outpatient copayment, or \$100 per day up to 4 days per admission</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> | <p><i>All charges.</i></p> |
| Oral and maxillofacial surgery | You pay |
| <p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. • Temporomandibular Joint (TMJ) Syndrome. Benefit includes surgical and non-surgical intervention, corrective orthopedic appliances, and physical therapy <p>Note: 20% of plan allowance for appliances associated with the treatment of TMJ.</p> <p>(See also “Orthopedic and prosthetic devices” information, Section 5(a), page 19.)</p> | <p>\$30 specialist office visit</p> <p>Nothing for surgery - \$100 outpatient copayment, or \$100 per day up to 4 days per admission</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> | <p><i>All charges.</i></p> |

| Organ/tissue transplants | You pay |
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| <p>Limited to:</p> <ul style="list-style-type: none"> • Cornea; • Heart; • Heart/lung; • Kidney; • Kidney/Pancreas; • Liver; • Lung: Single – Double; • Pancreas; • Allogeneic (donor) bone marrow transplants; • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin’s lymphoma; advanced non-Hodgkin’s lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors; • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. • All transplants must be prior authorized and use Centers of Excellence contracted with United Resource Network. <p>Note: We cover related medical and hospital expenses of the donor only when we cover the recipient.</p> | <p>Nothing for surgery - \$100 per day up to 4 days per inpatient admission</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Transplants not listed as covered</i> • <i>Non-human and artificial organs and their implantation</i> • <i>Bone marrow transplants (allogeneic, autologous or peripheral blood stem cells) for treatment of cancers or diseases of the brain, bone, large bowel, ovary, small bowel, testicle, esophagus, kidney, liver, lungs, pharynx, prostate, skin connective tissue and uterus</i> • <i>Bone marrow transplants for any congenital, genetic or metabolic disorders affecting or originating in the blood-forming (hematopoietic) system, except as stated above as covered</i> | <p><i>All charges.</i></p> |
| Anesthesia | |
| <p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Skilled nursing facility | <p>Nothing</p> |
| <p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Ambulatory surgical center • Office | <p>Nothing</p> |

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

Here are some important things to remember about these benefits:

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan 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 PRIOR AUTHORIZATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require prior authorization.

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| Benefit Description | You pay |
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| Inpatient hospital | You pay |
| Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. | \$100 per day up to 4 days per inpatient admission |
| Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home | Nothing |
| <i>Not covered:</i> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care • Collection and storage charges associated with donating blood | <i>All charges.</i> |

| Outpatient hospital or ambulatory surgical center | You pay |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------|
| <ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p> | \$100 copayment per treatment or service |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Blood and blood derivatives not replaced by the member</i> • <i>Collection and storage charges associated with donating blood</i> | <i>All charges.</i> |
| Extended care benefits/Skilled nursing care facility benefits | You pay |
| <p>Up to 120 days per member per calendar year when full-time skilled nursing care or confinement in a skilled nursing facility is medically necessary</p> <p>Services include:</p> <ul style="list-style-type: none"> • Bed, board, and general nursing; • Prescribed drugs and their administration; • Biologicals; • Supplies; • Durable medical equipment ordinarily furnished by the facility. | Nothing |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care,</i> • <i>Convalescent care, or respite care, including but not limited to meals, delivered to your home,</i> | <i>All charges.</i> |

| Hospice care | You pay |
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| <p>The Plan provides benefits for hospice care services if a participating provider provides the services, and you have less than six months to live in the judgment of the participating physician treating you. It is designed to help both the patient and the family. Hospice care emphasizes pain control and symptom management rather than life-sustaining measures. The Plan must authorize these services.</p> <p>Hospice care services include:</p> <ul style="list-style-type: none"> • Outpatient services; • Professional services of a physician; • Services of a psychologist, social worker or family counselor for individual and family counseling. | Nothing |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services or supplies not listed in the Hospice care program</i> • <i>Bereavement counseling</i> • <i>Services provided by an independent nurse, private duty nurse, or homemaker</i> • <i>Nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals</i> | <i>All charges.</i> |
| Ambulance | You pay |
| <ul style="list-style-type: none"> • Local professional ambulance service when medically appropriate | Nothing |

Section 5(d) Emergency services/accidents

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

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

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What is a medical emergency?

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

What to do in case of emergency:

When you face a life- or limb-threatening injury, go immediately to the nearest hospital emergency room or call 911. You are covered, whether or not you are in the service area at the time of the emergency. Once your condition has stabilized, please contact your PCP as soon as possible to inform him or her of your health status.

Emergencies at a participating facility:

Services and supplies that are emergency services are covered and subject to applicable copayments and coinsurance if provided at the emergency room of a participating hospital.

Emergencies at a non-participating facility:

Services and supplies that are provided for emergency care are covered when provided at a non-participating emergency room if it is not reasonably possible for you or someone acting on your behalf to go to a participating provider or a participating hospital. If you receive emergency treatment from a non-participating provider or facility, the provider may file a claim on your behalf. If the provider chooses **not** to file a claim for you, it will be your responsibility to file that claim to have the bill paid or to receive reimbursement for funds already paid. You will need to include all the codes for services received. If you have questions or help, you may contact our Customer Service department at 1-800-990-9247 (toll-free) or 816-271-1271.

Note: It is important to remember that even in an emergency, all hospital admissions and certain types of outpatient surgeries require prior authorization.

The Plan provides benefits for treatment of emergency medical conditions and supplies. You must notify the Plan of any admission within forty-eight (48) hours of the time of the admission or as soon as is reasonably possible. Emergency services are subject to the copayments and/or coinsurance requirements of the agreement as outlined in your benefits summary. If you require post evaluation or post stabilization services from a provider other than your primary care physician following an emergency room visit, a referral or appropriate authorization must be obtained from the Plan.

Note: The emergency room co-pay will be waived if the member is directly admitted to the facility.

| Benefit Description | You pay |
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| Emergency within our service area | You pay |
| <ul style="list-style-type: none"> Emergency care at a doctor's office Emergency care at an urgent care center Emergency care at an emergency room | \$15 primary care; \$30 specialist \$30 copayment \$100 copayment – copayment is waived if you are directly admitted as an inpatient. |
| <i>Not covered: Elective care or non-emergency care</i> | <i>All charges.</i> |
| Emergency outside our service area | You pay |
| <ul style="list-style-type: none"> Emergency care at a doctor's office Emergency care at an urgent care center Emergency care at an emergency room | \$30 copayment \$30 copayment \$100 copayment – copayment is waived if you are directly admitted as an inpatient. |
| <i>Not covered:</i> <ul style="list-style-type: none"> <i>Elective care or non-emergency care</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> | <i>All charges.</i> |
| Ambulance | You pay |
| Professional ambulance service when medically appropriate. Air or ground ambulance transportation to the nearest appropriate facility in order to obtain emergency services. Note: See 5(c) for non-emergency service. | 20% of plan allowance per trip |

Section 5(e) Mental health and substance abuse benefits

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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 PRIOR AUTHORIZATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require prior authorization.

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| Benefit Description | You pay |
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| Mental health and substance abuse benefits | You pay |
| <p>Inpatient</p> <p>The following services are covered when provided by a participating provider. Covered services include evaluation, crisis intervention and the treatment pursuant to a structured plan of treatment approved by the Plan for acute nervous or medical conditions, alcoholism or drug abuse or addiction.</p> <p>Benefits include:</p> <ul style="list-style-type: none"> • Acute inpatient; • Partial (Day) Hospitalization; • Intensive outpatient chemical dependency; • Residential (only on a case-by-case basis); • A day of partial, residential, or intensive outpatient chemical dependency counts as one-half day in accumulating the maximum number of inpatient days per calendar year. | <p>\$100 per day up to 4 days per inpatient admission</p> |
| <p>Outpatient benefits (referral required)</p> <p>Outpatient benefits include:</p> <ul style="list-style-type: none"> • Office visits if they are provided to you by a participating provider, and authorized by the Plan. • Office visits for short-term evaluation, crisis intervention, stabilization and short-term therapy for conditions which the participating provider treating you and the Plan determine can substantially benefit from short-term treatment. • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers | <p>\$30 specialist office visit</p> |

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| <p>Diagnosis or Assessment</p> <p>Additionally, coverage for diagnosis or assessment, but not dependent on findings, will be provided, to a maximum of two (2) sessions per calendar year, by a licensed psychiatrist, licensed psychologist, licensed professional counselor or licensed clinical social worker. No authorization or referral shall be required.</p> | <p>Nothing</p> |
| <p>Diagnostic tests</p> | <p>Nothing</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services we have not approved</i> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p> | <p><i>All charges.</i></p> |

Prior Authorization

To be eligible to receive these benefits, you must obtain a treatment plan and follow our authorization process. Your physician must contact the plan for authorization.

Please call 1-800-990-9247 (toll-free) or 816-271-1271 for prior authorization and referral information. You may call this number to locate a physician or to obtain a new copy of the provider directory

Limitation

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

Section 5(f) Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- Due to concerns with appropriate utilization, we require preauthorization for certain medications or classes of medication. To receive authorization, your physician will need to submit a statement of medical necessity to Community Health Plan.

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

- **Who can write your prescription?** A licensed participating provider, such as a physician, nurse practitioner, physician assistant, or dentist, must write the prescription for you.
- **Where you can obtain them?** You may fill the prescription at a participating pharmacy, a non-participating pharmacy, or by mail order. We pay a higher level of benefits when you use a participating pharmacy.
- **We use a formulary (preferred drug list).** A Pharmacy and Therapeutics (P&T) Committee comprised of practicing physicians and pharmacists make determinations for inclusion to the formulary. The committee takes into account the drug information presented as well as drawing on their clinical experience with the drugs to determine whether the drug should be included on the formulary. A formulary drug must demonstrate better safety, efficacy, ease of administration, clinical outcomes and price, as well as other factors, for inclusion.

Formulary drug (preferred): An FDA approved medication, which does not have a generic equivalent, that offers better safety, efficacy, compliance, ease of administration, better clinical outcome or price than other medications in the same drug class. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-800-990-9247 (toll-free) or 816-271-1271.

Non-formulary drug (non-preferred): An FDA approved medication, which may or may not have a generic equivalent, that does not demonstrate better safety, efficacy, ease of administration, better clinical outcomes or price than medications in the same drug class which are included in the formulary. You pay the highest copayment for these drugs.

Note: In the event your provider prescribes a brand name drug with no generic equivalent, you will be responsible for the applicable formulary or non-formulary copayment.

- **These are the dispensing limitations.** When a prescription drug is purchased at a participating pharmacy, you must pay the applicable copayment for each 34-day supply (e.g. up to 34 days = 1 copayment; 35-68 days = 2 copayments; 69-102 days = 3 copayments). When a prescription drug is purchased through the Pharmacy Benefit Manager (PBM) mail order, the member will only pay two (2) copayments for up to a 102-day supply. If you would like more information about the mail order program, please call Community Health Plan at 1-800-990-9247 (toll-free) or 816-271-1271. When another prescription is needed from the mail order PBM and you have not used/consumed 70% of the medication, the PBM will contact you with your options for fulfillment of the prescription.

We may impose administrative limits on the quantity or frequency by which a prescription drug may be dispensed. These limits will be based on recommendations of the drug manufacturer or by participating physicians and pharmacists

- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally approved generic drug is available, and your physician has not specified “Dispense as Written” for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.
- **Why use generic drugs?** To reduce your out-of-pocket expenses! Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

You can save money by using generic drugs. However, you and your provider have the option to request a name brand if a generic option is available. Using the most cost-effective medication saves money.

- **When you have to file a claim.** You will have to file a claim when you have a prescription filled at a non-participating pharmacy. (See Section 7, under “Prescription Drugs”, pages 39-40.)

| Benefit Description | You pay |
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| <p>Covered medications and supplies</p> <p>We cover the prescription drugs and supplies that have been approved for use in the United States by the Federal Food and Drug Administration (FDA). Your prescriptions may be obtained from a participating pharmacy or from our PBM mail order program.</p> <p>Prescription drugs include:</p> <ul style="list-style-type: none"> • “Legend” drugs, that is, drugs or medications that by Federal or State law can only be dispensed upon written prescription from an authorized prescriber • Compound medications that contain at least one legend drug in a therapeutic amount • Insulin • Syringes, needles, lancets, autolets, test tablets, test tape, acetone test tablets, oral anti-diabetic agents and blood glucose monitors • Contraceptive drugs and devices • Growth hormones <p>Limited benefit medication:</p> <ul style="list-style-type: none"> • Drugs to treat sexual dysfunction are limited to brand name and a quantity of 4 pills per 34-day supply. | <p>\$10 per generic drug up to a 34-day supply</p> <p>\$25 per formulary brand name drug up to a 34-day supply</p> <p>\$40 per non-formulary brand name drug up to a 34-day supply</p> <p>Note: If there is no generic equivalent available, you will be required to pay the applicable brand name copayment.</p> <p>Mail order: \$20 for generic, \$50 for brand name and \$80 for non-formulary, up to a 102-day supply.</p> |
| <p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Prescription drugs approved by the FDA for experimental or investigative services</i> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Nonprescription medicines</i> • <i>Appetite suppressants, anorexiant, and anti-obesity drugs</i> • <i>Immunizing agents, except those listed for adults and children</i> • <i>Replacement for lost, destroyed or stolen prescriptions</i> | <p><i>All charges.</i></p> |

Section 5(g) Special features

| Feature | Description |
|----------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Flexible benefits option | <p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. |
| Community Health Line (24-Hour Nurse Health Line) | <p>For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-800-455-2476 (toll-free) and talk with a registered nurse who will discuss treatment options and answer your health questions.</p> |
| High risk pregnancies | <p>Members are identified for the plan's high-risk pregnancy program in various ways: through claims data, hospital or emergency room visits, OB-GYN referral. Participation is strictly voluntary.</p> |
| Centers of excellence | <p>The Plan uses the Transplant Resource Services (TRS) Centers of Excellence Network through United Resource Network.</p> |
| Travel benefit/services overseas | <p>You are covered while traveling overseas. However, in most cases, you will have to pay for services and prescriptions out of your own pocket. When you return home, submit your receipts or bills to the plan for reimbursement, minus any applicable copayments.</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 provide benefits for dental services only when such services are for treatment of an accidental injury.
- 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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| Accidental injury benefit | You pay |
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| <p>We cover services that are limited to treatment of natural teeth and the purchase, repair or replacement of dental prosthesis needed as a direct result of an accidental injury (except injury resulting from biting or chewing) that occurs while coverage under the agreement is in force.</p> <p>Note: Treatment must be completed <i>within twelve months of the date of the accident</i> to be considered a covered service, unless the medical condition of the covered person prevents treatment from being rendered within twelve months of the date of the accident.</p> | <p>\$30 specialist office visit</p> <p>\$100 outpatient surgery copayment</p> <p>\$100 per day up to 4 days per inpatient admission</p> |

Dental benefits

We have no other dental benefits.

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

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

Routine Vision Care

Must be obtained from a Vision Service Plan (VSP) provider. Covered services include:

- Exam Plus with Annual Eye Exam
- Exam Copayment \$10.00
- Out-of-Network Exam Allowance \$35
- 20% discount off doctor's U&C fees for prescription lenses and frames with purchase of a pair of prescription glasses
- 20% discount off doctor's U&C fees for non-covered lens options
- 15% discount off U&C professional fees on elective and necessary contact lens (discount does not apply to materials)

Other Alternative Medicine Services

- Acupuncture
- Aromatherapy
- Biofeedback
- Hypnotherapy
- Health Club Programs
- Massage Therapy
- Vision Providers (not contracted with Vision Service Plan)

Note: These services are available through non-contracted providers with reduced rates for plan members. The Plan does not pay for these services. You must pay all services you receive at the time of service.

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

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

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800-990-9247 (toll-free) or 816-271-1271.

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

Submit your claims to:

Community Health Plan
Heartland Health Business Plaza
Attn: Claims Department
137 North Belt Highway
St. Joseph, MO 64506

Prescription drugs

When a prescription drug is purchased at a *participating* pharmacy and you pay the usual and customary price rather than your copayment, you must obtain a receipt from the participating pharmacy which identifies:

- the participating pharmacy;
- the patient;
- the date billed;
- the National Drug Code for the prescription;
- the prescribing provider;
- the quantity;
- the days supply; and
- the amount charged.

You must submit the receipt along with a claim form to our Pharmacy Benefit Manager for reimbursement.

When a prescription drug is purchased at a *non-participating* pharmacy, you must pay the non-participating pharmacy for the cost of the prescription drug and you must obtain a receipt from the non-participating pharmacy which identifies:

- the non-participating pharmacy;

- the patient;
- the date billed;
- the National Drug Code for the prescription;
- the prescribing provider;
- the quantity;
- the days supply; and
- the amount charged.

You must submit the receipt along with a claim form to our Pharmacy Benefit Manager for reimbursement. You may call Customer Service at 1-800-990-9247 (toll-free) or 816-271-1271 to obtain the claim form.

Note: If we fail to furnish the claim form to you within fifteen (15) days after we have received notice of a claim, you shall be deemed to have complied with the requirements for receiving reimbursement. At this point, you do not need to submit a claim form, but you must submit written proof of the loss that covers the occurrence, character and extent of the loss for which the claim is made as long as the proof of loss is submitted within 365 days of the date the prescription drug was purchased (unless it is not reasonably possible to submit the claim within this time period).

With respect to a prescription drug that is purchased at a non-participating pharmacy, you will be reimbursed as follows:

- You will pay for the cost of the prescription drug and submit a claim form to the Pharmacy Benefit Manager.
- You will be reimbursed for the cost of the prescription drug (at the contracted amount) minus the copayment that would have been applicable if the prescription drug had been purchased at a participating pharmacy.

Submit your claims to:

PharmaCare, Inc.
 Attn: DMR
 695 George Washington Highway
 Lincoln, RI 02865

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

| Step | Description |
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| 1 | <p>Ask us in writing to reconsider our initial decision. You must:</p> <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: <p style="margin-left: 40px;">Community Health Plan Heartland Health Business Plaza Attn: Appeals Analyst 137 North Belt Highway St. Joseph, MO 64506;</p> <p>and</p> <ol style="list-style-type: none">Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. |
| 2 | <p>We have 30 days from the date we receive your request to:</p> <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial – go to step 4; orAsk you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3. |
| 3 | <p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p> |
| 4 | <p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630.</p> |

The disputed claims process (*continued*)

Send OPM the following information:

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

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

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

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

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

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

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

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

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

- a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 202/606-0737 between 8 a.m. and 5 p.m. eastern time, 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 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you 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’ (NAIC) guidelines.

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

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

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has 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. (Coverage through private prescription drug plans will be available starting in 2006).

When you are enrolled in Original Medicare along with this plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by Community Health Plan.

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

- 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 claim 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 claim, call us at 1-800-990-9247 (toll-free) or 816-271-1271.

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.

| Primary Payer Chart | | |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------|------------------------------------|
| A. When you - or your covered spouse - are age 65 or over and have Medicare and you... | The primary payer for the individual with Medicare is... | |
| | Medicare | This plan |
| 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. When you or a covered family member... | | |
| 1) Have Medicare solely based on end stage renal disease (ESRD) and... • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period) | | ✓ |
| • It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD | ✓ | |
| 2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and... • This plan was the primary payer before eligibility due to ESRD | | ✓ for 30-month coordination period |
| • Medicare was the primary payer before eligibility due to ESRD | ✓ | |
| C. When either you or a covered family member are eligible for Medicare solely due to disability and you... | | |
| 1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee | | ✓ |
| 2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant | ✓ | |
| D. When you are covered under the FEHB Spouse Equity provision as a former spouse | ✓ | |

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

• 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.

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 or coinsurance. 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.

TRICARE and CHAMPVA

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

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

Medicaid

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

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

your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

| | |
|-------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Calendar year | January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year. |
| Coinsurance | Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 11. |
| Copayment | A copayment is a fixed amount of money you pay when you receive covered services. See page 11. |
| Covered services | Care we provide benefits for, as described in this brochure. |
| Custodial care | Care furnished mainly to train or assist in personal hygiene or other activities of normal daily living such as dressing, feeding, and walking, rather than to provide medical treatment. |
| Deductible | A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. We do not have a deductible. See page 11. |
| Experimental or investigational services | Those services, which include drugs, devices, medical treatment or procedures, and related services and supplies, which Community Health Plan determines to be Experimental or Investigative. |
| Group health coverage | Entity or entities identified in the group contract or request for proposal as the entity to which the group contract or request for proposal is issued which is acting on its own behalf and as the agent for subscribers and their dependents in securing this agreement. |
| Medical necessity | Services or supplies required to identify or treat your illness or injury and which, as determined by Community Health Plan subject to the right to submit a complaint: (1) consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or Injury; (2) appropriate with regard to standards of good medical practice; (3) not solely for your convenience, or for the convenience of your primary care physician, consultant physician, participating hospital, participating facility, participating provider or other health care provider; and (4) the most appropriate supply or level of service which can be safely provided to you. When specifically applied to care as an inpatient, it further means that diagnosis or treatment of your medical symptoms or conditions cannot be safely provided to you as an outpatient. |
| Plan allowance | Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: the allowable charge is the lesser of: 1) the amount the participating provider has agreed to accept as payment in full at the time of claim payment, or 2) Community Health Plan's basic fee schedule amount for the same services or supplies, or 3) the participating provider's billed charges. |
| Us/we/our/plan | Us, we, our, or plan refers to Community Health Plan. |
| You/your/yours | You, your, yours refers to the enrollee and each covered family member. |

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

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

- **Where you can get information about enrolling in the FEHB Program**

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

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

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

- **Types of coverage available for you and your family**

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive 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 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 January 1. If you joined this plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. 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 2003 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 former spouse to provide 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 Web site, 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 Federal job, if you are a covered dependent child and you turn 22 or marry, etc. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

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

- **Converting to individual coverage**

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

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

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

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

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

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

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at 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 information about Federal and State agencies you can contact for more information.

Section 12. Two Federal Programs complement FEHB benefits

Important information

OPM wants to make sure you are aware of two Federal programs that complement the FEHB Program. First, the **Federal Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside pre-tax 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)** helps cover long term care costs, which are 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 of a "family member" than is used under the FEHB Program to provide benefits by your FEHB plan.
- The maximum annual 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 dependent children under age 13, or any person of any age whom you claim as a dependent on your Federal Income Tax return (and who is mentally or physically incapable of self care).
- The maximum annual amount that can be allotted for the DCFSA is \$5,000. The minimum annual 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 childcare 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 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 is responsible for the 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 FSAs. *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 fewer than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers have signed on to participate. Under IRS law, FSAs are not available to annuitants. Also, the U.S. Postal Service and the Judicial Branch, among others, have their own plans with slightly different rules. However, 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 claims for eligible expenses.

The FSAFEDS Calculator at www.FSAFEDS.com will help you plan your FSA

• **What can my HCFSA pay for?**

Every FEHB health plan includes cost sharing features, such as 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. The out-of-pocket costs are summarized on page 11 and detailed throughout this brochure. Your HCFSA will reimburse you for such costs when they are for tax-deductible medical care for you and your dependents 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>. If you do not see your service or expense listed in Publication 502, please call a 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:

| Annual Tax Savings Example | With FSA | Without FSA |
|----------------------------------------------|-----------------|--------------------|
| 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 |
| Your tax savings: | \$576 | -\$0- |

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 the retirement system in which 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 \$50,000) would be eligible to be deducted on your Federal Income Tax return. In addition, money set aside through an HCFSA is also exempt from FICA taxes. This exemption is not available on your Federal Income Tax return.

Paperless Reimbursement – This plan participates in the FSAFEDS paperless reimbursement program. When you enroll for your HCFSA, you will have the opportunity to enroll for paperless reimbursement. If you do, we will send FSAFEDS the information they need to reimburse you for your out-of-pocket costs so you can avoid filing paper claims.

- **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 and download the Dependent Care Tax Credit Worksheet from the Forms and Literature page 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?**

Note: 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, 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
- Telephone: 1-877-FSAFEDS (1-877-372-3337)
- TTY: 1-800-952-0450

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 options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** In order to qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of 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 future change in your 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. Newly married spouses of employees 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.

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Summary of benefits for Community Health Plan - 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

| Benefits | You pay | Page |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|----------|
| Medical services provided by physicians: <ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office | \$15 primary care/OB-GYN office visit \$30 specialist office visit | 14 |
| Services provided by a hospital: <ul style="list-style-type: none"> • Inpatient • Outpatient | \$100 per day up to 4 days per admission \$100 per treatment or service | 26 27 |
| Emergency benefits <ul style="list-style-type: none"> • In area • Out-of-area | \$100 copayment per incident \$100 copayment per incident | 30 30 |
| Mental health and substance abuse treatment: <ul style="list-style-type: none"> • Inpatient • Outpatient office visits | \$100 per day up to 4 days per admission \$30 specialist office visit | 31 31 |
| Prescription drugs: <ul style="list-style-type: none"> • Participating plan pharmacy (up to 34-day supply) • Mail order (up to 102-day supply) | \$10 generic/\$25 formulary brand name/\$40 non-formulary brand name \$20 generic/\$50 formulary brand name/\$80 non-formulary brand name | 34 34 |
| Special features: <ul style="list-style-type: none"> • Flexible benefits option • Community Health Line (24-hour nurse health line) • High Risk Pregnancies • Centers of excellence • Travel benefit/services overseas | | 35 |
| Dental care | No benefit. | 36 |
| Protection against catastrophic costs (Your catastrophic protection out-of-pocket maximum)..... | Nothing after \$2,500/individual or \$5,000/family Prescription copayments do not apply toward the out-of-pocket maximum. | 11 |

