

# HealthSpring

<http://www.myhealthspring.com>



# 2002

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## A Health Maintenance Organization

**Serving:** Serving the Nashville metroplex and 27 counties of Middle Tennessee.

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



This Plan has URAC accreditation from the American Accreditation Healthcare Commission/URAC. See the 2002 Guide for more information on accreditation.

### Enrollment codes for this Plan:

- 6K1 Self Only
- 6K2 Self and Family

**Special notice:** This Plan is offered for the first time under the Federal Employees Health Benefits Program during the 2001 Open Season.

Authorized for distribution by the:



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



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## Table of Contents

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Introduction.....	4
Plain Language .....	4
Inspector General Advisory .....	4
Section 1. Facts about this HMO plan .....	6
How we pay providers .....	6
Your rights .....	6
Service area.....	7
Section 2. We are a new plan.....	8
Section 3. How you get care .....	9
Identification cards.....	9
Where you get covered care.....	9
• Plan providers.....	9
• Plan facilities .....	9
What you must do to get covered care.....	9
• Primary care.....	9
• Specialty care.....	10
• Hospital care.....	11
Circumstances beyond our control.....	11
Services requiring our prior approval.....	11
Section 4. Your costs for covered services .....	13
• Copayments .....	13
• Coinsurance .....	13
Your catastrophic protection out-of-pocket maximum .....	13
Section 5. Benefits .....	14
Overview.....	14
(a) Medical services and supplies provided by physicians and other health care professionals .....	15
(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	25
(c) Services provided by a hospital or other facility, and ambulance services.....	30
(d) Emergency services/accidents .....	33
(e) Mental health and substance abuse benefits.....	35
(f) Prescription drug benefits.....	37

(g) Special features .....	40
• HealthSpring Disease Management Program	
• Quarterly newsletters	
• Centers of excellence for transplant/heart surgery	
• Hospitals program	
(h) Dental benefits.....	41
(i) Non-FEHB benefits available to Members.....	42
Section 6. General exclusions -- things we don't cover.....	43
Section 7. Filing a claim for covered services .....	44
Section 8. The disputed claims process.....	45
Section 9. Coordinating benefits with other coverage .....	47
When you have...	
• Other health coverage .....	47
• Original Medicare.....	48
• Medicare managed care plan .....	49
TRICARE/Workers' Compensation/Medicaid .....	50
Other Government agencies.....	50
When others are responsible for injuries.....	50
Section 10. Definitions of terms we use in this brochure.....	51
Section 11. FEHB facts .....	52
Coverage information.....	52
• No pre-existing condition limitation .....	52
• Where you get information about enrolling in the FEHB Program .....	52
• Types of coverage available for you and your family .....	52
• When benefits and premiums start .....	53
• Your medical and claims records are confidential .....	53
• When you retire.....	53
When you lose benefits .....	53
• When FEHB coverage ends .....	53
• Spouse equity coverage.....	53
• Temporary Continuation of Coverage (TCC) .....	53
• Converting to individual coverage .....	54
• Getting a Certificate of Group Health Plan Coverage.....	54
Long term care insurance is coming later in 2002 .....	55
Index.....	56
Summary of benefits .....	57
Rates .....	Back cover

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## Introduction

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HealthSpring, Inc.  
44 Vantage Way, Suite 300  
Nashville, TN 37228

This brochure describes the benefits of HealthSpring under our contract (CS 2865) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

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

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002.

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## Plain Language

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

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

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

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## Inspector General Advisory

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### Stop health care fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at (615) 291-5030 and explain the situation.
- If we do not resolve the issue, call or write

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

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

**Penalties for Fraud**

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

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## Section 1. Facts about this HMO plan

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

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductible described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

**You should join an HMO because you prefer the Plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.**

### How we pay providers

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

### Your Rights

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

As a member of HealthSpring, you have rights:

- Confidentiality – Your medical information is confidential. HealthSpring is subject to applicable state and federal laws governing the release of your medical information.
- Consent – Your consent is required for treatment, unless you have an emergency, your life and health are in serious danger or you are unable to provide affirmative verbal or written consent. If your written consent is required for special procedures such as surgery, be sure you understand the procedure and why it is advised. Should you decide you do not want a particular treatment, discuss your concerns with your Primary Care Physician.
- Medical Records – You have the right to access your personal medical records maintained at your physician's office as provided by state and federal laws.
- Advance Directives – Legal provisions allow your wishes to be carried out when you are incapable of making health care decisions. Your health care professional or legal advisor can assist you with making a living will, a durable power of attorney for health care, or a mental health advance declaration a part of your medical records.
- Voice Grievances – You have the right to voice grievances about HealthSpring or the medical care you receive.
- Information – You have the right to be provided with information about HealthSpring, their participating providers, and your rights and responsibilities.

If you want more information about us, call (615) 291-5030 in Nashville or 1-800-917-3888 from outside Nashville, or write us at P. O. Box 20000, Nashville, TN 37202-9613. You may also contact us by visiting our website at <http://www.myhealthspring.com>.

## Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is the following Middle Tennessee counties:

### MIDDLE TENNESSEE:

Bedford	Humphreys	Rutherford
Cannon	Lawrence	Smith
Cheatham	Lewis	Stewart
Coffee	Macon	Sumner
Davidson	Marshall	Trousdale
DeKalb	Maury	Warren
Dickson	Montgomery	Wayne
Franklin	Moore	Williamson
Hickman	Robertson	Wilson

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 employment or retirement office.

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## **Section 2. We are a new plan**

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This Plan is new to the FEHB Program. We are being offered for the first time during the 2001 open season.

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## Section 3. How you get care

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### Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (615) 291-5030 in Nashville or from outside Nashville 1-800-917-3888.

### Where you get covered care

You get care from “Plan Providers” and “Plan Facilities.” You pay only copayments, and you will not have to file claims.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards. Our staff of medical professionals continually credentials and monitors participating doctors and hospitals to assure the network meets strict industry standards of care.

Some Primary Care Physicians belong to independent physician associations (IPAs). IPAs are groups of physicians who contract with managed care organizations to provide health care services. IPA networks may include general physicians or specialists like cardiologists and orthopedists. **Note: Physicians in an IPA may refer only to other physicians and hospitals affiliated with the same IPA. Members should look to their HealthSpring Provider Directory or call HealthSpring’s Customer Service line, (615) 291-5030 to find if a PCP has an IPA relationship.**

We list Plan providers in the provider directory, which we update periodically. The provider list is also on our website. The directory lists IPA primary care and specialty providers and independently contracted primary care providers and specialists. The provider list includes physician office addresses and phone numbers.

- **Plan facilities**

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

### What you must do to get covered care

**It depends on the type of care you need. First,** you and each family member must choose a Primary Care Physician (PCP). This decision is important since your Primary Care Physician provides or arranges most of your health care. Selection must be made from the HealthSpring network of Primary Care Physicians. Some Primary Care Physicians belong to IPAs that refer patients only to other Providers in the same IPA. **Members should look to their HealthSpring Provider Directory or call HealthSpring’s Customer Service line, (615) 291-5030 to find if a PCP has an IPA relationship.** Once a PCP has been selected, you should schedule an initial appointment with him/her to establish a physician/patient relationship.

- **Primary care**

Your Primary Care Physician can be a family practitioner, general practitioner, internist, or pediatrician. Your Primary Care Physician cannot be an OB/GYN. Your Primary Care Physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change Primary Care Physicians or if your Primary Care Physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your Primary Care Physician will refer you to a specialist for needed care. When you receive a referral from your Primary Care Physician, you must return to the Primary Care Physician after consultation, unless your Primary Care Physician authorized a certain number of visits without additional referrals. The Primary Care Physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your Primary Care Physician gives you a referral. However, you may see a network gynecologist for a routine examination once each calendar year without a referral. You do not need a referral for this annual exam. If you require additional care following your exam, you will need a referral from your Primary Care Physician. A complete list of HealthSpring gynecologists follows the Primary Care Physician listing in the provider directory.

**Remember: Some physician groups in the directory refer to a limited number of OB/GYNs. If your Primary Care Physician belongs to an IPA, you must choose an obstetrician/gynecologist who belongs to the same IPA.**

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your Primary Care Physician will work with the specialists and the Plan to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your Primary Care Physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your Primary Care Physician before seeing your specialist. Your Primary Care Physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your Primary Care Physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause; or
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
  - reduce our service area and you enroll in another FEHB Plan,you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (615) 291-5030 in Nashville or 1-800-917-3888. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

### **Circumstances beyond our control**

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

### **Services requiring our prior approval**

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

We call this review and approval process precertification. There are two review processes associated with review and approval of services. Precertification involves review of elective services 5-7 days before the service occurs. Authorization involves urgent/emergent services and usually occurs within one business day of the service. This review may be before or after the service occurs. Your Plan physician is responsible for obtaining approval for services. Below are some of the services requiring prior approval.

- All inpatient hospital care
- Extended care/skilled nursing facilities
- Mental Health or substance abuse services(through MHNet)
- Inpatient rehab services
- Cardiac and Pulmonary Rehab
- Organ and tissue transplants
- Infertility procedures
- Specialty referrals
- Home Health Care
- Durable Medical Equipment
- Orthopedic and prosthetic devices
- Growth Hormone Therapy
- Certain outpatient oral or injectable drugs
- Hospice
- Outpatient surgery
- Surgical treatment of morbid obesity
- Any request for non-par provider

Your Primary Care Physician must obtain a referral for specialty care physician services. If you receive services without obtaining a referral you may be obligated to pay for unauthorized services.

Your Primary Care Physician or Specialty Care Physician is responsible for calling the Health Services Department to obtain precertification or authorization. Failure to obtain authorization or precertification may result in payment denial. You, or a provider on your behalf, may appeal any decision as outlined in the appeal and grievance process.

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

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## Section 4. Your costs for covered services

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

- **Copayments**

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

Example: When you see your Primary Care Physician you pay a copayment of \$10 per office visit and when you go in the hospital, you pay nothing per admission.

- **Coinsurance**

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

Example: In our Plan, you pay 20% of the charges for the treatment of infertility.

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

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

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## Section 5. Benefits – OVERVIEW

(See page 57 for a benefits summary.)

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**NOTE:** This benefits section is divided into subsections. Please read the important things 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, claim filing advise, or more information about your benefits, contact us at (615) 291-5030 in Nashville or 1-800-917-3888 from outside Nashville or at our website at [www.myhealthspring.com](http://www.myhealthspring.com).

(a) Medical services and supplies provided by physicians and other health care professionals.....	15
• Diagnostic and treatment services	
• Lab, X-ray, and other diagnostic tests	
• Preventive care, adult	
• Preventive care, children	
• Maternity care	
• Family planning	
• Infertility services	
• Allergy care	
• Treatment therapies	
• Physical and occupational therapies	
• Speech therapy	
• Hearing services (testing, treatment, and supplies)	
• Vision services (testing, treatment, and supplies)	
• Foot care	
• Orthopedic and prosthetic devices	
• Durable medical equipment (DME)	
• Home health services	
• Chiropractic	
• Alternative treatments	
• Educational classes	
(b) Surgical and anesthesia services provided by physicians and other health care professionals .....	25
• Surgical procedures	
• Reconstructive surgery	
• Oral and maxillofacial surgery	
• Organ/tissue transplants	
• Anesthesia	
(c) Services provided by a hospital or other facility, and ambulance services .....	30
• Inpatient hospital	
• Outpatient hospital or ambulatory surgical center	
• Extended care benefits/skilled nursing care facility benefits	
• Hospice care	
• Ambulance	
(d) Emergency services/accidents .....	33
• Medical emergency	
• Ambulance	
(e) Mental health and substance abuse benefits .....	35
(f) Prescription drug benefits .....	37
(g) Special features .....	40
• HealthSpring Disease Management Program	
• Quarterly Newsletters	
• Centers of excellence for transplants/heart surgery	
• Hospitalist Program	
(h) Dental benefits .....	41
(i) Non-FEHB benefits available to Plan Members.....	42
Summary of benefits .....	57

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

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

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- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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Benefit Description	You pay
<b>Diagnostic and treatment services</b>	
Professional services of physicians <ul style="list-style-type: none"> <li>• In physician’s office</li> <li>• Office medical consultation</li> <li>• Second surgical opinion</li> <li>• During a hospital stay</li> <li>• In a skilled nursing facility</li> <li>• At home</li> </ul>	\$10 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Services, drugs, or supplies you receive while you are not enrolled in this Plan;</i></li> <li>• <i>Services or supplies related to self-treatment; or services or supplies provided by any person related to you by blood or marriage or any person who resides in your immediate household;</i></li> <li>• <i>Services and supplies related to routine care, elective surgery or mental health received by a student member while out of the service area;</i></li> </ul>	<i>All charges</i>

*Diagnostic and treatment services- Continued on next page*

Diagnostic and treatment services <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>• Charges for telephone calls between a provider's office and the member for consultations or medical management;</li> <li>• Benefits for services otherwise covered when you have refused to comply with or have terminated scheduled services or treatment against the advice of a participating physician or behavioral health provider; or</li> <li>• Charges incurred due to your failure to keep a scheduled appointment or charges to complete a claim form or to provide medical records.</li> </ul>	All charges
Lab, X-ray and other diagnostic tests	
<p>Tests, such as:</p> <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine Mammograms</li> <li>• Cat Scans/MRI</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	\$10 per visit
Preventive care, adult	
<p>Routine screening, such as:</p> <ul style="list-style-type: none"> <li>• Total Blood Cholesterol – once every three years</li> <li>• Colorectal Cancer Screening, including <ul style="list-style-type: none"> <li>- Fecal occult blood test</li> <li>- Sigmoidoscopy, screening -- every five years starting at age 50</li> </ul> </li> </ul> <p>Prostate Specific Antigen (PSA test) – one annually for men age 40 and older</p>	\$10 per office visit
<p>Routine pap test</p> <p><b>Note:</b> The pap test is covered at no additional charge when provided in conjunction with an office visit. See <i>Diagnosis and Treatment</i>, above.</p>	\$10 per office visit

*Preventive care, adult – Continued on next page*

Preventive care, adult <i>(continued)</i>	You pay
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> <li>• From age 35 through 39, one during this five year period</li> <li>• Over age 40, one every calendar year</li> </ul>	\$10 per office visit
Routine immunizations, limited to: <ul style="list-style-type: none"> <li>• Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations)</li> <li>• Influenza/Pneumococcal vaccines, annually, age 65 and over</li> </ul>	\$10 per office visit
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>Services related to obtaining or continuing employment or medical research.; or</i></li> <li>• <i>Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i></li> </ul>	<i>All charges</i>
Preventive care, children	
<ul style="list-style-type: none"> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> <li>• Well-child care charges for routine examinations, immunizations and care (under age 22)</li> </ul>	\$10 per office visit
<ul style="list-style-type: none"> <li>• Examinations, such as:               <ul style="list-style-type: none"> <li>– Eye exams through age 18 to determine the need for vision correction.</li> <li>– Ear exams through age 18 to determine the need for hearing correction.</li> </ul> </li> </ul>	\$10 per office visit
Maternity care	
Complete maternity (obstetrical) care, such as: <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> </ul> <p><b>Note:</b> Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need to precertify your normal delivery. See page 11 for other circumstances, such as extended stays for you or your baby.</li> <li>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.</li> </ul>	\$10 for initial office visit to confirm pregnancy. All additional care related to the pregnancy is covered for no additional copays.

*Maternity care – Continued on next page*

Maternity care <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>We cover routine nursery care of the newborn child during the covered portion of the mother’s maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment.</li> <li>We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).</li> </ul>	
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex</i></p>	<p><i>All charges</i></p>
Family planning	
<p>A broad range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>Voluntary sterilization</li> <li>Surgically implanted contraceptives (such as Norplant)</li> <li>Injectable contraceptive drugs (such as Depo-Provera)</li> <li>Intrauterine devices (IUDs)</li> <li>Diaphragms</li> </ul> <p><b>Note:</b> We cover oral contraceptives under the Prescription Drug benefit.</p>	<p>\$10 per office visit 20% coinsurance \$35 copay \$35 copay \$20 copay</p>
<p><i>Not covered: Reversal of voluntary surgical sterilization; genetic counseling</i></p>	<p><i>All charges</i></p>
Infertility services	
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> <li>Artificial insemination <ul style="list-style-type: none"> <li><i>– Intravaginal insemination (IVI)</i></li> <li><i>– Intracervical insemination (ICI)</i></li> <li><i>– Intrauterine insemination (IUI)</i></li> </ul> </li> </ul>	<p>\$10 per office visit &amp; 20% coinsurance for treatment</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> <li><i>– in vitro fertilization</i></li> <li><i>– embryo transfer, gamete GIFT and zygote ZIFT</i></li> <li><i>– Zygote transfer</i></li> </ul> </li> </ul>	<p><i>All charges</i></p>

*Infertility services – Continued on next page*

Infertility services (continued)	You pay
<ul style="list-style-type: none"> <li>• Services and supplies related to excluded ART procedures;</li> <li>• Treatment of infertility when the cause for the infertility was a previous sterilization;</li> <li>• Cost of donor sperm;</li> <li>• Services and supplies related to sperm preservation;</li> <li>• Fertility drugs;</li> <li>• Cost of donor egg</li> </ul>	<i>All charges</i>
<b>Allergy care</b>	
<p>Testing and treatment</p> <p>Allergy injections</p> <p>Allergy serum</p>	<p style="text-align: center;">\$10 per office visit</p> <p style="text-align: center;">\$10 per office visit</p> <p style="text-align: center;">Nothing</p>
<p><i>Not covered: provocative food testing and sublingual allergy desensitization.</i></p>	<p><i>All charges</i></p>
<b>Treatment therapies</b>	
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> <p><b>Note:</b> High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 28.</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</li> <li>• Dialysis – Hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> <li>• Growth hormone therapy (GHT)</li> </ul> <p><b>Note:</b> Growth hormone is covered under the prescription drug benefit. We will only cover GHT when we preauthorize the treatment. Your physician will be given a prior authorization form and asked to submit information that establishes that GHT is medically necessary. This process must occur before you begin treatment or this treatment may not be covered. If you do not obtain precertification or if we determine that GHT is not medically necessary, we will not cover the GHT.</p>	<p>\$10 per office visit</p>

*Treatment therapies – Continued on next page*

Treatment therapies <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Non-medical ancillary services, testing and treatment which include, but are not limited to, such services as: vocational rehabilitation, cognitive behavioral training/therapy, sleep therapy, recreational therapy, employment counseling, educational testing or therapy for learning disabilities or mental retardation, hypnotherapy, assertiveness training, stress management, biofeedback and marital sex or family therapy; or</i></li> <li>• <i>Recreational Therapy.</i></li> </ul>	<p><i>All charges</i></p>
<b>Physical and occupational therapies</b>	
<ul style="list-style-type: none"> <li>• 60 visits per calendar year for the services of each of the following (including respiratory therapy) combined therapies <ul style="list-style-type: none"> <li>– qualified physical therapists; and</li> <li>– occupational therapists.</li> </ul> </li> </ul> <p><b>Note:</b> We cover therapy only to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.</p>	<p>\$10 per outpatient visit; Nothing per visit during covered inpatient admission</p>
<p>Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up six (6) weeks of treatment, if begun within 90 days following discharge from the initial hospital.</p>	<p>\$10 per outpatient visit</p>
<p><i>Not covered: exercise programs.</i></p>	<p><i>All charges</i></p>
<b>Speech therapy</b>	
<ul style="list-style-type: none"> <li>• 30 visits per calendar year</li> </ul>	<p>\$10 per office visit</p>
<b>Hearing services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>• Hearing screening</li> <li>• Hearing testing for children through age 18 (see <i>Preventive care, children</i>)</li> </ul>	<p>\$10 per office visit</p>

*Hearing services – Continued on next page*

<b>Hearing services (testing, treatment, and supplies) (continued)</b>	<b>You pay</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• All other hearing testing;</li> <li>• Hearing aids, testing and examinations for hearing aids;</li> <li>• Charges and supplies related to hearing aids;</li> <li>• Cochlear implants; or other hearing devices</li> </ul>	<p><i>All charges</i></p>
<b>Vision services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>• Treatment of eye disease or injury</li> <li>• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as cataracts)</li> <li>• Eye exam, including refraction, by a participating provider, once every 12 months</li> <li>• Eye exam to determine the need for vision correction for children through age 18 (see Preventive care, children)</li> </ul>	<p>\$10 per office visit</p>
<ul style="list-style-type: none"> <li>• Contact lenses used to treat Keratoconus</li> </ul>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Eyeglasses (lenses and frames, contact lenses);</li> <li>• Eyeglasses for glaucoma patients;</li> <li>• Eye exercises and orthoptics; or</li> <li>• Radial keratotomy and other refractive surgery.</li> </ul>	<p><i>All charges</i></p>
<b>Foot care</b>	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Routine foot care or the treatment of flat feet, corns, calluses, toe nails, fallen arches, weak feet, chronic foot strain, or symptomatic complaints relating to the feet, unless determined by the Plan Medical Director to be Medically Necessary in the preventive treatment of Diabetics;</li> </ul>	<p><i>All charges</i></p>

*Foot care – Continued on next page*

Foot care <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>• Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above;</li> <li>• Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by surgery); or</li> <li>• Foot orthotics.</li> </ul>	
Orthopedic and prosthetic devices	
<p><b>Note:</b> The maximum plan allowance for external orthopedic and prosthetic devices and DME is limited to a combined benefit of \$1,500.</p> <ul style="list-style-type: none"> <li>• Artificial limbs and eyes;</li> <li>• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy;</li> <li>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome;</li> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, surgically implanted breast implants following mastectomy, and lenses following cataract removal.</li> </ul> <p><b>Note:</b> We pay for internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See 5(b) for coverage of the surgery to insert the device.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups;</li> <li>• Lumbosacral supports;</li> <li>• Corsets, trusses, elastic stockings, support hose, and other supportive devices;</li> <li>• Penile prostheses or erection devices whether implantable or external;</li> <li>• Replacement of external prosthetics or orthotics due to wear and tear, loss, theft, destruction or improved available technology of the device. Repair of external prosthetics or orthotics or payment of warranties related to the prosthetic or orthotic device. Replacement of prosthetics and orthotics is covered only when due to the member's physical development or growth; or</li> <li>• Supportive devices, including repairs (example: arch supports), orthotics for the feet or orthopedic shoes, except when necessary as a component of an authorized brace.</li> </ul>	<i>All charges</i>

Durable medical equipment (DME)	You pay
<p><b>Note:</b> The maximum plan allowance for external orthopedic and prosthetic devices and DME is limited to a combined benefit of \$1,500.</p> <p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> <li>• oxygen delivery systems;</li> <li>• nebulizers;</li> <li>• hospital beds;</li> <li>• wheelchairs;</li> <li>• crutches;</li> <li>• walkers;</li> <li>• blood glucose monitors; and</li> <li>• insulin pumps ( with approval of Medical Director)</li> </ul> <p><b>Note:</b> Your Plan physician prescribes this equipment. The Plan physician will call the Plan when equipment is prescribed. We will arrange with a health care provider to rent or buy you durable medical equipment.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Rentals of equipment that extend beyond the original prescription and authorization if recertification has not been obtained;</i></li> <li>• <i>Braces and splints that are used primarily to assist a member during athletic activities;</i></li> <li>• <i>Repairs of DME except for repairs necessary due to reasonable wear and tear. Replacement of DME equipment is covered only if due to the member's physical development or growth;</i></li> <li>• <i>Air conditioners, air filters, heaters, humidifiers, and other equipment that adjusts or regulates the interior environment, even if ordered by a participating provider;</i></li> <li>• <i>Physical fitness equipment, saunas, whirlpools, water purifiers, swimming pools, tanning beds or recreational equipment even if ordered by a participating provider; or</i></li> <li>• <i>Self-help or hygienic products including, but not limited to, bathtub and shower chairs, safety-grab bars, stair gliders or elevators, over-the-bed tables, or motorized vehicles.</i></li> </ul>	<p><i>All charges</i></p>

Home health services	You pay
<ul style="list-style-type: none"> <li>Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide.</li> </ul> <p>Services include oxygen therapy, intravenous therapy and medications.</p> <p><b>Note:</b> Oxygen covered as a DME benefit (see benefit coverage above).</p>	\$10 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>Nursing care requested by, or for the convenience of, the patient or the patient's family;</li> <li>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative; or</li> <li>Rest, custodial, domiciliary, convalescent care; personal comfort or convenience items, sitter services, Private Duty Nursing, homemaker services, (including home-delivered meals) or transportation services.</li> </ul>	<i>All charges</i>
Chiropractic	
<p>Limited to members 18 years of age and older. Maximum of 20 visits per calendar year per member.</p> <ul style="list-style-type: none"> <li>Manipulation of the spine and extremities</li> <li>Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application</li> </ul> <p><b>Note:</b> All diagnostic and lab procedures must be coordinated by Member's Primary Care Physician. We will not cover these services if not arranged by the PCP.</p> <p><b>Note:</b> Plan benefits are payable only when care is clinically appropriate to treat your condition and provided by providers contracted by the Plan.</p>	\$10 per office visit
<ul style="list-style-type: none"> <li><i>Not covered: Services or supplies related to the use of acupuncture or acupressure.</i></li> </ul>	<i>All charges</i>
Alternative treatments	
<i>No benefit</i>	<i>All charges</i>
Educational classes and programs	
<p>Coverage is limited to:</p> <p>Diabetes self-management</p>	\$10 per office visit

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- *We have no calendar year deductible.*
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

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Benefit Description	You pay
<b>Surgical procedures</b>	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see reconstructive surgery)</li> <li>• Surgical treatment of morbid obesity – is covered when the following criteria are met:               <ul style="list-style-type: none"> <li>– Eligible members must be 18 years or older, AND</li> <li>– Documented history of repeated failure of physicians supervised medical dietary therapies, AND</li> <li>– A body mass index (BMI) exceeding 40 or greater than 35 in conjunction with severe co-morbidity such as cardiopulmonary complications or severe diabetes.</li> </ul> </li> </ul>	\$10 per visit

*Surgical procedures- Continued on next page*

Surgical procedures <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>• Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information.</li> </ul> <p><b>Note:</b> 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>	
<ul style="list-style-type: none"> <li>• Voluntary sterilization</li> <li>• Treatment of burns</li> </ul>	\$10 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization;</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care;</i></li> <li>• <i>Refractive eye surgery, such as radial keratotomy; or</i></li> <li>• <i>Consultations that are required to comply with hospital rules.</i></li> </ul>	<i>All charges</i>
Reconstructive surgery	
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>- the condition produced a major effect on the member’s appearance and</li> <li>- the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.</li> </ul>	\$10 per visit

*Reconstructive surgery - Continued on next page*

Reconstructive surgery <i>(continued)</i>	You pay
<ul style="list-style-type: none"> <li>• All stages of breast reconstruction surgery following a mastectomy, such as:               <ul style="list-style-type: none"> <li>– surgery to produce a symmetrical appearance on the other breast;</li> <li>– treatment of any physical complications, such as lymphedemas;</li> <li>– breast prostheses and surgical bras and replacements (see Prosthetic devices)</li> </ul> </li> </ul> <p><b>Note:</b> 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><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury; or</i></li> <li>• <i>Surgeries related to sex transformation.</i></li> </ul>	<i>All charges</i>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> <li>• Reduction of fractures of the jaws or facial bones;</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;</li> <li>• Removal of stones from salivary ducts;</li> <li>• Excision of leukoplakia or malignancies;</li> <li>• Treatment for TMJ;</li> <li>• Excision of cysts and incision of abscesses when done as independent procedures; and</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures.</li> </ul>	\$10 per visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants;</i></li> <li>• <i>Dental care involved with the treatment of temporomandibular joint dysfunction;</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone).</i></li> </ul>	<i>All charges</i>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Kidney</li> <li>• Kidney/Pancreas</li> <li>• Liver</li> <li>• Lung: Single – Double</li> <li>• Pancreas</li> <li>• Small Bowel</li> <li>• Small Bowel/Liver</li> <li>• Allogeneic (donor) bone marrow transplants</li> <li>• Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors</li> <li>• Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas</li> </ul> <p>Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.</p> <p><b>Note:</b> We cover related medical and hospital expenses of the donor when we cover the recipient. Covered services are limited to those services and supplies directly related to the transplant procedure itself.</p>	<p>Nothing</p>
<p>Transportation services, lodging and meals for the member, and one companion.</p> <p>Our maximum Plan allowance for this benefit is \$5,000 per person, with prior approval and coordination by HealthSpring Case Management Department.</p>	<p>Nothing</p>

*Organ/tissue transplants – Continued on next page*

<b>Organ/tissue transplants (continued)</b>	<b>You pay</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Donor screening tests and donor search expenses, except those performed for the actual donor;</i></li> <li>• <i>Artificial, mechanical or animal heart, or any other artificial organ or associated expenses;</i></li> <li>• <i>Furnishing an organ or tissue;</i></li> <li>• <i>Transportation and living costs associated with transplant services for the donor; or</i></li> <li>• <i>Transplants not listed as covered.</i></li> </ul>	<p><i>All charges</i></p>
<b>Anesthesia</b>	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> </ul>	<p>Nothing</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> <li>• Hospital outpatient department</li> <li>• Skilled nursing facility</li> <li>• Ambulatory surgical center</li> <li>• Office</li> </ul>	<p>Nothing</p>

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

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

*Inpatient hospital - Continued on next page*

<b>Inpatient hospital (continued)</b>	<b>You pay</b>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Custodial care;</li> <li>• Non-covered facilities, such as nursing homes;</li> <li>• Personal comfort items, such as telephone, television, barber services, guest meals and beds;</li> <li>• Private nursing care; or</li> <li>• Storage of autologous blood.</li> </ul>	<p><i>All charges</i></p>
<b>Outpatient hospital or ambulatory surgical center</b>	
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma, if donated or replaced</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> </ul> <p><b>Note:</b> We cover hospital services and supplies related to dental procedures when necessitated by non-dental procedures by a non-dental physical impairment. We do not cover the dental procedure.</p>	<p>Nothing</p>
<p><i>Not covered: blood and blood derivatives not replaced by the member</i></p>	<p><i>All charges</i></p>
<b>Extended care benefits/skilled nursing care facility benefits</b>	
<p>Skilled nursing facility (SNF): Limited to 100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan.</p>	<p>Nothing</p>
<p><i>Not covered: custodial care.</i></p>	<p><i>All charges</i></p>
<b>Hospice care</b>	
<p>Hospice Services</p> <ul style="list-style-type: none"> <li>• We cover a maximum plan benefit of \$10,000 per calendar year</li> </ul>	<p>Nothing</p>
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<p><i>All charges</i></p>

<b>Ambulance</b>	<b>You Pay</b>
<ul style="list-style-type: none"><li>• <b>Non-Emergency</b> local professional ambulance service when medically appropriate.</li></ul>	\$10 per trip

## Section 5 (d). Emergency services/accidents

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including 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 medical problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

### What to do in case of emergency:

**Emergencies within our service area:** In an emergency, go to the nearest medical facility for treatment. Notify your Primary Care Physician and HealthSpring within 24 hours of receiving emergency services unless it is not reasonably possible to do so. Your Primary Care Physician must coordinate all follow-up care including suture removal. Emergency treatment does not require a written referral. You will have coverage for emergency room charges only when the presenting symptoms to the emergency room meet the definition of an emergency. Emergency service copayment will be waived if admitted to the hospital from the emergency room.

**Emergencies outside our service area:** If an emergency occurs outside the service area, and you could not reasonably return to the service area, you should contact your Primary Care Physician the next business day after receiving treatment to coordinate follow-up care or arrange for a transfer back into the service area. Emergency Service copayment will be waived if admitted as an inpatient from the emergency room.

Benefit Description	You pay
<b>Emergency within our service area</b>	
<ul style="list-style-type: none"> <li>• Emergency care at a doctor's office</li> </ul>	\$10 per office visit
<ul style="list-style-type: none"> <li>• Emergency care at an urgent care center</li> </ul>	\$25 per visit
<ul style="list-style-type: none"> <li>• Emergency care as an outpatient or inpatient at a hospital, including doctors' services</li> </ul>	\$50 per visit
<p><b>Note:</b> Hospital emergency room copayment is waived if member is admitted to the hospital.</p>	
<p><i>Not covered: Elective care or non-emergency care.</i></p>	<p><i>All charges</i></p>

<b>Emergency outside our service area</b>	
<ul style="list-style-type: none"> <li>• Emergency care at a doctor's office</li> <li>• Emergency care at an urgent care center</li> <li>• Emergency care as an outpatient or inpatient at a hospital, including doctors' services</li> </ul> <p><b>Note:</b> Hospital emergency room copayment is waived if member is admitted to hospital.</p>	<p>\$10 per office visit</p> <p>\$25 per visit</p> <p>\$50 per visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Elective care or non-emergency care;</i></li> <li>• <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area; or</i></li> <li>• <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.</i></li> </ul>	<p><i>All charges</i></p>
<b>Ambulance</b>	
<ul style="list-style-type: none"> <li>• Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.</li> <li>• Air ambulance service when medically appropriate and pre-approved by Plan.</li> </ul>	<p>Nothing</p>

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

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

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION FOR THESE SERVICES.** See the instructions after the benefits description below.

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Benefit Description	You pay
<b>Mental health and substance abuse benefits</b>	
<ul style="list-style-type: none"> <li>• All diagnostic and treatment services must be recommended by a Plan provider and contained in a treatment plan we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</li> </ul> <p><b>Note:</b> Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	Your cost sharing responsibilities are no greater than for other illness or conditions.
<ul style="list-style-type: none"> <li>• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers</li> </ul>	\$10 per visit
<ul style="list-style-type: none"> <li>• Diagnostic tests</li> </ul>	\$10 per visit
<ul style="list-style-type: none"> <li>• Services provided by a hospital or other facility</li> <li>• Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment</li> </ul>	Nothing

*Mental health and substance abuse benefits- Continued on next page*

<b>Mental health and substance abuse benefits</b> <i>(continued)</i>	<b>You pay</b>
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All charges</i></p>

**Preauthorization**

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

All mental health and substance abuse care must be coordinated by a Participating Provider and prior authorization received from the Mental Health Organization contracted by HealthSpring. Your Participating provider is responsible for obtaining prior approval for services. Before giving approval, we consider benefit design, medical necessity, and generally accepted practices.

**Limitation**

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

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## Section 5 (f). Prescription drug benefits

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

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

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

- **Who can write your prescription.** A plan physician or referral physician must write the prescription
- **Where you can obtain them.** You may fill the prescription at a participating pharmacy or by mail for maintenance medications. You must use a network pharmacy. Walgreen's is not a participating pharmacy. For a complete list of participating pharmacies, please check our web page at [www.myhealthspring.com](http://www.myhealthspring.com).
- **We use a formulary.** The formulary is a list of prescription drugs that physicians use in prescribing medications. A Pharmacy and Therapeutics Committee evaluates prescription drugs for safety, effectiveness, quality, and overall value and schedules the medications as preferred or non preferred brand after they have been on the market for at least 6 months. The formulary is subject to change. For a current list of covered medications included in the formulary, as well as their classifications as generic, preferred brand, or non preferred brand, please check our web page at [www.myhealthspring.com](http://www.myhealthspring.com) or you may request a list of covered products by calling Customer Service at (615) 291-5030 in Nashville or 1-800-917-3888. All therapeutic classes are covered. Your physician may request a non-formulary drug by submitting to us medical record information regarding treatment failure with formulary alternatives, but such requests may require up to 5 working days for approval. All injectable medication with a cost of \$500 per course of treatment requires prior approval. Your physician must send a request, with medical records, to our Medical Management/Pharmacy authorization desk at:

*HealthSpring*

*Medical Management/Pharmacy Authorization*

*Phone: 615-291-7024*

*Fax: 615-291-7025*

and such drugs are listed on the web site [www.myhealthspring.com](http://www.myhealthspring.com).

- **These are the dispensing limitations.** When the prescription is filled at participating pharmacy, the pharmacy may dispense up to a 30 day supply for each oral drug or refill, or 1 vial of insulin, or one commercially prepared unit (one inhaler, one bottle of ophthalmic medication, one tube of topical ointment, etc.) A prescription may not be refilled before 75% of it has been used. You pay \$10 per generic prescription, \$20 per preferred brand, or \$35 per non-preferred brand.
- **Mail Order** -- Maintenance medication prescribed by participating doctors for long term use may be obtained through our mail order program for up to a 90-day supply for two copays. Certain classes of drugs are not available for mail order. For the list, please check the web site. Mail order forms are available from Customer Service at (615) 291-5030 in Nashville or 1-800-917-3888.

- Certain limitations apply:
  - Covered drugs are limited to the formulary;
  - In no event will the copayment exceed the cost of the drug;
  - Certain injectables require prior authorization (when course of treatment exceeds \$500);
  - Viagra, or similar drugs for sexual dysfunction, is limited to 8 tablets per month;
  - Some medications have quantity dispensing limits per month, in accordance with FDA guidelines and to promote patient safety. (See our web site, [www.myhealthspring.com](http://www.myhealthspring.com), for monthly quantity limits).
- **Why use generic drugs?** 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, which have the lowest copayment. However, you and your physician have the option to request a name-brand drug. When a FDA approved generic is available and you or your physician requests the brand name drug, you must pay the difference in cost between the generic and the brand name drug, plus the brand copayment. Certain drugs are exempt from the mandatory generic program and such drugs are listed on the web site [www.myhealthspring.com](http://www.myhealthspring.com).

- **When you have to file a claim.** In most cases, you do not have to file a claim when purchasing drugs at a participating pharmacy. However you must pay for the drug when dispensed, and file a claim for reimbursement when the following occurs:
  - Your plan ID is not available, eligibility cannot be determined, or when the prescription is filled for a medical emergency outside the service area.

For assistance in filing a claim for direct member reimbursement, call Customer Service at (615) 291-5030 in Nashville or 1-800-917-3888.

Benefit Description	You pay
<p><b>Covered medications and supplies</b></p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except as listed as <i>Not covered</i>.</li> <li>• Insulin</li> <li>• Diabetic supplies and meters (preferred product only)</li> </ul>	<p><b>Retail Pharmacy</b> – per 30 day supply</p> <p>\$10 Generic</p> <p>\$20 Brand Name – Preferred</p> <p>\$35 Brand Name – Non-Preferred</p>

*Covered medications and supplies – Continued on next page*

Covered medications and supplies <i>(continued)</i>	You Pay
<ul style="list-style-type: none"> <li>• Disposable needles and syringes for the administration of covered medications</li> <li>• Drugs for sexual dysfunction (see limitations on page 38)</li> <li>• Self administered injectables, subject to prior approval</li> <li>• Oral contraceptive and diaphragms (for implant or injected contraceptives and IUDs, see section 5(a).</li> <li>• Intravenous and provider administered medications are covered under medical, surgical, or home health benefits see section 5(a).</li> <li>• Growth hormone</li> </ul>	<p><b>Mail Order (Maintenance medications only)</b> – per 90 day supply</p> <p>\$20 Generic</p> <p>\$40 Brand Name – Preferred</p> <p>\$70 Brand Name – Non Preferred</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs and supplies for cosmetic purposes;</i></li> <li>• <i>Drugs to enhance athletic performance;</i></li> <li>• <i>Fertility drugs;</i></li> <li>• <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies;</i></li> <li>• <i>Smoking cessation drugs and medications;</i></li> <li>• <i>Drugs used for purpose of weight reduction or appetite suppression (unless approved as part of a treatment plan for morbid obesity);</i></li> <li>• <i>Medical supplies such as dressings and antiseptic;</i></li> <li>• <i>Drugs for orthodontic care, dental implants, and periodontal disease;</i></li> <li>• <i>Replacement of drugs due to loss, theft, or destruction;</i></li> <li>• <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them; or</i></li> <li>• <i>Nonprescription medicines or over the counter medications.</i></li> </ul>	<p><i>All charges</i></p>

## Section 5 (g). Special features

Feature	Description
<b>HealthSpring Disease Management Program</b>	Disease Management Programs are designed to assist you and your family in managing chronic disease states. This management is done through educational assistance, dedicated telephonic nurse coordinator, integrated member care and case management.
<b>Quarterly Newsletters</b>	You receive Healthful News, a quarterly newsletter. The newsletter provides updates, changes and/or important news about your Health Plan and promotes health and wellness.
<b>Centers of excellence for transplants/heart surgery/etc</b>	Patients requiring transplant services have access to nationally recognized transplant centers. HealthSpring has dedicated Case Managers who follow the transplant candidate from initial referral, facility selection, initial evaluation, pre-transplant services, transplant and post-transplant care.
<b>Hospitalist Program</b>	Hospitalists are highly skilled hospital-based physicians who work with your Primary Care Physician in coordinating and managing your overall medical care during inpatient admissions. The hospitalists are readily available to monitor your daily progress and improve the physician/patient communication.

## Section 5 (h). Dental benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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Accidental injury benefit	You pay
<p>We cover treatment of accidental injury to sound natural teeth to relieve pain and stop bleeding when service occurs within 24-hours of the injury. The need for these services must result from an accidental injury.</p>	<p>\$10 per office visit</p>

**Dental benefits**

We have no other dental benefits.

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

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

*This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 47, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare managed care plan when one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether it covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare managed plan. Contact us at 1-800-618-4294 for information on the Medicare managed plan and the cost of that enrollment. If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 1-800-618-4294 for information on the benefits available under the Medicare HMO.*

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

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The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition, and we agree, as discussed under *What Services Require Our Prior Approval* on page 11.**

We do not cover the following:

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

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## Section 7. Filing a claim for covered services

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

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

### Medical, hospital and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at (615) 291-5030 in Nashville or 1-800-917-3888 from outside Nashville.

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

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

**Submit your claims to: HealthSpring**

**P. O. Box 20000**

**Nashville, TN 37202-9613**

### Deadline for filing your claim

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

### When we need more information

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

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## Section 8. The disputed claims process

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

Step	Description
<b>1</b>	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none"><li>(a) Write to us within 6 months from the date of our decision; and</li><li>(b) Send your request to us at: HealthSpring, P. O. Box 20000, Nashville, TN 37202-9613; and</li><li>(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</li><li>(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</li></ul>
<b>2</b>	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"><li>(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</li><li>(b) Write to you and maintain our denial -- go to step 4; or</li><li>(c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.</li></ul>
<b>3</b>	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
<b>4</b>	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none"><li>• 90 days after the date of our letter upholding our initial decision; or</li><li>• 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or</li><li>• 120 days after we asked for additional information.</li></ul> <p>Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, 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 different claims, you must clearly identify which documents apply to which claim.

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

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

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

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

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

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

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

- (a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (615) 291-5030 and we will expedite our review; or
- (b) We denied your initial request for care or preauthorization/prior approval, then:
  - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
  - You can call OPM's Health Benefits Contracts Division at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

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## Section 9. Coordinating benefits with other coverage

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

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

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

### •What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

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

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

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

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

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Your care must be coordinated by your Primary Care Physician (PCP) and provided by participating plan providers unless approved in advance by the Plan, except in an emergency. We will not waive any of our copayment or coinsurance.

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

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

Please note, if your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

**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 claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at (615) 291-5030 or contact us through our web site at [www.myhealthspring.com](http://www.myhealthspring.com).

**When you have the Original Medicare Plan we do not waive any out-of-pocket costs.**

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

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

**This Plan and our Medicare managed care plan:** You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments or coinsurance for your FEHB coverage.

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

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

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

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

## **TRICARE**

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

## **Workers' Compensation**

We do not cover services that:

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

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

## **Medicaid**

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

## **When other Government agencies are responsible for your care**

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

## **When others are responsible**

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

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

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

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<b>Calendar year</b>	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care. See page 13.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See page 13.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	Care that is provided primarily for maintenance of your condition. Custodial care is designed to assist in activities of daily living (walking, bathing, dressing, feeding, housekeeping) and includes self-administration of medications not requiring constant attention of medical personnel.
<b>Experimental or investigational services</b>	Service not already in general use or not recognized by the United States Pharmacopeial Convention, the American Medical Association, or the American Society of Pharmacists Compendia.
<b>Medical necessity</b>	Treatment that is non-experimental or investigational, consistent with the symptoms or diagnosis of the condition, appropriate in regards to standards of good medical practice, not primarily for the convenience of the patient, physician, hospital or other provider, and the most appropriate supply or level of service which can safely be provided.
<b>Us/We</b>	Us and we refer to HealthSpring.
<b>You</b>	You refers to the enrollee and each covered family member.

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## Section 11. FEHB facts

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### No pre-existing condition limitation

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

### Where you can get information about enrolling in the FEHB Program

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

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

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

### Types of coverage available

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

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

## When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

## Your medical and claims records are confidential

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

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

## When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as temporary continuation of coverage (TCC).

## When you lose benefits

### •When FEHB coverage ends

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

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

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

### • Spouse equity coverage

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

### •Temporary continuation of coverage (TCC)

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

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

**Enrolling in TCC.** Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*,

from your employing or retirement office or from [www.opm.gov/insure](http://www.opm.gov/insure). It explains what you have to do to enroll.

- **Converting to individual coverage**

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

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

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

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

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

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

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

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

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

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

### What is long term care (LTC) insurance?

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

### I'm healthy. I won't need long term care. Or, will I?

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

### Is long term care expensive?

- Yes. A year in a nursing home can exceed \$50,000 and only three 8- hour shifts a week can exceed \$20,000 a year, that's before inflation!
- Long term care can easily exhaust your savings. But LTC insurance can protect it.

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

- Not FEHB. Look at the "Not covered" blocks in sections 5(a) and 5(c) of your FEHB brochure. Custodial care, assisted living, continuing home health care for activities of daily living are not covered. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care after a hospitalization with a 100 day limit.
- Medicaid covers LTC for those who meet their state's guidelines, but restricts covered services and where they can be received. LTC insurance can provide choices of care and preserve your independence.

### When will I get more information?

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

### How can I find out more about the program NOW?

- A toll-free telephone number will begin in mid-2002. You can learn more about the program now at [www.opm.gov/insure/ltc](http://www.opm.gov/insure/ltc).

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## Index

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

- Accidental injury 41
- Allergy tests 19
- Ambulance 32, 34
- Anesthesia 29
- Blood and blood plasma 31
- Chemotherapy 19
- Chiropractic 24
- Contraceptive devices and drugs 18
- Diagnostic services 31
- Durable medical equipment (DME) 23
- Emergency 33
- Family planning 18
- General Exclusions 43
- Home health services 24
- Hospice care 31
- Hospital 30
- Immunizations 17
- Infertility 18
- Inpatient Hospital Benefits 30
- Laboratory and pathological services 31
- Mail Order Prescription Drugs 37
- Mammograms 16
- Maternity Benefits 17
- Medicare 47
- Mental Conditions/Substance Abuse Benefits 35
- Occupational therapy 20
- Orthopedic devices 22
- Oxygen 23
- Pap test 16
- Physical therapy 20
- Precertification 30
- Preventive care, adult 16
- Preventive care, children 17
- Prescription drugs 37
- Prior approval 11
- Prosthetic devices 22
- Skilled nursing facility care 31
- Speech therapy 20
- Surgery 25
- Transplants 28
- Vision services 21

## Summary of benefits for HealthSpring - 2002

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

Benefits	You Pay	Page
Medical services provided by physicians: <ul style="list-style-type: none"> <li>• Diagnostic and treatment services provided in the office.....</li> </ul>	Office visit copay: \$10 primary care; \$10 specialist	31
Services provided by a hospital: <ul style="list-style-type: none"> <li>• Inpatient.....</li> <li>• Outpatient.....</li> </ul>	<i>Nothing</i> <i>Nothing</i>	30 31
Emergency benefits: <ul style="list-style-type: none"> <li>• In-area.....</li> <li>• Out-of-area.....</li> </ul>	\$25 per urgent care center visit; 50 per emergency care visit	33
Mental health and substance abuse treatment.....	Regular cost sharing.	35
Prescription drugs.....	<b>Retail Pharmacy:</b> \$10 generic / \$20 brand preferred / \$35 brand non-preferred  <b>Mail Order Maintenance Drugs:</b> \$20 generic / \$40 brand preferred / \$70 brand non-preferred	37
Dental Care (Accidental Injury Only).....	\$10 per office visit	41
Vision Care (Eye exam, including annual refraction).....	\$10 per office visit	21
Special features: HealthSpring Disease Management Program; Quarterly Newsletters, Centers of Excellence for transplants/heart surgery, etc; Hospitalists Program		40
Protection against catastrophic costs (your out-of-pocket maximum).....	We do not have an out of pocket maximum.	13



## 2002 Rate Information for HealthSpring

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

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

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

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

### Nashville-Middle Tennessee Areas

Self Only	6K1	\$87.29	\$29.09	\$189.12	\$63.04	\$103.29	\$13.09
Self and Family	6K2	\$223.41	\$100.89	\$484.06	\$218.59	\$263.75	\$60.55