

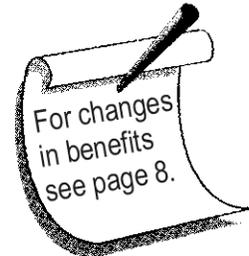


M•Plan
<http://www.mplan.com>

2003

A Health Maintenance Organization

Serving: Indiana Metropolitan areas



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



*This Plan has Excellent accreditation from the NCQA.
See the 2003 Guide for more information on accreditation*

Enrollment codes for this Plan:

IN1 Self Only
IN2 Self and Family

Authorized for distribution by the:



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



RI 73-578



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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

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

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

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

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

Sincerely,

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

Kay Coles James
Director



Notice of the Office of Personnel Management's Privacy Practices

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Introduction

This brochure describes the benefits of M•Plan under our contract (CS2643) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for M•Plan's administrative office is:

M•Plan
8802 North Meridian Street
Suite 100
Indianapolis, Indiana 46260

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

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

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

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

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

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

Stop Health Care Fraud!

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

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

Protect yourself from fraud – Here are some things you can do to prevent fraud:

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

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 317/571-5320 and explain the situation.
 - If we do not resolve the issue:

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

OR WRITE TO:

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

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

Section 1. Facts about this HMO plan

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

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

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

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

How we pay providers

We contract with hospital networks to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

M•Plan provides health care through several different networks of physicians. Provider networks are comprised of a specific group of primary care physicians, specialists and other providers affiliated with a specific hospital or network of hospitals. Services are only available from providers within the provider network you select. If a particular service is not available from your network, you will be referred to another M•Plan health network provider. We will cover the services of a specialty care doctor only when you receive a referral from your primary care doctor.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about your us, our networks, providers, and facilities. OPM's FEHB website (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.

- M•Plan is licensed by the State of Indiana as a Competitive Medical Plan.
- We have been in existence since 1989.
- M•Plan is a for-profit HMO owned by The Health Care Group.

If you want more information about us, call 317/571-5320, or write to M•Plan Member Services, 8802 N. Meridian Street, Suite 100, Indianapolis, IN 46260. You may also contact us by fax at 317/571-5337 or visit our website at www.mplan.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This means you must maintain a permanent residence within or work within our service area. You must select a participating primary care physician whose office is located within fifty (50) miles of where you live or work. Our service area includes the Indiana counties of: Adams, Allen, Bartholomew, Boone, Brown, Carroll, Cass, Clinton, Decatur, DeKalb, Delaware, Fulton, Grant, Hamilton, Hancock, Hendricks, Henry, Howard, Huntington, Jackson, Jennings, Johnson, Kosciusko, Lagrange, Madison, Marion, Marshall, Miami, Monroe, Morgan, Noble, Putnam, Rush, St. Joseph, Shelby, Steuben, Tipton, Wabash, Wells and Whitley.

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 service area unless the services have prior plan approval.

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

Section 2. How we change for 2003

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

Program-wide changes

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

Changes to this Plan

- Your share of the non-Postal premium will increase by 44.6% for Self Only or 44.2% for Self and Family.
- The office visit copay for visits to a specialist has increased from \$10.00 to \$15.00. (Section 5(a))
- Members have a \$250.00 copay for all inpatient hospital admissions. Previously, members paid nothing for inpatient hospital admissions. (Section 5(c))
- Members have a \$100 copay for outpatient surgical procedure performed at participating hospitals or ambulatory surgery centers. Previously, members paid nothing. (Section 5(c))
- The hospital emergency room copay will increase from \$25.00 to \$75.00.
- Members pay \$10.00 per office visit for all maternity care visits. Previously, members paid nothing after the initial office visit. (Section 5(a))
- The copay for speech therapy has increased from nothing to 50%. (Section 5(a))
- We provide coverage for Pervasive Developmental Disorders as mandated by the State of Indiana. Benefits vary for type of service. (Section 5(a))
- We have a 4-tier prescription drug benefit. The prescription drug copays are now \$5.00 for Tier 1, \$10.00 for Tier 2, \$15.00 for Tier 3, and \$50.00 for Tier 4. (Section 5(f))
- Members pay 50% for drugs that treat sexual dysfunction. (Section 5(f))
- Members pay \$100.00 for human growth hormone and other such biotech products. Previously, members paid the office visit copay. (Section 5(a))
- The copay for an annual eye refraction has increased from \$5.00 to \$10.00. (Section 5(a))

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 317/571-5320 or write to us at M•Plan, 8802 North Meridian Street, Suite 100, Indianapolis, Indiana 46260. You may also request replacement cards through our website at www.mplan.com.

Where you get covered care

You get care from “Plan providers” and “Plan facilities” that work within specific networks. Our directory lists M•Plan providers and facilities according to their networks. You will only pay copays or coinsurance for covered services 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 the National Committee for Quality Assurance standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members.

We list these in the provider directory, which we update periodically. The list is also on our website at www.mplan.com.

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 one of the M•Plan provider networks. Then, you choose a primary care physician within that network. Your decision is important because your primary care physician provides or arranges for your health care services within his or her network. Services of a specialty care doctor can only be received by referral from your primary care doctor.

You may only receive services from providers within your selected network unless a particular service is unavailable from network providers. If this happens, you will be referred to another M•Plan health network provider who can provide the service you need.

- **Primary care**

Your primary care physician can be a family practitioner, general practitioner, internist or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist within their health network.

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. Except in a medical emergency, or when a primary care doctor has designated another doctor to see patients when he or she is unavailable, you must receive a referral from your primary care doctor before seeing any other doctor or obtaining special services. Referrals to a participating specialist are given at the primary care doctor's discretion; if non-Plan specialists or consultants are required, the primary care doctor will make arrangements for appropriate referrals.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause; or
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
 - reduce our service area and you enroll in another FEHB Plan,you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the FEHB 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 317/571-5320. If you

are new to the FEHB Program, we will arrange for you to receive care.

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

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

These provisions apply only to the hospital benefit 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 *the “prior authorization” process*. Your physician must obtain prior authorization for coverage of services, including but not limited to:

- Elective Surgery
- Extended Care Facility/Skilled Nursing Facility/Home Health
- Durable Medical Equipment (DME)
- Habilitative and Rehabilitative Therapies
- Hospital admissions
- Infertility Services
- Organ/Tissue Transplants
- Biologic Products
- Biotech Products such as Growth Hormone Therapy
- Orthotic and Prosthetic Devices
- Certain Prescription Drugs

You must obtain authorization for Mental Health and Substance Abuse treatment prior to seeking services.

Section 4. Your costs for covered services

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

- **Copay** A copay is a fixed amount of money you pay to the provider, facility or pharmacy, etc. when you receive services.

Example: When you see your primary care physician you pay a copay of \$10 per office visit and when you go in the hospital, you pay \$250 per admission.
 - **Deductible** We do not have a deductible.
 - **Coinsurance** Coinsurance is the percentage of our negotiated fee that you must pay for your care.

Example: In our Plan, you pay 50% coinsurance for covered infertility services, speech therapy, durable medical equipment and prosthetic devices.
- Your catastrophic protection out-of-pocket maximum** We do not have catastrophic protection out-of-pocket maximum. You simply pay the stated copays and coinsurance as shown in this brochure.

Section 5. Benefits Overview

(See page 8 for how our benefits changed this year and page 56 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 317/571-5320 or at our website at www.mplan.com.

(a) Medical services and supplies provided by physicians and other health care professionals.....	14
• 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	
• Orthotic and prosthetic devices	
• Durable medical equipment (DME)	
• Home health services	
• Chiropractic	
• Alternative treatments	
• Educational classes and programs	
(b) Surgical and anesthesia services provided by physicians and other health care professionals	23
• Surgical procedures	
• Reconstructive surgery	
• Oral and maxillofacial surgery	
• Organ/tissue transplants	
• Anesthesia	
(c) Services provided by a hospital or other facility, and ambulance services	27
• Inpatient hospital	
• Outpatient hospital or ambulatory surgical center	
• Extended care benefits/skilled nursing care facility benefits	
• Hospice care	
• Ambulance	
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Section 5 (a) Medical services & supplies provided by physicians and other health care professionals

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

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We do not have a 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
Diagnostic and treatment services	You pay
Professional services of physicians <ul style="list-style-type: none"> • In physician's office 	\$10 per office visit to your primary care physician \$15 per office visit to a specialist
<ul style="list-style-type: none"> • Office medical consultations • Second surgical opinion 	\$10 per office visit to your primary care physician \$15 per office visit to a specialist
<ul style="list-style-type: none"> • In an urgent care center 	\$25 per urgent visit
Professional services of physicians <ul style="list-style-type: none"> • During a hospital stay • Initial examination in the hospital of a newborn child • In a skilled nursing facility 	Nothing
At home	\$25 per visit
Lab, X-ray and other diagnostic tests	You pay
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing

Preventive care, adult	You pay
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Blood Sugar • Cholesterol • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 • Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older • Routine pap test • Routine mammogram – covered for women age 35 and older as follows: <ul style="list-style-type: none"> – From age 35 through 39, one during this five year period – From age 40 through 64, one every calendar year – At age 65 and older, one every two consecutive calendar years 	<p>\$10 per office visit to your primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>Nothing for lab or diagnostic tests</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Physical examinations and related tests and reports for the purpose of obtaining or maintaining employment, insurance, governmental licensure, attending camp, participating in sports, admissions to school and for premarital purposes.</i> • <i>Employer requested annual physical examinations and other services or supplies that are not Medically Necessary for the maintenance or improvement of the health of a Member.</i> 	<p><i>All charges</i></p>
<p>Routine immunizations based on accepted medical practice, such as:</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster - once every 10 years, ages 19 and over (except as provided under Childhood immunizations) • Influenza vaccines, annually • Pneumococcal vaccine, age 65 and over 	<p>Nothing</p>
<p><i>Not covered: Immunizations for travel</i></p>	<p><i>All Charges</i></p>

Preventive care, children	You pay
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing
<ul style="list-style-type: none"> Well-child care charges for routine examinations, immunizations and care (through age 22) Examinations, such as: <ul style="list-style-type: none"> Eye exams through age 17 to determine the need for vision correction. Ear exams through age 17 to determine the need for hearing correction Examinations done on the day of immunizations (through age 22) 	<p>\$10 per office visit to your primary care physician</p> <p>\$15 per office visit to a specialist</p>
Maternity care	You pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> Prenatal care Delivery Postnatal care <p>NOTE: OB/GYN visits for maternity care will be considered a \$10 primary care visit.</p> <p>NOTE: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> 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. We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. A child born to a Subscriber or a Subscriber's eligible spouse is automatically Covered for the first thirty-one (31) days from date of birth. For Coverage beyond the first thirty-one (31) days, an Enrollment Application must be filed with the Plan and applicable premiums paid within the first thirty-one (31) days from the date of birth. Subscribers with full family Coverage currently in effect may enroll newborn dependents after the thirty-one (31) day period from date of birth. We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits Section (5c) and Surgery benefits Section (5b). 	\$10 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Routine sonograms to determine fetal age, size or sex</i> <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>

Family planning	You pay
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization 	<p>\$10 per office visit to your primary care physician per procedure</p> <p>\$15 per office visit to a specialist per procedure</p>
<ul style="list-style-type: none"> • Surgically implanted contraceptives • Intrauterine devices (IUDs) • Diaphragms and cervical caps <p>NOTE: We cover oral and injectable contraceptives under the Prescription Drug Benefits Section 5(f)</p>	<p>50% of all covered charges</p> <p>50% of all covered charges</p> <p>50% of all covered charges</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>reversal of voluntary surgical sterilization</i> • <i>genetic counseling</i> 	<p><i>All charges</i></p>
Infertility services	You pay
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI) 	<p>50% coinsurance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> – <i>in vitro fertilization</i> – <i>embryo transfer, gamete GIFT and Zygote ZIFT</i> – <i>Zygote transfer</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> • <i>Infertility drugs and infertility drug therapy including therapeutic injections for the treatment of infertility</i> 	<p><i>All charges</i></p>
Allergy care	You pay
<ul style="list-style-type: none"> • Testing and treatment • Allergy injection 	<p>\$10 per office visit to your primary care physician</p> <p>\$15 per office visit to a specialist</p>
<p>Allergy serum</p>	<p>Nothing</p>
<p><i>Not covered: provocative food testing and sublingual allergy desensitization</i></p>	<p><i>All charges</i></p>

Treatment therapies	You pay
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>NOTE: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 25.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy 	<p>\$10 per office visit if procedure is performed in your primary care physician's office</p> <p>\$15 per office visit to a specialist</p> <p>Nothing if procedure is performed in the hospital or ambulatory surgical center</p>
<ul style="list-style-type: none"> • Biologic Products <p>NOTE: Biologic products are viruses, therapeutic serums, toxins, antitoxins, vaccines, bloods, blood components or derivatives, allergenic products, or analogous products, or arsphenamine or its derivatives (or any other trivalent organic arsenic compounds), applicable to the prevention, treatment or cure of a disease or condition of human beings. Examples of Biologic Products are: vaccines, various toxoids, skin test antigens, allergenic extracts, blood and blood products and certain in vitro test kits intended for testing of Biological Products. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>Nothing</p>
<ul style="list-style-type: none"> • Biotech Products are Biologic Products manufactured by biotechnology from recombinant, monoclonal, or other similar technology, products containing genes, vectors, plasmids or other genetic components, such as Growth hormone therapy (GHT) <p>NOTE: We will only cover Biotech Products when we prior authorize the treatment. Your primary care physician or specialists to whom you have been referred will request prior authorization. We will ask your provider to submit information that establishes that the Biotech Product is medically necessary. If we determine the Biotech Product is not medically necessary, we will not cover the Biotech Product or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>\$100 copay</p>

Physical and occupational therapies	You pay
<ul style="list-style-type: none"> • Up to two consecutive months per condition for the services of each of the following: <ul style="list-style-type: none"> – qualified physical therapists – occupational therapists <p>NOTE: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation following a cardiac event, such as a heart transplant, bypass surgery or a myocardial infarction <ul style="list-style-type: none"> – Phase I - Inpatient – Phase II - Outpatient <p>Qualified cardiac rehabilitation candidates have been diagnosed with coronary artery disease following a recent (within twelve (12) months) acute event such as acute myocardial infarction, coronary artery bypass graft surgery, percutaneous transluminal coronary angioplasty, cardiac transplantation, cardiac valve surgery, cardiac stent placement, or one course of therapy following the initial diagnosis of congestive heart failure. We cover cardiac rehabilitation in Phase I/Inpatient Stay and Phase II/Outpatient services are limited to thirty-six (36) sessions over a twelve (12) week period.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>long-term rehabilitative therapy</i> • <i>exercise programs</i> 	<i>All charges</i>
Speech therapy	You pay
<ul style="list-style-type: none"> • Up to two consecutive months per condition 	50% coinsurance
Pervasive Developmental Disorders	You pay
<ul style="list-style-type: none"> • We cover medically necessary services for the treatment of a Pervasive Developmental Disorder when prescribed by the member's treating Physician in accordance with a treatment plan. • The term Pervasive Developmental Disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association includes, but is not limited to, Asperger's syndrome or autism. • This is a State of Indiana mandated benefit. <p>NOTE: Services for treatment vary. All services may not be shown in this brochure. Please see the specific benefit section. Please contact us for coverage information.</p>	<p>Applicable copay for services prescribed by the primary care physician</p> <p>Note: Your copay will vary based on the type of service. Please see the specific benefit section for copay information.</p>
<p><i>Not covered</i></p> <ul style="list-style-type: none"> • <i>Services not prescribed or referred by the member's primary care physician</i> 	<i>All charges</i>

Hearing services (testing, treatment, and supplies)	You pay
<ul style="list-style-type: none"> • Hearing testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	<p>\$10 per office visit to your primary care physician</p> <p>\$15 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • all other hearing testing • hearing aids, testing and examinations for them 	<p><i>All charges</i></p>
Vision services (testing, treatment and supplies)	You pay
<p>Annual eye refractions when obtained through participating vision care providers</p>	<p>\$ 10 per office visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Eyeglasses or contact lenses and examinations for them (for Post cataract lenses coverage see <i>Orthotic and Prosthetic Devices</i>) • Eye exercises and orthoptics • Radial keratotomy and other refractive surgery 	<p><i>All charges</i></p>
Foot care	You pay
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>See Orthopedic and Prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$10 per office visit to your primary care physician</p> <p>\$15 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above • Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery) 	<p><i>All charges</i></p>

Orthotic and prosthetic devices	You pay
<p>Orthotic and Prosthetic devices are covered when Medically Necessary and authorized in accordance with the Plan's prior authorization process and are included on the Plan's Orthotic and Prosthetic Device List.</p> <ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Corrective appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • One pair of refractive lenses or contact lenses following crystalline lens removal (primary cataract surgery) or the congenital absence of the crystalline lens of the eye. Contact lenses as required for the treatment of corneal disease with prior authorization 	50% coinsurance
<ul style="list-style-type: none"> • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants (initial device only), and surgically implanted breast implant following mastectomy. <p>NOTE: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See Section 5(b) for coverage of the surgery to insert the device</p> <p>NOTE: You may contact us for a list of covered orthotic and prosthetic devices. Please call Member Services at 317/571-5320.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Items not included in the Plan's Orthotic and Prosthetic Device List</i> • <i>Loss, theft, misuse or neglect of orthotic or prosthetic devices</i> 	<i>All charges</i>
Durable medical equipment (DME)	You pay
<p>Durable Medical Equipment is covered when Medically Necessary and authorized in accordance with the Plan's prior authorization process and included on the Plan's Durable Medical Equipment list, such as:</p> <ul style="list-style-type: none"> • hospital beds • wheelchairs • crutches • walkers <p>NOTE: You may contact us for a list of covered orthopedic and prosthetic devices. Please call Member Services at 317/571-5320.</p>	50% coinsurance

<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Personal comfort or convenience items</i> • <i>Items not included on the Plan's DME list</i> • <i>Loss, theft or misuse of DME</i> 	<p><i>All charges</i></p>
<p>Home health services</p>	<p>You pay</p>
<ul style="list-style-type: none"> • Home health services of nurses and health aides, in lieu of hospitalization when prescribed by your Plan doctor, who will periodically review the programs for continuing appropriateness and need • Services include oxygen therapy, intravenous therapy and medications 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Nursing care requested by, or for the convenience of, the patient or the patient's family</i> • <i>Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication</i> • <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative</i> • <i>Self-administered dressings</i> 	<p><i>All charges</i></p>
<p>Chiropractic</p>	<p>You pay</p>
<p>We do not cover chiropractic treatments.</p> <p>NOTE: Please refer to Section 5(i). Non-FEHB benefits available to Plan members</p>	<p><i>All charges</i></p>
<p>Alternative treatments</p>	<p>You pay</p>
<p>We do not cover alternative treatments.</p> <p>NOTE: Please refer to Section 5(i). Non-FEHB benefits available to Plan members</p>	<p><i>All charges</i></p>
<p>Educational classes and programs</p>	<p>You pay</p>
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Diabetes self-management classes • Smoking Cessation - up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs 	<p>Nothing</p>

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

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We do not have a 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 charge (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION OF SOME SURGICAL PROCEDURES.** Please refer to the prior authorization information shown in Section 3 to be sure which services require precertification and identify which surgeries require prior authorization.

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Benefit Description	You pay
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- non-experimental treatment of morbid obesity provided that the morbid obesity has persisted for at least five (5) years and non-surgical treatment, supervised by your physician for at least eighteen (18) months, has been unsuccessful. • Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization • Treatment of burns <p>NOTE: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>\$10 per office visit to your primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>Nothing for the surgical procedure</p> <p>Note: Please see Section 5(c) to determine your liability for the facility charge</p>
<p><i>Not Covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot (See Foot care)</i> 	<p><i>All charges</i></p>

Reconstructive surgery	
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – the condition produced a major effect on the member’s appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are protruding ear deformities; cleft lip; cleft palate; birthmarks; webbed fingers and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – surgery to produce a symmetrical appearance on the other breast – treatment of any physical complications, such as lymphedemas – breast prosthesis and surgical bras and replacements (see Prosthetic devices) <p>NOTE: If you need a mastectomy, you may have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$10 per office visit to your primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>Nothing for the surgical procedure</p> <p>Note: Please see Section 5(c) to determine your liability for the facility charge</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>\$10 per office visit to your primary care physician</p> <p>\$15 per office visit to a specialist</p> <p>Nothing for the surgical procedure</p> <p>Note: Please see Section 5(c) to determine your liability for the facility charge</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva and alveolar bone)</i> 	<p><i>All charges</i></p>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas • Allogenic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach and pancreas <p>NOTE: We must authorize all transplant services in advance.</p> <p>NOTE: We cover transplant services for the donor only when the transplant recipient is a Member of the Plan. Coverage for the donor includes the following:</p> <ul style="list-style-type: none"> • A Covered transplant predetermination work-up • Medical treatment directly related to a Covered transplant procedure prior to the transplant • Hospital, professional and related follow-up services for human organs and tissue transplants • Any Covered transplant related follow-up treatment incurred during the original twelve (12) month period provided by the transplant Physician. • If the donor is not a Member, Covered Services for the donor are limited to those services and supplies directly related to the transplant procedure (itself) including complications and are Covered only to the extent that services are not Covered by other health insurance. 	<p>Nothing</p> <p>Note: Please see Section 5(c) to determine your liability for the facility charge</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Medical and hospital services of an organ donor or prospective donor when the recipient of the organ transplant is not a member of the Plan</i> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<p><i>All charges</i></p>

Anesthesia	You pay
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	Nothing

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

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Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We do not have a 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 Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require prior authorization.

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Benefit Description	You pay
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> • ward, semiprivate or intensive care accommodations • general nursing care • meals and special diets NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$250 per admission
Other inpatient hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma and other biologicals • Dressings, splints and sterile tray services • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment and any covered items billed by a hospital for use at home 	Nothing (included in the \$250 admission copay)
Not covered: <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds and take home items • Private nursing care 	All charges

Outpatient hospital or ambulatory surgical center	You pay
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>NOTE: We cover hospital services and hospital supplies related to dental procedures when necessitated by a non-dental physical or mental impairment. We do not cover the dental procedures or dental supplies.</p>	\$100 per outpatient surgery
Extended care benefits/skilled nursing care facility benefits	You pay
<p>We cover up to 80 days per contract year with no dollar limit when full-time necessary confinement in a skilled nursing facility is medically appropriate. The service must be prescribed by your Plan doctor and approved by us. All necessary services are covered, including:</p> <ul style="list-style-type: none"> • Bed, board and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor 	Nothing
<p><i>Not covered: Custodial care, nursing home care, rest cures, domiciliary care regardless of location or setting.</i></p>	<i>All charges</i>
Hospice care	You pay
<p>We cover supportive and palliative care for a terminally ill member in the home or hospice facility. Covered services billed by the hospice include inpatient and outpatient care, and family counseling. Hospice services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.</p>	Nothing
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<i>All charges</i>
Ambulance	You pay
<p>Professional ambulance transport service when medically appropriate</p>	20% coinsurance

Section 5 (d) Emergency services/accidents

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

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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What is a medical emergency?

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

What to do in case of emergency:

Emergencies within or outside our service area: If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911-telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify us. You or a family member should notify us within 48 hours unless it is not reasonably possible to do so. It is your responsibility to ensure that we have been timely notified.

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

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability, or significant jeopardy to your condition. To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> Emergency care at a doctor's office 	\$10 per office visit to your primary care physician \$15 per office visit to a specialist
<ul style="list-style-type: none"> Emergency care at an urgent care center Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$75 per visit \$75 per visit (waived if admitted to hospital)
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>
Emergency outside our service area	
<ul style="list-style-type: none"> Emergency care at a doctor's office 	\$10 per office visit to your primary care physician \$15 per office visit to a specialist
<ul style="list-style-type: none"> Emergency care at an urgent care center Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$75 per visit to an urgent care center or hospital emergency room Note: We waive the hospital emergency room copay if you are admitted to the hospital.
<i>Not covered:</i> <ul style="list-style-type: none"> <i>Elective care or non-emergency care</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> <i>Routine care outside the service area</i> 	<i>All charges</i>
Ambulance	
Professional ambulance service when medically appropriate. See Section 5(c) for non-emergency service.	20% coinsurance

Section 5 (e) Mental health and substance abuse benefits

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.

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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.
- We do not have a 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 PRIOR AUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

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Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>NOTE: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illness or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	<p>\$15 per office visit</p>
<ul style="list-style-type: none"> • Diagnostic evaluation and psychological testing 	<p>Nothing</p>
<ul style="list-style-type: none"> • Inpatient services provided by a hospital or other facility 	<p>\$250 per admission</p>
<ul style="list-style-type: none"> • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	<p>\$250 per inpatient admission Nothing for outpatient services</p>
<p><i>Not covered: Services we have not approved.</i></p> <p>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.</p>	<p><i>All charges</i></p>

Prior authorization

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

Your provider directory lists the phone number of your network mental health provider. You must call for authorization prior to seeking care unless in an emergency. See Section 5(d) for instructions in an emergency. Your network provider will develop a treatment plan based on your needs and authorize a certain number of visits to a mental health or substance abuse professional. You do not need a referral from your primary care doctor.

Limitation

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

Section 5 (f) Prescription drug benefits

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Some drugs may require prior authorization by the plan.
- We do not have a 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 licensed plan physician must write the prescription.
- **Where you can obtain them?** You must fill the prescription at a plan pharmacy or by mail for a maintenance medication only. Non-Select drugs are not available through the mail-order program.
- **We use a four tier formulary.** The four tiers are Generic One, Generic Two, Select, and Non-Select. The first 3 tiers contain drugs that we have approved for dispensing through Plan pharmacies. Our Pharmacy and Therapeutics Committee developed the list for our use. Please contact Member Services at 317/571-5320 for a copy of our formulary.
 - Generic One drugs are generic prescription drugs that have the lowest total cost.
 - Generic Two drugs are generic prescription drugs that have a higher total cost.
 - Select drugs are those name brand prescription drugs that don't have generic equivalents and offer safe and effective therapy at a better value than non-select name brand drugs.
 - Non-Select drugs are those prescription name brand drugs that are not on our formulary.
- **These are the dispensing limitations.** Plan pharmacies will dispense up to a 30-day supply or one commercially prepaid unit (i.e., one inhaler, one vial ophthalmic medication or insulin). Plan pharmacies will dispense Generic One or Generic Two equivalent drugs when substitution is permissible and your physician has not indicated "dispense as written" on the prescription. Prescriptions filled through the Plan's mail order program will be dispensed for up to a 90-day supply or three (3) times the retail quantity amount. Non-Select drugs are not available through the mail order program. All drugs will be dispensed within FDA guidelines. Some prescriptions require prior-authorization for coverage. Your primary care physician or specialist to whom you have been referred will request prior-authorization for you.
- **Why use generic drugs?** Generic drugs are effective therapeutic treatment at a lower cost to us and you. Generic drugs are those prescription drugs whose name brand counterparts are no longer under patent protection. Generic equivalent drugs contain the same active ingredients as their name brand counterparts and are identical in strength, dosage, form, and route of administration. Generic drugs also supply the same amount of the active ingredient in the body, at the same rate, as the name brand drug. Generic drugs can be marketed only if they have been approved by the Food and Drug Administration (FDA). Generic drugs are produced in accordance with stringent government regulations called current Good Manufacturing Practices (GMP).

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies	
<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"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except as excluded below • Disposable needles and syringes for the administration of covered medications • Diabetic supplies, including disposable needles, syringes and test strips • Oral and injectable contraceptives • Insulin with a copay applied to each vial <p>NOTE: If there is no generic equivalent available, you will still have to pay the appropriate Select or non-Select name brand copay.</p>	<p>When your prescription is filled at a participating retail pharmacy, you pay:</p> <ul style="list-style-type: none"> • \$ 5 for Generic One drugs • \$10 for Generic Two drugs • \$15 for Select drugs • \$50 non-Select drugs <p>For up to a 90-day supply from the mail order program:</p> <ul style="list-style-type: none"> • \$10 Generic One drugs • \$20 for Generic Two drugs • \$30 for Select drugs <p>Note: You cannot obtain non-Select drugs under the mail order program.</p>
<ul style="list-style-type: none"> • Diabetic supplies, including disposable needles, syringes and test strips 	<p>\$15 per prescription unit or refill</p> <p>Note: We cover diabetic supplies at the Select name brand copay.</p>
<ul style="list-style-type: none"> • Drugs used to treat sexual dysfunction 	<p>50% coinsurance</p> <p>Note: A 30-day supply is 6 doses. These drugs are not available through the mail order program.</p>
<ul style="list-style-type: none"> • Contraceptive devices, including diaphragms and cervical caps 	<p>50% coinsurance</p>

Limited Prescription Drug Benefits	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Over the counter (OTC) medical supplies such as dressings and antiseptics; except diabetic supplies as ordered in writing by a participating provider and authorized and approved by the Plan</i> • <i>Prescription drugs which have an over-the-counter (OTC) equivalent; over-the-counter (OTC) non-prescription drugs</i> • <i>Drugs for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Infertility drugs and infertility drug therapy including therapeutic injections for the treatment of infertility</i> • <i>Convenience items</i> • <i>Take home drugs from the hospital</i> 	<p><i>All Charges</i></p>

Section 5 (g) Special Features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none">• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.• Alternative benefits are subject to our ongoing review.• By approving an alternative benefit, we cannot guarantee you will get it in the future.• The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits.• Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for the deaf and hearing impaired	<p>A Telecommunication Device for the Deaf (TDD) is available for the deaf and hearing impaired by calling 317/580-4680.</p>

Section 5 (h) Dental benefits

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan providers or dentists must provide or arrange your care.
- *We have no calendar year deductible.*
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of a patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedures or dental supplies 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

We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Services must be provided within 24 hours of the injury. You pay nothing.

Nothing

Not covered:

- *Services that you receive more than twenty-four (24) hours after the accident*
- *Injuries that happen when you are eating or chewing*

All Charges

Dental benefits

We have no other dental benefits.

NOTE: Please refer to Section 5(i) Non FEHB benefits available to Plan members

All Charges

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

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

Expanded Vision Care

- Participating providers will grant a 20% discount on eyeglasses and lenses

Expanded Dental Services

- Members receive a 25% discount on preventive, diagnostic services and minor restorative services when provided by a Plan dentist.
- Specialty dental care and orthodontia services are not covered.
- All other services will be provided at a 15% discount.

- ★ **Members receive a 25% discount on acupuncture, chiropractic, massage therapy and LASIK services when using a Plan provider.**

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

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

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical, Hospital and Prescription 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 317/571-5320.

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

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

Submit your claims to:

M•Plan Member Services
8802 N. Meridian Street, Suite 100
Indianapolis, IN 46260

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
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| 1 | Ask us in writing to reconsider our initial decision. You must: <ol style="list-style-type: none">Write to us within 6 months from the date of our decision; andSend your request to us at: M•Plan, 8802 N. Meridian Street, Suite 100, Indianapolis, Indiana 46260; andInclude a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; andInclude copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records and explanation of benefits (EOB) forms. |
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| 2 | We have 30 days from the date we receive your request to: <ol style="list-style-type: none">Pay the claim (or, if applicable, arrange for the health care provider to give you the care); orWrite to you and maintain our denial -- go to step 4; orAsk you or your medical provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3. |
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| 3 | You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.
If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.
We will write to you with our decision. |
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| 4 | If you do not agree with our decision, you may ask OPM to review it.
You must write to OPM within: <ul style="list-style-type: none">90 days after the date of our letter upholding our initial decision; or120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or120 days after we asked for additional information. |
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Write to OPM at:

Office of Personnel Management
Office of Insurance Programs
Health Benefits Contracts Division 3
1900 E Street, NW
Washington, DC 20415-3630

The Disputed Claims Process (*continued*)

Send OPM the following information:

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

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

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

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

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

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

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

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

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

- (a) We haven't responded yet to your initial request for care or prior authorization/prior approval, then call us at 317/571-5320 and we will expedite our review; or
- (b) We denied your initial request for care or prior authorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Benefits Contracts Division 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. 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. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

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

authorized by your Primary Care Physician and us. **We do not waive deductibles or coinsurance under the FEHB Plan.**

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 provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 317/571-5320 or visit our website at www.mplan.com.

We do not waive your out-of-pocket costs (copays or coinsurance) when you have the Original Medicare Plan

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

Primary Payer Chart		
A. When either you – or your covered spouse – are age 65 or over and ...	Then the primary payer is...	
	Original Medicare	This Plan
Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
Are an annuitant,	✓	
Are a re-employed annuitant with the Federal government when... The position is excluded from FEHB	✓	
Or, the position is not excluded from FEHB (Ask your employing office which of these applies to you.)		✓
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),	✓	
Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and...		
Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and...		
Are eligible for Medicare based on disability, and Are an annuitant	✓	
Are an active employee, or		✓
Are a former spouse of an annuitant, or	✓	
Are a former spouse of an active employee		✓

- **Medicare managed care plan**

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

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

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

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

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

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

- **TRICARE and CHAMPVA**

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

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

- **Workers' Compensation**

We do not cover services that:

- you need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.
- Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

- **Medicaid**

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

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

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

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

- **When others are responsible for injuries**

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of covered charges that you must pay for your care. See page 12.
Copay	A copay is a fixed amount of money you pay when you receive covered services.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial Care	These are non-health related services that do not seek to cure or which are provided during periods when the medical condition of the patient is not changing. Custodial care is primarily assistance with activities of daily living, transportation, meal preparation and companion activities.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. We do not have a deductible.
Experimental or investigational services	Medical technology or a new application of existing medical technology, including medical procedures, drugs and devices for treating a medical condition, illness or diagnosis that: <ul style="list-style-type: none">• Is not generally accepted by informed health care professionals in the United States as effective; or• Has not been proven by scientific testing or evidence to be effective in treating the medical condition, illness or diagnosis for which its use is proposed.
Medical necessity	Services and/or supplies provided by a Hospital, Physician, or other provider to identify and treat an illness or injury that are: <ul style="list-style-type: none">• Consistent with symptoms, or diagnosis and treatment of the condition, disease, ailment or injury;• Appropriate with regard to standards of good medical practice; and• Not primarily for the convenience of the patient, the patient's family, the Physician or the Provider.
Us/We	Us and we refer to M•Plan.
You	You refers to the enrollee and each covered family member.

Section 11. FEHB facts & Coverage information

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

- **Children's Equity Act**

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

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

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

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

- **When benefits and premiums start**

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

When you retire

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

When you lose benefits

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

- **When FEHB coverage ends**

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

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

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to supply

health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

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

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

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

- **Converting to individual coverage**

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

Long Term Care Insurance Is Still Available!

Open Season for Long Term Care Insurance

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

FEHB Doesn't Cover It

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

You Can Also Apply Later, But...

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

You Must Act to Receive an Application

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

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

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

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NOTES:

Summary of benefits for M•Plan - 2003

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	\$10 per office visit to your primary care physician \$15 per office visit to a specialist	14
Services provided by a hospital: • Inpatient.....	\$250 per inpatient admission	27
• Outpatient	\$100 per outpatient surgical admission	28
Emergency benefits: • In-area.....	\$10 per office visit to your primary care physician \$15 per office visit to a specialist	30
• Out-of-area	\$75 Urgent Care Center visit, or \$75 Emergency Room visit	30
Mental health and substance abuse treatment	Regular cost sharing.	31
Prescription drugs: 30-day or 100-unit supply from a Plan Retail Pharmacy	\$5 Generic One, \$10 Generic Two, \$15 Select, and \$50 non-Select drugs	33
Up to 90-day supply from Mail-order Program	\$10 Generic One, \$20 Generic Two, and \$30 Select	
Dental Care - No Benefit	All Charges	37
Vision Care (limited to one annual eye refraction)	You pay \$10 per annual visit	20
Special features: Flexible Benefit Option		36
Protection against catastrophic costs (your out-of-pocket maximum).....	We do not have an out-of-pocket maximum.	12

2003 Rate Information for M•Plan

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 organization who are not career postal employees. Refer to the applicable FEHB Guide.

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

Self Only	IN1	\$109.30	\$ 60.24	\$236.82	\$130.52	\$129.03	\$ 40.51
Self and Family	IN2	\$249.62	\$139.49	\$540.84	\$302.23	\$294.70	\$ 94.41