

HomeTown Health Plan



<http://www.hometownhealthnet.com>

2004

A Health Maintenance Organization

Serving: Akron, Canton and Massillon, Ohio and the surrounding area.

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

Enrollment codes for this Plan:

- MZ1 Self Only**
- MZ2 Self and Family**

Special notice: This Plan is offered for the first time under the Federal Employees Health Benefits Program during the 2003 Open Season.

Authorized for distribution by the:



**United States
Office of Personnel Management**

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



RI 73-824



**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 2004 Federal Employees Health Benefits (FEHB) Program plan brochure. The brochure describes the benefits this plan offers you for 2004. Because benefits vary from year to year, you should review your plan's brochure every Open Season – especially Section 2, which explains how the plan changed.

It takes a lot of information to help a consumer make wise healthcare decisions. The information in this brochure, our FEHB Guide, and our web-based resources, make it easier than ever to get information about plans, to compare benefits and to read customer service satisfaction ratings for the national and local plans that may be of interest. Just click on www.opm.gov/insure!

The FEHB Program continues to be an enviable national model that offers exceptional choice, and uses private-sector competition to keep costs reasonable, ensure high-quality care, and spur innovation. The Program, which began in 1960, is sound and has stood the test of time. It enjoys one of the highest levels of customer satisfaction of any healthcare program in the country.

I continue to take aggressive steps to keep the FEHB Program on the cutting edge of employer-sponsored health benefits. We demand cost-effective quality care from our FEHB carriers and we have encouraged Federal agencies and departments to pay the full FEHB health benefit premium for their employees called to active duty in the Reserve and National Guard so they can continue FEHB coverage for themselves and their families. Our carriers have also responded to my request to help our members to be prepared by making additional supplies of medications available for emergencies as well as call-up situations and you can help by getting an Emergency Preparedness Guide at www.opm.gov. OPM's *HealthierFeds* campaign is another way the carriers are working with us to ensure Federal employees and retirees are informed on healthy living and best-treatment strategies. You can help to contain healthcare costs and keep premiums down by living a healthy life style.

Open Season is your opportunity to review your choices and to become an educated consumer to meet your healthcare needs. Use this brochure, the FEHB Guide, and the web resources to make your choice an informed one. Finally, if you know someone interested in Federal employment, refer them to www.usajobs.opm.gov.

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 are effective April 14, 2003.

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Introduction

This brochure describes the benefits of HomeTown Health Plan under our contract (CS 2880) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for HomeTown Health Plan administrative offices is:

HomeTown Health Network
100 Lillian Gish Boulevard
PO Box 4816
Massillon, OH 44648

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, 2004, unless those benefits are also shown in this brochure. OPM negotiates benefits and rates with each plan annually. Rates are shown at the end of this brochure.

Plain Language

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

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

Stop Health Care Fraud!

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

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

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

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

- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at (330) 837-6880 or (800) 426-9013, Monday through Friday, 8 a.m. to 5 p.m., 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.

Preventing Medical Mistakes

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

1. **Ask questions if you have doubts or concerns.**
 - Ask questions and make sure you understand the answers.
 - Choose a doctor with whom you feel comfortable talking.
 - Take a relative or friend with you to help you ask questions and understand answers.
2. **Keep and bring a list of all the medicines you take.**
 - Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
 - Tell them about any drug allergies you have.
 - Ask about side effects and what to avoid while taking the medicine.
 - Read the label when you get your medicine, including all warnings.
 - Make sure your medicine is what the doctor ordered and know how to use it.
 - Ask the pharmacist about your medicine if it looks different than you expected.
3. **Get the results of any test or procedure.**
 - Ask when and how you will get the results of test or procedures.
 - Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
 - Call your doctor and ask for your results.
 - Ask what the results mean for your care.
4. **Talk to your doctor about which hospital is best for your health needs.**
 - Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
 - Be sure you understand the instructions you get about follow-up care when you leave the hospital.
5. **Make sure you understand what will happen if you need surgery.**
 - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.

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

Want more information on patient safety?

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

Section 1. Facts about this HMO plan

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

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments, 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 individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Your Rights

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

- HomeTown Health Plan is licensed by the Ohio Department of Insurance as a Health Insuring Corporation.
- Years in existence: We began operations in 1987.
- Profit status: We are a not-for-profit organization.

If you want more information about us, call (330) 837-6880 or (800) 426-9013, Monday through Friday, 8 a.m. to 5 p.m., or write to us at HomeTown Health Network, 100 Lillian Gish Boulevard, PO Box 4816, Massillon, OH 44648. You may also contact us by fax at (330) 837-6869 or visit our Web site at www.hometownhealthnet.com.

Service Area

To enroll in this Plan, you must work in our Service Area. This is where our providers practice. Our service area is the following counties in Ohio: Stark, Medina, and Portage Counties and the portions of the following counties that are within a 30-mile radius of a Network Hospital: Carroll, Columbiana, Holmes, Mahoning, Summit, Trumbull, Tuscarawas, Wayne, Ashland, Coshocton, Cuyahoga, Geauga, Guernsey, Harrison, Knox, Lorain, Muskingum and Richland. Please refer to the Provider Directory to determine which Hospitals are in the HomeTown Network.

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 healthcare services out of our service area unless the services have prior plan approval.

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

Section 2. We are a new plan

This Plan is new to the FEHB Program. We are being offered for the first time during the 2003 open season.

Flexible Spending Accounts through FSAFEDS are now available to most Federal employees. You can set aside tax-free money to pay for health and dependent care expenses. The result can be a discount of 20-40% on services you routinely incur and pay for out-of-pocket. See pages 57-60.

We included information regarding Preventing Medical Mistakes. See pages 8-9.

We included information regarding applying for Medicare. See page 49.

We revised the Medicare Primary Payer Chart. See page 51.

Section 3. How you get care

Identification cards

We will send you two identification (ID) cards when you enroll, one from HomeTown Health Plan for your medical benefits and one from CareMark for your prescription drug benefits. You should carry your ID cards with you at all times. You must show your HomeTown Health Plan ID card whenever you receive services from a Plan provider and your CareMark ID card whenever you fill a prescription at a Plan pharmacy. Until you receive your ID cards, 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 cards within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at (330) 837-6880 or (800) 426-9013, Monday through Friday, 8 a.m. to 5 p.m., or write to us at HomeTown Health Network, 100 Lillian Gish Boulevard, PO Box 4816, Massillon, OH 44648.

Where you get covered care

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

- **Plan providers**

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

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

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician (PCP). This decision is important since your PCP provides or arranges for most of your health care. Please refer to Provider Directory for a list of PCPs under contract with HomeTown. If you do not select a PCP it may result in nonpayment of your claims.

- **Primary care**

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

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

- **Specialty care**

Your PCP will submit a referral request to HomeTown to request approval for you to see a Specialist for needed care. You, your PCP and the Specialist will receive a letter from HomeTown indicating HomeTown's referral authorization number. You must have the authorization number prior to visiting the Specialist. Your PCP can call for an authorization number if the appointment is urgent/emergent. If you see a Specialist without the authorization from HomeTown, the Specialist may reschedule your appointment. **Do not go to the Specialist (unless specifically allowed by this Certificate) without written authorization from your PCP and approval from HomeTown.** If you do not have authorization, the care is not a Covered Service and you may be required to pay for the services.

However, women may seek appropriate services from Network obstetricians or gynecologists without referral from the primary care physician. Your obstetrician or gynecologist may only provide obstetrical or gynecological services and may only refer you to another Specialist as provided below. The obstetrician or gynecologist must be a Network Provider and is required to follow HomeTown pre-certification and other practice procedures.

Members may seek appropriate mental health services from the Network provider listed on the Member's ID card without referral from the primary care physician.

Here are other things you should know about specialty care:

- If a Specialist, to whom your PCP has referred you, determines that you need care from another Specialist for the same medical condition that was the basis for the original referral, the Specialist may submit a referral request on your behalf directly to HomeTown. The referral need not be coordinated by your PCP. However, you, your PCP and the Specialist will receive a letter from HomeTown indicating the referral authorization number. If the appointment is urgent/emergent, the Specialist may call HomeTown for an authorization number. If the Specialist determines you need care from another Specialist for an unrelated medical condition, you must contact your PCP and request the referral. The PCP needs to coordinate the referrals for each episode of care. If you see a Specialist without authorization from HomeTown, the Specialist may reschedule your appointment. Do not go to the Specialist without written authorization from the referring Specialist and approval from HomeTown. If you do not have authorization, the care is not a Covered Service and you may be required to pay for the services.
- If your PCP, in consultation with a Specialist, determines you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your PCP may submit a request to HomeTown for a standing referral to the Specialist. If approved, the standing referral may be limited to a certain number of visits, to a certain period of time or require the Specialist to provide progress reports to the PCP. You, your PCP and the Specialist will receive a letter from HomeTown confirming the details of your referral and providing a referral authorization number.
- If you are seeing a Specialist when you enroll in our Plan, talk to your PCP. Your PCP will decide what treatment you need. If he or she decides to refer you to a Specialist, ask if you can see your current Specialist. If your current Specialist does not participate with us, you must receive treatment from a Specialist who does. Generally, we will not pay for you to see a Specialist who does not participate with our Plan.
- If you are seeing a Specialist and your Specialist leaves the Plan, call your PCP, who will arrange for you to see another Specialist. You may receive services from your current Specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your Specialist because we:
 - terminate our contract with your Specialist for other than cause; or
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
 - reduce our service area and you enroll in another FEHB Plan,

you may be able to continue seeing your Specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

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

• **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at (330) 837-6880 or (800) 426-9013, Monday through Friday, 8 a.m. to 5p.m. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member’s benefits under the new plan begin on the effective date of enrollment.

Circumstances beyond our control

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

Services requiring our prior approval

Your PCP has authority to refer you for most services. However, your physician must obtain approval from us as stated below. Before giving approval, we consider if the service is covered, medically appropriate, and follows generally accepted medical practice.

We call this review and approval process “prior authorization.” If you need Hospital care, your PCP will refer you to a Network Hospital. Your PCP will coordinate diagnosis, treatment and progress. If you need care from a Specialist, your PCP will refer you to the appropriate Specialist. This gives you the benefit of an ongoing relationship with one Physician and the expertise of other Physicians and health professionals.

Your PCP will submit a referral request to HomeTown to request approval for you to see the Specialist. You, your PCP and the Specialist will receive a letter from HomeTown

indicating HomeTown's referral authorization number. You must have the authorization number prior to visiting the Specialist. Your PCP can call for an authorization number if the appointment is urgent/emergent. If you see a Specialist without the authorization from HomeTown, the Specialist may reschedule your appointment. **Do not go to the Specialist (unless specifically allowed by this Certificate) without written authorization from your PCP and approval from HomeTown.** If you do not have authorization, the care is not a Covered Service and you may be required to pay for the services.

If a Specialist, to whom your PCP has referred you, determines that you need care from another Specialist for the same medical condition that was the basis for the original referral, the Specialist may submit a referral request on your behalf directly to HomeTown. The referral need not be coordinated by your PCP. However, you, your PCP and the Specialist will receive a letter from HomeTown indicating HomeTown's referral authorization number. If the appointment is urgent/emergent, the Specialist may call HomeTown for an authorization number. If the Specialist determines you need care from another Specialist for an unrelated medical condition, you must contact your PCP and request the referral. The PCP needs to coordinate referrals for each episode of care. If you see a Specialist without the authorization from HomeTown, the Specialist may reschedule your appointment. Do not go to the specialist without written authorization from the referring Specialist and approval from HomeTown. If you do not have authorization, the care is not a Covered Service and you may be required to pay for the services.

If your PCP, in consultation with a Specialist, determines that your condition or disease is life-threatening, degenerative or disabling and that it requires specialized medical care over a prolonged period of time, your PCP may submit a referral request to HomeTown for a Specialist who has expertise treating the condition or disease. Upon approval by HomeTown, the Specialist may coordinate your health care and refer you to other Physicians in the same manner.

Any specialty care you seek should be at the direction of your PCP, or Specialist to whom you have been referred, and should be received from a Network Specialist who practices at a Network Hospital. If you are referred to a Specialist who is not a part of the HomeTown Network, a special referral must be submitted by your PCP or Specialist and approved by HomeTown's Medical Director. When HomeTown is unable to provide a Covered Service from a Network Provider, including a Network Hospital, HomeTown will authorize a Non-Network Provider to provide the service, consistent with the terms of this Certificate. The service will be covered at the same level of benefits as if it were provided by a Network Provider.

Section 4. Your costs for covered services

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

- **Copayments**

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

Example: When you see your PCP you pay a copayment of \$15 per office visit, and when you go in the hospital, you pay \$250 per admission.

Your catastrophic protection out-of-pocket maximum for copayments

After your copayments total \$1,500 per person or \$3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription drugs.

Section 5. Benefits – OVERVIEW

(See page 64 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 (330) 837-6880 or (800) 426-9013, Monday through Friday, 8 a.m. to 5 p.m., or at our Web site at www.hometownhealthnet.com.

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Section 5 (a). Medical services and supplies provided by physicians and other healthcare professionals

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

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

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Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office	\$15 for each visit to a PCP and \$20 for each visit to a Network Specialist.
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Office medical consultations • Second surgical opinion	\$15 for each visit to a PCP and \$20 for each visit to a Network Specialist. \$35 for each visit to an urgent care center. Nothing, if you receive these services in a skilled nursing facility or hospital.
At home	\$15 for each visit by a PCP and \$20 for each visit by a Network Specialist.
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing additional, if you receive these services during your office visit or at an outpatient facility.

Preventive care, adult	You pay
<p>Routine screenings, such as:</p> <ul style="list-style-type: none"> • Total Blood Cholesterol – as determined to be medically necessary by your physician. • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – as determined to be medically necessary by your physician. <p>Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older.</p> <p>Routine Pap test</p> <p>Note: The office visit is covered if Pap test is received on the same day; see <i>Diagnosis and Treatment</i>, above.</p>	<p>\$15 for each visit to a PCP and \$20 for each visit to a Network Specialist.</p>
<p>Routine mammogram –covered for women age 35 and older, as determined to be medically necessary by your physician.</p>	<p>\$15 for each visit to a PCP and \$20 for each visit to a Network Specialist.</p>
<p><i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, travel or recreation, licensure, or under court order.</i></p>	<p><i>All charges.</i></p>
<p>Routine immunizations, limited to:</p> <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations). • Influenza vaccine, annually. • Pneumococcal vaccine, as determined to be medically necessary by your physician. 	<p>\$15 for each visit to a PCP and \$20 for each visit to a Network Specialist.</p> <p>No copay for immunizations.</p>
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics • 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>\$15 for each visit to a PCP and \$20 for each visit to a Network 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: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby. • 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. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	<p>\$20 only for the first visit to a Network Specialist.</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex.</i></p>	<p><i>All charges.</i></p>
Family planning	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>NOTE: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$15 for each visit to a PCP and \$20 for each visit to a Network Specialist.</p>
<p><i>Not covered: reversal of voluntary surgical sterilization and elective abortions.</i></p>	<p><i>All charges.</i></p>

Infertility services	You pay
<p>Diagnosis and treatment of infertility, such as:</p> <ul style="list-style-type: none"> • Artificial insemination (coverage is provided for one course of one of the following): <ul style="list-style-type: none"> – Intravaginal insemination (IVI) – Intracervical insemination (ICI) – Intrauterine insemination (IUI) • Fertility drugs <p>Services for primary infertility (couples who have never conceived and delivered) and secondary infertility (couples who have conceived and delivered one or more children) are covered when determined to be Medically Appropriate and approved in advance by HomeTown’s Medical Director.</p> <p>Initial diagnostic evaluation and/or therapy for infertility is covered. Subsequent evaluations and/or therapy is covered when determined to be Medically Appropriate and approved in advance by HomeTown’s Medical Director.</p> <p>For those individuals who have been diagnosed with a potentially correctable problem, various therapies will be considered for coverage. All therapies must be provided by a Network Specialist who has submitted a specific protocol for their use and is designated as having expertise in infertility and approved by HomeTown’s Medical Director.</p> <p>Note: We cover fertility drugs under the prescription drug benefit.</p>	<p>\$15 for each visit to a PCP and \$20 for each visit to a Network Specialist.</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> 	<p><i>All charges.</i></p>
Allergy care	
<p>Testing and treatment</p>	<p>\$15 for each visit to a PCP and \$20 for each visit to a Network Specialist.</p>
<p>Allergy injection</p>	<p>\$15 for each visit to a PCP and \$20 for each visit to a Network 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 30.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: We will only cover GHT when we preauthorize the treatment. Your physician must call for preauthorization. We will ask your physician to submit information that establishes that the GHT is medically appropriate. GHT must be authorized before you begin treatment. Otherwise, we will only cover GHT services from the date authorization is approved following the submission of required information. If you do not ask or if we determine GHT is not medically appropriate, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	<p>\$15 for each visit to a PCP and \$20 for each visit to a Network Specialist.</p>
Physical and occupational therapies	
<ul style="list-style-type: none"> • 60 visits per year for the services of each of the following: <ul style="list-style-type: none"> – qualified physical therapists, and – 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 heart transplant, bypass surgery or a myocardial infarction, is provided for up to 30 visits per lifetime. 	<p>\$15 for each visit to a PCP and \$20 for each visit to a Network Specialist.</p> <p>\$20 for each outpatient visit.</p> <p>Nothing per visit during covered inpatient admission.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>long-term rehabilitative therapy</i> • <i>exercise programs</i> 	<p><i>All charges.</i></p>

Speech therapy	You pay
<ul style="list-style-type: none"> 60 visits per year. 	<p>\$15 for each visit to a PCP and \$20 for each visit to a Network Specialist.</p> <p>\$20 for each outpatient visit.</p> <p>Nothing per visit during covered inpatient admission.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Speech therapy for developmentally delayed speech. 	<p><i>All charges.</i></p>
Hearing services (testing, treatment and supplies)	You pay
<ul style="list-style-type: none"> First hearing aid and testing only when necessitated by accidental injury Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	<p>\$15 for each visit to a PCP and \$20 for each visit to a Network 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)	
<ul style="list-style-type: none"> One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) 	<p>\$20 per office visit.</p>
<p>VSP WellVision Coverage (Note: These vision benefits are provided through Vision Service Plan)</p> <ul style="list-style-type: none"> Exam: Annual eye refractions. Lenses: 20% discount off the VSP doctor's usual and customary fees for prescription lenses (when a complete pair of prescription glasses is purchased). To receive the discount, lenses must be purchased within 12 months of a covered eye exam, and only through the doctor who performed the exam. Frames: 20% discount off the VSP doctor's usual and customary fees for frames (when a complete pair of prescription glasses is purchased). Contact Lens Evaluation and Fitting: 15% discount off the VSP doctor's usual and customary contact lens professional fees (the discount does not apply to eyewear). <p>Note: See Preventive care, children for eye exams for children</p>	<p>\$10 per office visit.</p> <p>20% discount.</p> <p>20% discount.</p> <p>15% discount.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> Eyeglasses or contact lenses. 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>\$15 for each visit to a PCP and \$20 for each visit to a Network Specialist.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<p><i>All charges.</i></p>
Orthopedic and prosthetic devices	
<p>Implanted prosthetic devices and pacemakers are covered without Copayment if they are part of a required medical treatment and are in accordance with accepted standards and criteria of HomeTown. Non-implanted prosthetics, such as eyes, limbs and external breast prostheses are subject to a 50% Copayment up to a \$200 maximum.</p> <p>Custom-made and/or custom-filled orthotics and prosthetics must be authorized in writing by HomeTown. Coverage limitations and Copayments apply whether the item is applied in the Hospital, emergency department, Physician's office or the home.</p> <p>Orthotics and equipment for the feet are specifically excluded. These exclusions include shoe inserts, arch appliances and special orthopedic shoes. Foot care and orthotics for diabetic Members will be considered on a case-by-case basis according to HomeTown guidelines after review of treatment plans and documented Medical Appropriateness submitted by the Provider.</p> <p>Maintenance, repair or replacement of orthotics and prosthetics is your responsibility and is not covered in cases of loss, damage or wear and tear. Coverage will be considered in cases where replacement is required due to a change in your condition or growth.</p> <p>Under this benefit we also cover:</p> <ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	<p>50% for all orthopedic and prosthetic devices.</p>

Orthopedic and prosthetic devices- Continued on next page

Orthopedic and prosthetic devices <i>(Continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>orthopedic and corrective shoes</i> • <i>arch supports</i> • <i>foot orthotics</i> • <i>heel pads and heel cups</i> • <i>lumbosacral supports</i> • <i>corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>prosthetic replacements</i> 	<p><i>All charges.</i></p>

Durable medical equipment (DME)	You pay
<p>Durable medical equipment is equipment that 1) can withstand repeated use for one or more years, 2) is used to serve only a medical purpose, 3) is not useful in the absence of Illness or Injury, and 4) is appropriate for use in the home. This equipment must be prescribed by your Network Physician, be appropriate for your condition, and be obtained from one of our Network Providers of durable medical equipment. You must receive authorization from HomeTown before you purchase or rent any durable medical equipment.</p> <p>HomeTown will decide whether you should purchase or rent a standard version of a piece of durable medical equipment. Any upgrades to a piece of equipment are at your expense even if they help the equipment to perform better. You must replace the supplies and accessories you need to use the equipment. Disposable supplies are not covered unless they are provided in the Hospital or by a Physician or home health care nurse. These include chux, cleaning agents, rubber gloves, tape, gauzes, scissors and other dressing materials. If a disposable item such as IV tubing or medication pump supplies and hoses is required to operate a piece of equipment and a HomeTown case manager determines that the item is a Covered Service, HomeTown will cover the item, and a 50% Copayment will apply.</p> <p>Upon purchase, the durable medical equipment is considered to be your property. Maintenance, repair or replacement of durable medical equipment is your responsibility and is not covered in cases of loss, damage, or wear and tear. Coverage will be considered in cases where replacement is required due to a change in your condition or growth.</p> <p>HomeTown may limit the number of items that it will cover in a month or during an illness, using federal government or other established standards.</p> <p>Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • hospital beds; • wheelchairs; • crutches; • walkers; • standard blood glucose monitors; and • insulin pumps. 	<p>50% of all durable medical equipment.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Motorized wheel chairs.</i> • <i>Liquid food supplements and enteral feeding.</i> • <i>Nonstandard blood glucose monitors.</i> • <i>Home monitoring or testing equipment including blood pressure equipment; bed wetting alarms; home pregnancy, ovulation, HIV and any other home testing kits.</i> • <i>Home exercise equipment, air purifiers and humidifiers, whirlpool and hot tubs, back cushions, adaptive aids, elastic hose and surgical stockings, cervical collars and abdominal supports, and electric stimulation systems.</i> 	<p><i>All charges.</i></p>

Home health services	You pay
<ul style="list-style-type: none"> • Medically Appropriate home care by Physician-supervised professionals including registered nurses; home health aides; physical, respiratory, occupational and speech therapists; and registered dietitians. Services must be provided or arranged for by a home health agency, approved in advance in writing by HomeTown, and prescribed by a Network Physician. These services must be prescribed in lieu of care in a Hospital or skilled nursing facility. • Services include oxygen therapy, medical supplies (except ostomy supplies and diabetic test tape) and medications given by injection or infusion are Covered Services. 	Nothing.
<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>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic or rehabilitative.</i> • <i>Meals;</i> • <i>Custodial care; and</i> • <i>Housekeeping services.</i> 	<i>All charges.</i>
Chiropractic	
Not covered.	<i>All charges.</i>
Alternative treatments	You pay
<i>Not covered, including homeopathic treatments, acupuncture, massotherapy and some manipulation therapy, hypnotherapy and biofeedback.</i>	<i>All charges.</i>

Educational classes and programs	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking Cessation – Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. • Diabetes self-management • HomeTown-approved health education services and education in the appropriate use of the Plan and Covered Services including: instructions on achieving and maintaining physical and mental health; preventing illness and injury; nutrition counseling; and referral to, but not payment for, appropriate medical social services. 	<p>\$15 for each visit to a PCP and \$20 for each visit to a Network Specialist.</p> <p>There may be a nominal charge for some courses.</p>

Section 5 (b). Surgical and anesthesia services provided by physicians and other healthcare 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 Appropriate.
- Network Physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other healthcare professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

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Benefit Description	You pay After the calendar year deductible...
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 non-cosmetic tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>\$15 for each visit to a PCP and \$20 for each visit to a Network Specialist.</p> <p>Nothing for hospital visits.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care.</i> • <i>Elective pre-surgery testing on an Inpatient basis without the prior authorization.</i> • <i>Salabrasion, chemosurgery, or other such skin abrasion procedures to remove scars or tattoos.</i> 	<p><i>All charges.</i></p>

Reconstructive surgery	You pay
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> --the condition produced a major effect on the member's appearance and --the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> — surgery to produce a symmetrical appearance on the other breast; — treatment of any physical complications, such as lymphedemas; — breast prostheses and surgical bras and replacements (see Prosthetic devices). • Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. 	<p>\$15 for each visit to a PCP and \$20 for each visit to a Network Specialist.</p> <p>Nothing for hospital visits.</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>\$15 for each visit to a PCP and \$20 for each visit to a Network Specialist.</p> <p>Nothing for hospital visits.</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>

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 Appropriate.
- Network Physicians must provide or arrange your care and you must be hospitalized in a Network facility.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

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Benefit Description	You pay
Inpatient hospital	
<p>Room and board, such as:</p> <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. <p>NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.</p>	\$250 copay per admission for all Inpatient Hospital services.
<p>Other hospital services and supplies, such as:</p> <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home. 	Nothing.
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Custodial care and private nursing care</i> • <i>Non-covered facilities, such as nursing homes and schools</i> • <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i> • <i>Elective pre-surgery testing on an Inpatient basis without the prior authorization.</i> • <i>Salabrasion, chemosurgery, or other such skin abrasion procedures to remove scars or tattoos.</i> 	<i>All charges.</i>

<p>Outpatient hospital or ambulatory surgical center</p>	
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>NOTE: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	<p>\$100 per visit for all Outpatient facility services.</p>
<p>Extended care benefits/skilled nursing care facility benefits</p>	<p>You pay</p>
<p>Inpatient Rehabilitation and Skilled Nursing Facility (SNF) Services:</p> <p>Medical care and treatment, including semi-private room and board in a skilled nursing or rehabilitation facility when the stay is ordered by a Network Physician, and approved by HomeTown in lieu of a Hospital stay, and you meet the Medicare criteria for admission to a skilled nursing facility. Covered services are limited to 30 days per stay in a Network facility, unless otherwise provided by law.</p>	<p>\$250 copay per admission for all Inpatient Rehabilitation and Skilled Nursing Facility Services.</p>
<p><i>Not covered: Custodial or domiciliary care and convalescent care.</i></p>	<p><i>All charges.</i></p>
<p>Hospice care</p>	
<p>Members who are diagnosed as having a terminal illness with a life expectancy of six months or less may elect home-based Hospice care for the terminal illness instead of traditional services covered under this Certificate. The focus in Hospice is care, not cure, and treatment is provided for symptom and pain management. Care must be provided by a Network Hospice Provider under the supervision of the PCP with the participation of HomeTown's case manager. While the Hospice election is in effect, Covered Services are provided without charge except for applicable Copayments.</p>	<p>Nothing.</p>
<p><i>Not covered: Independent nursing, homemaker services</i></p>	<p><i>All charges.</i></p>
<p>Ambulance</p>	
<ul style="list-style-type: none"> • Local professional ambulance service for non-emergency transportation when medically appropriate. Prior approval of HomeTown is required. 	<p>\$50 for each trip, and 20% of non-emergency ambulance charges over \$500.</p>

Section 5 (d). Emergency services/accidents

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

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

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What is a medical emergency?

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

What to do in case of emergency.

Emergencies within our service area:

In an emergency, make every attempt to contact your PCP. Your PCP's phone number is on your HomeTown identification card. If you cannot contact your PCP, and further delay may cause serious harm to you, call 9-1-1 or try to go to a Network Hospital for Emergency treatment.

Call your PCP if you experience problems such as: sprains and strains, vomiting, swollen glands, rashes, poison ivy, diarrhea, colds, sore throats, coughs, fever, intermittent abdominal pain, small lacerations, minor burns, bruises, pinkeye, cramps, earache, back pain, insect bites, etc.

Examples of Emergencies: Go immediately to the emergency room if you experience problems such as: severe chest pain, uncontrolled bleeding, suspected overdose of medication, sudden onset of paralysis and/or slurred speech, loss of consciousness, severe shortness of breath, poisoning, severe burns, etc.

Emergency services must be received from a Network Hospital unless:

- Due to circumstances beyond your control, you were unable to utilize a Network Hospital's emergency department without serious threat to life or health.
- A prudent person with an average knowledge of health and medicine would have reasonably believed that, under the circumstances, the time required to travel to a Network Hospital's emergency department could result in placing the health of the individual, or unborn baby, in serious jeopardy or cause serious harm to body functions, organs, or parts.
- A person authorized by HomeTown referred you to an emergency department other than a Network Hospital's emergency department.
- An ambulance took you to a non-Network Hospital other than at your direction.
- You were unconscious.
- A natural disaster precluded the use of a Network Hospital's emergency department.
- The status of a Hospital changed from Network to non-Network with respect to Emergency services during a Contract Year, and HomeTown did not make a good faith effort to notify you of this change.

Tell the Hospital staff you are a HomeTown Member and ask them to call your PCP immediately. Unless your condition prevents it, you should notify your PCP within 24 hours so he or she can coordinate your treatment. Your PCP will provide or arrange all follow-up care. If further care in a Hospital is required, or care by a Specialist is needed, you must work with your PCP to obtain necessary authorizations.

Emergencies outside our service area:

Emergency services outside the Service Area are limited to situations in which care is required immediately and unexpectedly. Services needed for chronic conditions/ongoing care must be authorized, in advance, by HomeTown.

If an Emergency occurs while you are outside of the Service Area, obtain Emergency care at the nearest medical facility. Notify your PCP within 24 hours or as soon as possible thereafter.

Follow-up treatment for the Emergency is limited to care required before you can, without medical harm, return to the Service Area. Follow-up care is otherwise covered only in the Service Area in accordance with this Certificate.

Elective or specialized care or care required through circumstances which could reasonably have been foreseen prior to departure from the Service Area is not covered. Services for normal term delivery outside the Service Area are not covered, but benefits do include complications of pregnancy or unexpected delivery. Also, in order for medical and Hospital services to be covered, the travel outside the Service Area must be for some purpose other than the receipt of medical treatment, unless otherwise authorized by HomeTown.

Note: In no cases will coverage be provided for services of an emergency room for the sole purpose of administering medications and/or immunizations, whether inside or outside the Service Area.

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$15 for each visit to a PCP and \$20 for each visit to a Network Specialist. \$50 per visit to an urgent care center. \$50 per visit to a 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 • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$50 per visit.
<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>All charges.</i>
Ambulance	
Professional ambulance service and other transportation when medically appropriate. Prior approval is required for means other than an ambulance. See 5(c) for non-emergency service.	\$50 per trip.

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

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

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

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

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Benefit Description	You pay After the calendar year deductible...
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>\$20 per visit.</p>
<ul style="list-style-type: none"> • Diagnostic tests 	<p>\$20 per visit.</p>
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility-based intensive outpatient treatment 	<p>\$250 copay per admission for all Inpatient Hospital or partial hospitalization services.</p> <p>\$20 per intensive outpatient visit.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Services we have not approved.</i> • <i>Services for and treatment of mental retardation.</i> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All charges.</i></p>

Mental health and substance abuse benefits *(Continued)*

Preauthorization

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

All services must be arranged by the HomeTown Network mental health Providers listed on your HomeTown identification card. Members may seek appropriate mental health services from the Network Provider listed on the Member's identification card without referral from the Member's PCP.

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 appropriate.
- 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 Network Physician must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a Network pharmacy, or by mail order via Caremark for a maintenance medication.
- **We use a formulary.** The formulary is a preferred list of drugs that have been selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 1-800-378-9302.

If your physician believes a name brand drug is necessary, or there is no generic available, your physician may prescribe a name brand drug from the formulary list. You will pay a higher copay for name brand drugs as specified in the benefit description below.

We cover non-formulary drugs prescribed by a Plan doctor. In most cases, you pay a higher copay for non-formulary drugs as specified in the benefit description below.

- **These are the dispensing limitations.** You may obtain up to a 30-days supply of prescription drugs at a Network pharmacy. You may obtain up to a 90-days supply of prescription drugs by mail order via Caremark for maintenance medications.

A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally approved generic drug is available, and your physician has not specified "Dispense as Written" for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

If a member has a prescription written by a Physician who has left the HomeTown Network, it must be filled within 90 days after the date the Physician left the network in order to be covered. Outstanding, refillable prescriptions must be rewritten by a Network Physician to be covered after that date.

Plan members called to active military duty (or members in time of national emergency) who need to obtain prescribed medications should call our Customer Service Department at (800) 426-9013.

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- **Why use generic drugs?** Generic drug products are always a preferred choice since they are cost effective and tested to have the same quality, strength, purity and stability as brand-name medications. The FDA requires that these generic products must contain the same active ingredients as the original brand and produce the same effects in the body. A generic is given an “A” rating when it is determined that it is equal in terms of safety, efficacy and quality. A generic is given an “AB” rating when it is determined that all actual or potential problems in equality have been resolved. HomeTown’s pharmacy benefit manager, Caremark, only utilizes A- or AB- rated generics and maintains its own review and approval process above and beyond the FDA guidelines.
 - **When you have to file a claim.** In most cases you will not need to file a claim form. In the event you pay for a prescription that is a covered prescription drug, you may file a claim using the Caremark Prescription Drug Claim Form. You may obtain claim forms by contacting Caremark at 1-800-378-9302.
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Benefit Description	You pay After the calendar year deductible...
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Federal Legend Drugs: Any medicinal substance which bears the legend, "Caution: Federal Law Prohibits Dispensing Without a Prescription," except for those medicinal substances classified as Exempt Narcotics under state law. • State-Restricted Drugs: Any medicinal substance that may only be dispensed by a prescription according to state law. • Compounded Medications: Any medicinal substance that must be mixed, compounded or prepared by a Registered Pharmacist with at least one ingredient that is a Federal Legend or State-Restricted Drug in a therapeutic amount. • Diabetic Treatment: Diabetic needles and syringes and injectable insulin. Unless otherwise provided by HomeTown, the maximum amount to be dispensed at one time is: 1) a 30-days supply of needles and syringes; and 2) a 30-days supply or one 10 ml. bottle of injectable insulin, whichever is greater. Diabetic test strips used in a glucose meter testing device are covered with a 25% Copayment. Each of the above supplies requires a separate prescription. • Fertility Drugs: Covered according to HomeTown policy. If covered, a 25% Copayment applies. • Needles and syringes needed to administer self-injectable medications. The maximum amount to be dispensed at any one time is a 30-days supply. • Self-administered injectable medications, other than insulin and fertility drugs, are covered. Self-administered injectable medications, other than insulin and fertility drugs, may require prior authorization in accordance with HomeTown policy. These medications are subject to the greater of a 10% copayment or the member's standard prescription copayment. 	<p>\$15 at a retail pharmacy for up to a 30-days supply and \$15 for each 30-days supply (maximum \$45) via mail order for up to a 90-days supply for each prescription or refill of a generic drug that is listed on the HomeTown formulary.</p> <p>\$25 at a retail pharmacy for up to a 30-days supply and \$25 for each 30-days supply (maximum \$75) via mail order for up to a 90-days supply for each prescription or refill:</p> <ul style="list-style-type: none"> • For a brand name drug if no generic equivalent is listed on the HomeTown formulary; • For a brand name drug which is on the HomeTown formulary when the Member's physician requests that the prescription be dispensed as written because the generic equivalent is ineffective or harmful to the Member; • For a non-formulary drug if HomeTown authorizes the non-formulary drug because the formulary equivalent has been shown to be ineffective or harmful to the Member; or • For a brand name drug when the member selects the brand-name drug instead of the available generic equivalent. In addition, the Member will be required to pay the difference between the cost of the brand name drug and the cost of the generic equivalent. <p>\$40 at a retail pharmacy for up to a 30-days supply and \$40 for each 30-days supply (maximum \$120) via mail order for up to a 90-days supply for each prescription or refill for a brand name drug that is not listed on the HomeTown formulary.</p>

Covered medications and supplies -- continued on next page

Covered medications and supplies <i>(continued)</i>	You pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Federal Legend Drugs used for unapproved or unlabeled indications unless the efficacy and safety is documented in current peer review literature.</i> • <i>Over-the-counter items unless specifically included (e.g. insulin).</i> • <i>Therapeutic devices and appliances other than for family planning.</i> • <i>Drugs and supplies for cosmetic purposes (e.g. Rogaine). Coverage for Retin A will be provided for Members under age 26 and will be reviewed for coverage if over age 26 in cases of severe acne.</i> • <i>Any dietary supplements, diet pills, beauty aids or cosmetic drugs, and nicotine products and other smoking cessation products in excess of the \$100 limit for smoking cessation.</i> • <i>Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any state or governmental agency, or medication furnished by any other drug or medical service in which no charge is made to the recipient.</i> • <i>Any drug labeled, "Caution: Limited by Federal Law to Investigational Use" or any experimental drugs, even though a charge is made to the patient.</i> • <i>Medication which is to be taken in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.</i> • <i>Refilling a prescription in excess of the number specified by the Physician, or any refill dispensed after one year from the order of a Physician.</i> • <i>Drugs to enhance athletic performance.</i> • <i>Drugs obtained at a non-Plan pharmacy, except for out-of-area emergencies.</i> • <i>Megavitamin therapy and nutritional based therapy.</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.

Section 5 (h). Dental benefits

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

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

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Accidental injury benefit	You pay
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.	\$20 per visit.

Dental benefits

We have no other dental benefits.

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

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

DeltaPreferred Option USA (point-of-service) Benefits Features for Federal Government Employees:

DeltaPreferred Option USA (DPO USA) is a national point-of-service preferred provider organization administered by Delta Dental Plan of Ohio. You can go to any licensed dentist, but you could lower your out-of-pocket costs by going to a DPO dentist. If you do not go to a DPO dentist, you will be covered by DeltaPremier USA, our carefully managed fee-for-service program. However, you might have to pay more.

 Delta Dental Plan of Ohio	 DeltaPreferred Option (DPO) Dentist		DeltaPremier or Nonparticipating Dentist	
	Plan Pays	You Pay	Plan Pays	You Pay
Diagnostic and Preventive Service - Used to diagnose and/or prevent dental abnormalities or disease. Includes: <ul style="list-style-type: none"> ▪ 2 cleanings per calendar year. ▪ 2 exams per calendar year. 	80%	20%	80%	20%
Emergency Palliative Treatment - Used to temporarily relieve pain. <ul style="list-style-type: none"> ▪ 1 set of bitewing X-rays per calendar year. ▪ 1 set of full mouth X-rays per 5 years. 	80%	20%	80%	20%
Radiographs - X-rays as required for routine care or as necessary for the diagnosis of a specific condition. Includes: <ul style="list-style-type: none"> ▪ 1 set of bitewing X-rays per calendar year. ▪ 1 set of full mouth X-rays per 5 years. 	80%	20%	80%	20%

HomeTown Health Plan customer service toll-free number 1-800-426-9013
www.hometownhealthnet.com

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 appropriate to prevent, diagnose, or treat your illness, disease, injury, or condition** and we agree, as discussed under *What Services Require Our Prior Approval* on pages 9 and 10.

We do not cover the following:

- Services not provided, arranged or authorized by your PCP, except in an Emergency or when allowed in this brochure.
- 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.
- 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.

- Services for an Illness or Injury which an employer is required by law to furnish. Examples include workers' compensation, occupational disease or other employer liability laws. This provision applies even if you have waived your rights under those laws.
- Services received from a member of the immediate family, or rendered by a Physician or another Provider to himself/herself.
- Any service for which the Member has no legal obligation to pay in the absence of similar coverage.

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at (330) 837-6880 or (800) 426-9013, Monday through Friday, 8 a.m. to 5 p.m.

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: HomeTown Health Plan
100 Lillian Gish Boulevard
PO Box 4816
Massillon, OH 44648

Prescription drugs

In the event you pay for a prescription that is a covered prescription drug, you may file a claim using the Caremark Prescription Drug Claim Form. You may obtain claim forms by contacting Caremark at 1-800-378-9302. A receipt must be submitted with the claim form. The receipt must show:

- Member name;
- Prescription number;
- Pharmacy name and address or NABP number;
- Drug name/strength or NDC number;
- Metric quantity/days supply;
- Dispense As Written (DAW), if applicable;
- Doctor's name or DEA number;

- Purchase date;
- Total charge.

Submit your claims to: Caremark
PO Box 686005
San Antonio, TX 78268-6005

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">(a) Write to us within six months from the date of our decision; and(b) Send your request to us at: HomeTown Health Plan, 100 Lillian Gish Boulevard, PO Box 4816, Massillon, OH 44648; and(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none">(a) Pay the claim (or, if applicable, arrange for the healthcare provider to give you the care); or(b) Write to you and maintain our denial -- go to step 4; or(c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">• 90 days after the date of our letter upholding our initial decision; or• 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or• 120 days after we asked for additional information. <p>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.</p>

The Disputed Claims process (*Continued*)

Send OPM the following information:

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

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

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

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

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

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

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

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

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

- (a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at (330) 837-6880 or (800) 426-9013, Monday through Friday, 8 a.m. to 5 p.m. and we will expedite our review; or
- (b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health 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 covered family member have coverage under another group health plan or have automobile insurance that pays healthcare 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. When HomeTown is secondary, our payments will be based on the balance left after the primary plan has paid. We will pay no more than that balance. In no event will we pay more than we would have paid had we been primary. We will pay only for healthcare expenses that are covered under this Certificate. We will pay only if you have followed all of our procedural requirements, including obtaining care from or arranged by your PCP, obtaining necessary authorizations and following HomeTown's pre-certification process, if required. We will pay no more than the allowable expense for the health care involved. If our allowable expense is lower than the primary plan's, we will use the primary plan's allowable expense. This amount may be less than the actual bill. If we have a contract with the healthcare provider, we will pay no more than we would have paid under the terms of the contract if HomeTown were primary.

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

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

- **Should I enroll in Medicare?**

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

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

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

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

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

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

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care, including obtaining care from or arranged by your PCP, obtaining necessary authorizations and following HomeTown's pre-certification process, if required.

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 then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at (330) 837-6880 or (800) 426-9013, Monday through Friday, 8 a.m. to 5p.m.

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

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

Primary Payer Chart

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

* Unless you have FEHB coverage through your spouse who is an active employee

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

•Medicare + Choice

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare + Choice 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 + Choice plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare + Choice plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and our Medicare + Choice plan: You may enroll in our Medicare + Choice plan and also remain enrolled in our FEHB plan. In this case, we do not waive cost sharing for your FEHB coverage.

This Plan and another plan's Medicare + Choice plan: You may enroll in another plan's Medicare + Choice plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare + Choice plan is primary, even out of the Medicare + Choice 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 + Choice plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare + Choice plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare + Choice plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare + Choice plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare + Choice 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 + Choice plan's service area.

TRICARE and CHAMPVA

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

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in 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.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 12.
Covered services	Care we provide benefits for, as described in this brochure.
Dependent	A person eligible for Dependent coverage under this brochure.
Group health coverage	The contract entered into between your employer and HomeTown Health Plan under which you are provided healthcare coverage under this brochure.
Hospice	An agency or organization that mainly provides palliative care to terminally ill patients.
Hospital	An institution licensed and operated primarily as a general or special acute care hospital giving Inpatient healthcare services for medical and surgical cases. The institution must be accredited by the Joint Commission on Accreditation of Health Care Facilities or the American Osteopathic Association or be otherwise acceptable to HomeTown to provide Hospital services to Members.
Illness	A condition for which a Member is treated. Illness means any covered disease or bodily or mental infirmity, including normal pregnancy and resulting childbirth.
Injury	Accidental bodily damage suffered by a Member.
Inpatient	A Member admitted to a Hospital as a registered bed patient and receiving services under the direction of a Physician.
Medically appropriate, or Medical Appropriateness	<p>A service or supply that is all of the following as determined by HomeTown:</p> <ul style="list-style-type: none">• Necessary and appropriate for the symptoms, diagnosis or treatment of the Member's condition, Illness or Injury;• Provided for the diagnosis, or the direct care and treatment of the Member's condition, Illness or Injury;• In accord with current standards of good medical practice;• Not primarily for the convenience of the Member or Provider; and• The most suitable level of service or supply needed to provide safe and adequate diagnosis or treatment. <p>In addition, a hospitalization is considered Medically appropriate only if the Member requires acute care as a bed patient due to the nature of the services or the Member's condition and the Member cannot receive safe or adequate care as an Outpatient.</p> <p>The fact that a Physician has prescribed, ordered, recommended or approved a service, supply or treatment does not, of itself, make that service, supply or treatment Medically Appropriate.</p>

Member	Any Subscriber or Dependent.
Network	Network, In-Network, or the HomeTown Network mean the Physicians, Hospitals or other Providers under contract with HomeTown. A complete list of Providers in the HomeTown Network can be found in your HomeTown Provider Directory.
Network Provider	A Physician, Hospital or other health service Provider who has a contract with HomeTown to provide Covered Services to Members. Network Providers are listed in your HomeTown Provider Directory.
Non-Network Provider	A Provider not under contract with HomeTown to furnish health care.
Open Season	A period of time designated by your employer during which eligible persons may enroll in this group plan without regard to when their eligibility began.
Out-of-Area	Locations outside HomeTown's Service Area. Members are usually covered for treatment outside the service area only for emergencies.
Outpatient	Treatment that is received by a Member at an Outpatient facility under a Physician's direction, but not on an Inpatient Hospital basis.
Physician	A licensed doctor of medicine, doctor of osteopathy or doctor of dental surgery acting within the scope of his/her license.
Primary Care Physician (PCP)	The HomeTown Network general practitioner, family practitioner, internist or pediatrician that you choose to be your or your Dependent's personal Physician. Your PCP provides you with basic health care and coordinates your referrals to Specialists.
Providers	Physicians, Hospitals and any other facility or person providing health care or medical services.
Service Area	The geographical area served by HomeTown Health Plan.
Specialist	A physician specializing in a particular field such as cardiology, urology or dermatology.
Subscriber	The individual employed by the group who is covered under this brochure for whom subscription rates are being paid.
Us/We	Us and we refer to HomeTown Health 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 cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2004 benefits of your old plan or option. However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2003 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

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

When you lose benefits

• When FEHB coverage ends

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

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

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC); or a conversion policy (a non-FEHB individual policy).

• Spouse equity coverage

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

- **Temporary continuation of coverage (TCC)**

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

Two new Federal Programs complement FEHB benefits

Important information

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

The Federal Flexible Spending Account Program - *FSAFEDS*

- **What is an FSA?**

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

There are two types of FSAs offered by the FSAFEDS Program:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible healthcare expenses not reimbursed by this Plan, or any other medical, dental, or vision care plan you or your dependents may have.
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal income tax return, even if you don't have self and family health benefits coverage. **Note:** The IRS has a broader definition than that of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum amount that can be allotted for the HCFSA is \$3,000 annually. The minimum amount is \$250 annually.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you can work, or if you are married, so you and your spouse can work, or your spouse can look for work or attend school full-time.
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified IRS dependent and/or with whom you jointly file your Federal income tax return.
- The maximum that can be allotted for the DCFSA is \$5,000 annually. The minimum amount is \$250 annually. **Note:** The IRS limits contributions to a Dependent Care FSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive.

- **Enroll during Open Season**

You **must make an election** to enroll in an FSA during the FEHB Open Season. Even if you enrolled during the initial Open Season for 2003, you must make a new election to continue participating in 2004. Enrollment is easy!

- Enroll online anytime during Open Season (November 10 through December 8, 2003) at www.fsafeds.com.
- Call the toll-free number 1-877-FSAFEDS (372-3337) Monday through Friday, from 9 a.m. until 9 p.m. eastern time, and a FSAFEDS Benefit Counselor will help you enroll.

What is SHPS?

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

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB– you can choose to participate in either, or both, of the flexible spending accounts. If you are not eligible for FEHB, you are not eligible to enroll for a Health Care FSA. However, almost all Federal employees are eligible to enroll for the Dependent Care FSA. The only exception is intermittent (also called when actually employed [WAE]) employees expected to work less than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers signed on. Under IRS law, FSAs are not available to annuitants. In addition, the U.S. Postal Service and the Judicial Branch, among others, are Federal agencies that have their own plans with slightly different rules, but the advantages of having an FSA are the same no matter what agency you work for.

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

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits of an FSA, the IRS places strict guidelines on them. You need to estimate how much you want to allocate to an FSA because current IRS regulations require you forfeit any funds remaining in your account(s) at the end of the FSA plan year. This is referred to as the “use-it-or-lose-it” rule. You will have until April 29, 2004, to submit claims for your eligible expenses incurred during 2003 if you enrolled in FSAFEDS when it was initially offered. You will have until April 30, 2005, to submit claims for your eligible expenses incurred from January 1 through December 31, 2004, if you elect FSAFEDS during this Open Season.

The **FSAFEDS Calculator** at www.fsafeds.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

- **What can my HCFSA pay for?**

Every FEHB health plan, includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 61 and detailed throughout this brochure. Your HCFSA will reimburse you for such costs when they are for tax deductible medical care for you and your dependents that is NOT covered by this FEHB Plan or any other coverage that you have.

Under this plan typical out-of-pocket costs include: copayments for primary care, specialty care, inpatient care, surgical care, emergency care, mental health care and prescription drugs.

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

- **Tax savings with an FSA**

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

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

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

- **Tax credits and deductions**

Health care expenses

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

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

Only healthcare expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal income tax return. Using the example listed in the above chart, only healthcare expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal income tax return. In addition, money set aside through a HCFSA is also exempt from FICA taxes. This exception is not available on your Federal income tax return.

Dependent care expenses

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

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

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

Probably not. While there is an administrative fee of \$4.00 per month for an HCFSA and 1.5% of the annual election for a DCFSA, most agencies have elected to pay these fees out of their share of employment tax savings. To be sure, check the FSAFEDS.com Web site or call 1-877-FSAFEDS (372-3337). Also, remember that participating in FSAFEDS can cost you money if don't spend your entire account balance by the end of the plan year and wind up forfeiting your end of year account balance, per the IRS "use-it-or-lose-it" rule.

- **Contact us**

To find out more or to enroll, please visit the **FSAFEDS Web site** at www.fsafeds.com, or contact SHPS by email or by phone. SHPS Benefit Counselors are available from 9:00 a.m. until 9:00 p.m. eastern time, Monday through Friday.

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

The Federal Long Term Care Insurance Program

It's important protection

Here's why you should consider enrolling in the Federal Long Term Care Insurance Program:

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

To find out more and to request an application

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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

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Summary of benefits for the HomeTown Health Plan – 2004

- **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 covered expenses; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: \$15 primary care; \$20 specialist	14
Services provided by a hospital: • Inpatient	\$250 copay per admission	28
• Outpatient	\$100 copay per outpatient visit	29
Emergency benefits: • In-area	\$50 per visit	30
• Out-of-area	\$50 per visit	31
Mental health and substance abuse treatment	Regular cost sharing.	32
Prescription drugs	\$15 for generic drugs \$25 for formulary name brand drugs \$40 for non-formulary drugs	34
Dental Care	No benefit	39
Vision Care	\$10 per visit for annual eye exam 20% discount on frames and lenses purchased within 12 months of a covered eye exam 15% discount off doctor's professional fees for contact lens evaluation and fitting	19
Special features: Flexible benefits option		56
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$1,500/Individual or \$3,000/Family per year Some costs do not count toward this protection	12

2004 Rate Information for HomeTown Health 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 a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

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

Type of Enrollment	Code	<i>Non-Postal Premium</i>				<i>Postal Premium</i>	
		<u>Biweekly</u>		<u>Monthly</u>		<u>Biweekly</u>	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Northeastern Ohio

High Option Self Only	MZ1	\$ 97.25	\$ 32.42	\$210.71	\$ 70.24	\$115.08	\$ 14.59
High Option Self & Family	MZ2	\$243.14	\$ 81.05	\$526.81	\$175.60	\$287.72	\$ 36.47