

# Blue HMO [sm]

<http://www.anthem.com>

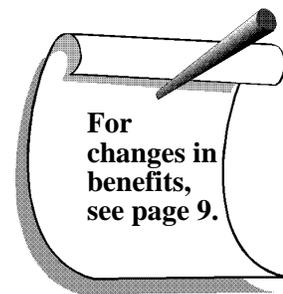
## 2007

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### A Health Maintenance Organization

**Serving: Most of Ohio**

**Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 8 for requirements.**



**Enrollment code for this Plan:**

**R51 Self Only**

**R52 Self and Family**



**Combined HMO/POS**



Authorized for distribution by the:



**United States  
Office of Personnel Management**

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

**Important Notice from Anthem Blue Cross and Blue Shield About  
Our Prescription Drug Coverage and Medicare**

OPM has determined that the Blue HMO prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. Thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefit coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you terminate your FEHB coverage, you may not re-enroll in the FEHB Program.

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**Please be advised**

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If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (November 15th through December 31st) to enroll in Medicare Part D.

**Medicare's Low Income Benefits**

*For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).*

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit [www.medicare.gov](http://www.medicare.gov) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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## Table of Contents

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Table of Contents .....	1
Introduction .....	3
Plain Language.....	3
Stop Health Care Fraud! .....	3
Preventing medical mistakes.....	4
Section 1 Facts about this HMO plan .....	7
Section 2 How we change for 2007 .....	9
Section 3. How you get care .....	10
Identification cards .....	10
Where you get covered care .....	10
• Plan providers .....	10
• Plan facilities.....	10
What you must do to get covered care .....	10
• Primary care .....	11
• Specialty care .....	11
• Hospital care .....	11
• If you are hospitalized when your enrollment begins.....	11
How to get approval for.....	12
• Your hospital stay .....	12
• How to precertify an admission .....	12
• Maternity care .....	12
• What happens when you do not follow the precertifications rules when using non-network facilities .....	12
Circumstances beyond our control.....	12
Services requiring our prior approval.....	12
Section 4 Your costs for covered services .....	14
Copayments .....	14
Deductible .....	14
Coinsurance.....	14
Your catastrophic protection out-of-pocket maximum .....	14
Carryover.....	14
Section 5 High Option Benefits .....	15
Section 6 General exclusions – things we don’t cover .....	46
Section 7 Filing a claim for covered services .....	47
Section 8 The disputed claims process .....	48
Section 9 Coordinating benefits with other coverage .....	50
When you have other health coverage .....	50
What is Medicare?.....	50
• Should I enroll in Medicare?.....	50
• The Original Medicare Plan (Part A or Part B) .....	51
• Medicare Advantage (Part C) .....	51
• Medicare prescription drug coverage (Part D).....	52
TRICARE and CHAMPVA .....	58
Workers’ Compensation.....	58
Medicaid.....	58
When other Government agencies are responsible for your care.....	58
When others are responsible for injuries .....	58

Section 10 Definitions of terms we use in this brochure .....	55
Section 11 FEHB Facts .....	58
Coverage information.....	58
• No pre-existing condition limitation .....	58
• Where you can get information about enrolling in the FEHB Program .....	58
• Types of coverage available for you and your family .....	58
• Children’s Equity Act .....	58
• When benefits and premiums start.....	59
• When you retire.....	59
When you lose benefits .....	60
• When FEHB coverage ends .....	60
• Upon divorce.....	60
• Temporary Continuation of Coverage (TCC).....	61
• Converting to individual coverage.....	61
• Getting a Certificate of Group Health Plan Coverage .....	61
Section 12 Three Federal Programs complement FEHB benefits .....	61
Important information .....	61
It’s important protection.....	61
What is an FSA?.....	61
What expenses can I pay with an FSAFEDS account? .....	62
Who is eligible to enroll? .....	62
When can I enroll? .....	62
Who is SHPS? .....	62
Who is BENEFEDS? .....	62
Important Information .....	63
Dental Insurance.....	63
Vision Insurance.....	64
What plans are available?.....	64
Premiums.....	64
Who is eligible to enroll? .....	64
Enrollment types available .....	64
Which family members are eligible to enroll? .....	64
When can I enroll? .....	64
How do I enroll?.....	64
When will coverage be effective? .....	65
How does this coverage work with my FEHB plan’s dental or vision coverage? .....	65
Summary of benefits for the High Option of Blue HMO - 2007.....	66
2007 Rate Information for - Blue HMO .....	68

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## Introduction

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This brochure describes the benefits of **Blue HMOsm** under our contract (CS 1659) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by Community Insurance Company, dba Anthem Blue Cross and Blue Shield\*. The address for the Blue HMO administrative offices is:

Anthem Blue Cross and Blue Shield

Blue HMO, Mail No. OH0402-B014

1351 William Howard Taft Road

Cincinnati, OH 45206-1775

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, 2007, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2007, and changes are summarized on page 9. Rates are shown at the end of this brochure.

\*An independent licensee of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. ®Registered marks Blue Cross and Blue Shield Association.

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## Plain Language

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

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

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

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## Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except for your health care providers, authorized health benefits 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) statements that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

Call the provider and ask for an explanation. There may be an error.

If the provider does not resolve the matter, call us at 800/848-9276 and explain the situation.

If we do not resolve the issue:

**CALL --- THE HEALTH CARE FRAUD HOTLINE**

**202-418-3300**

**OR WRITE TO:**

**United States Office of Personnel Management**

**Office of the Inspector General Fraud Hotline**

**1900 E Street NW Room 6400**

**Washington, DC 20415-1100**

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

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

Your child over age 22 (unless he/she is disabled and incapable of self support).

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

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## **Preventing medical mistakes**

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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.**

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.

## **3.Get the results of any test or procedure.**

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

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

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

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

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

Visit these Web sites for more information about patient safety.

Ø [www.ahrq.gov/path/beactive.htm](http://www.ahrq.gov/path/beactive.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 health care providers and improve the quality of care you receive.

Ø [www.npsf.org](http://www.npsf.org). The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.

Ø [www.talkaboutrx.org/](http://www.talkaboutrx.org/). The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.

Ø [www.leapfroggroup.org](http://www.leapfroggroup.org). The Leapfrog Group is active in promoting safe practices in hospital care.

Ø [www.ahqa.org](http://www.ahqa.org). The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Ø [www.quic.gov/report](http://www.quic.gov/report). Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

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## Section 1 Facts about this HMO plan

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

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only 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.**

### **General features of our High Option Plan**

#### **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, and our providers. OPM's FEHB Web site ([www.opm.gov/insure](http://www.opm.gov/insure)) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Disenrollment rates for 2005
- Compliance with State and Federal licensing or certification requirements and the dates met. If noncompliant, the reason for noncompliance
- Accreditations by recognized accrediting agencies and the dates received
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records
- Years in existence
- Profit status
- Transitional Care
- Medical Records

If you want more information about us, call 800-228-4375, or write to Mail No. OH0402-B014, 1351 William Howard Taft Road, Cincinnati, Ohio 45206-1775. You may also contact us by fax at 513-872-3929 or visit our Web site at [www.anthem.com](http://www.anthem.com).

The Plan has a Confidentiality Policy. This policy sets forth guidelines regarding a member's right to access and amend information in the Plan's possession. The Policy specifically addresses when a release, signed by a member, is required before information may be disclosed by the Plan to parties such as a member's provider, spouse, or other family members. Through the contract under which the Plan is administering your benefits, the Plan is not required to obtain your consent to the release of any information or records concerning claims for routine uses as may be reasonably necessary for the administration of your benefits. Please refer to our Web site [www.anthem.com](http://www.anthem.com), *Frequently Asked Questions*, for further details.

## **Service Area**

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is:

**Cincinnati Area:** In *Ohio* -- Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland and Warren Counties

**Cleveland Area:** In *Ohio* – Ashtabula, Cuyahoga, Geauga, Lake, Lorain, Medina, and Summit Counties

**Dayton Area:** In *Ohio* -- Butler, Champaign, Clark, Clinton, Darke, Greene, Logan, Miami, Montgomery, Preble, Shelby and Warren counties, and ZIP codes 43128 and 43142 in Fayette County

**Akron-Canton Area:** In *Ohio* -- Ashland, Carroll, Harrison, Holmes, Medina, Portage, Stark, Summit, Tuscarawas, and Wayne Counties

**Warren-Youngstown Area:** In *Ohio* – Belmont, Columbiana, Jefferson, Mahoning, and Trumbull Counties

**Columbus Area:** In *Ohio* -- Athens, Coshocton, Crawford, Delaware, Fairfield, Franklin, Guernsey, Hocking, Knox, Licking, Madison, Marion, Morrow, Muskingham, Perry, Pickaway, Pike, Richland, Ross, Scioto, Union and Washington Counties

**Toledo-Defiance Area:** In *Ohio* -- Allen, Auglaize, Defiance, Erie, Fulton, Hancock, Hardin, Henry, Huron, Lucas, Mercer, Ottawa, Paulding, Putnam, Sandusky, Seneca, Williams, Wood, Wyandot and Van Wert Counties

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

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan, or an HMO that has agreements with affiliates in other areas, or refer to Section 5(g) *Special Features* on page 41 for details regarding our reciprocity benefits. 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.

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## Section 2 How we change for 2007

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

### Changes to this Plan

- Your share of the non-Postal premium will increase by 20.3% for Self Only or 20.4% for Self and Family
- Inpatient hospital services now include a \$200 copay per admission. Previously, there was no copay for inpatient hospital services. ( Section 5(c) )
- Outpatient hospital facility charges will now include a \$100 copay. Previously, there was no copay for outpatient facility services. ( Section 5(c) )
- The office visit copay for professional services by a physician is now \$15. Previously, the copay was \$10. ( Section 5(a) )
- The office visit copay for professional services by a specialist is now \$15. Previously, the copay was \$10. Maternity visits will remain covered in full. ( Section 5(a) )
- The office visit copay for professional services by a chiropractor is now \$15. Previously, the copay was \$10. ( Section 5(a) )
- The Emergency room copay is now \$75. Previously, the copay was \$50. ( Section 5(d) )
- The prescription drug copayments for a 30-day supply will increase from \$20 copay for formulary name brand and \$30 copay for non-formulary name brand to \$25 copay for formulary name brand and \$40 copay for non-formulary name brand. ( Section 5(f) )
- The prescription drug copayments for a 90-day supply will increase from \$40 copay for formulary name brand and \$60 copay for non-formulary name brand to \$50 copay for formulary name brand and \$80 copay for non-formulary name brand. ( Section 5(f) )

### Clarifications to this Plan

- We updated the criteria for Surgical treatment of morbid obesity to reflect a Body Mass Index (BMI) of 35 or greater. ( Section 5(b) )
- We updated the Inpatient hospital exclusions to remove *Inpatient hospital stays when the patient checks out Against Medical Advice (A.M.A.)*. ( Section 5(c) and 5(e) )
- We updated the Prescription drug section to clarify the applicable copays for off-label use of covered medications. ( Section 5(f) )
- We added automatic blood pressure monitors to the list of covered Durable medical equipment (DME). ( Section 5(a) )
- We updated the Emergency services section to clarify the applicable copays by adding: Note: Emergency Care-Observation setting without an inpatient admission – member emergency room copay applies. ( Section 5(d) )
- We updated General exclusions to include; Telephone consultations or consultations via electronic mail or internet/web, except as required by law or authorized by us. ( Section 6 )

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## Section 3. How you get care

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### Identification cards

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

Note: Beginning January 1, 2006, we will no longer use your Social Security Number as your identification number. In order to help protect your identity we will begin using randomly generated alpha/numeric characters (unique IDs).

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-228-4375 or write to us at Blue HMO, Mail No. OH0402-B014, 1351 William Howard Taft Road, Cincinnati, Ohio 45206-1775. You may also request replacement cards through our Web site: [www.anthem.com](http://www.anthem.com)

### Where you get covered care

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

- **Plan providers**

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

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

- **Plan facilities**

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

### What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician (PCP). This decision is important since your primary care physician provides or arranges for most of your health care.

#### How you choose a PCP

1. Ask family and friends about their doctors. While you're at it, ask health care practitioners you respect, too. Personal recommendations can mean a lot.
2. After you choose a PCP, make an appointment to get to know your PCP and help your PCP get to know you. At your first appointment, talk to your PCP about:
  - What are your office hours?
  - Who will handle my care when you aren't available?
3. Pay attention. Does the physician explain things so you can understand? Are you comfortable talking with him or her? Is the tone of the conversation friendly and respectful? Is the physician listening carefully to you?

#### How you change your PCP

You are encouraged to develop a long-term relationship with one Physician, but you may change your PCP if you feel it is necessary, or if your PCP leaves this Plan. Select your new Physician from the Plan's Provider Directory, and then contact us to make the change. If you need help selecting your PCP, call us. You can only change your PCP once in a 30-day period.

### Timing a Physician change

- If you notify us before the 15th of the month, your new PCP choice is effective the first day of the following month
- If you notify us on or after the 15th of the month, your new PCP choice is effective on the first day of the second month

- **Primary care**

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

- **Specialty care**

Your primary care physician will refer you to a specialist when necessary; however, we do not require referrals from your PCP for participating specialty care providers. If specialists or consultants are required beyond those participating with us, your primary care doctor will make arrangements for appropriate referrals. There are certain services that may require prior approval by us; see Section 3, page 12. It is always a good idea for you to talk with your PCP before receiving care from any specialty care provider.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will work with you and the Plan to develop a treatment plan.
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and 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 program Plan; or
  - Reduce our service area and you enroll in another FEHB Plan,

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

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

- **Hospital care**

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

- **If you are hospitalized when your enrollment begins**

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800-228-4385. If you are new to the FEHB Program, we will arrange for you to receive care and reimburse you for your covered expenses while you are in the hospital beginning on the effective date of your coverage.

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

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

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

### **How to get approval for...**

- **Your hospital stay** Your Plan physician will make the appropriate arrangements for you when you need a hospital stay. If you are seeing a non-network physician you should contact us at 800-228-4375 for additional instructions.
- **How to precertify an admission** Plan physicians are required to obtain precertification for you when you are in need of certain services. However, if you visit an out-of-network physician then the precertification process becomes your responsibility.  
  
Most providers know which services require precertification and will obtain any required precertification. Generally, the ordering provider, facility or attending physician will call to request a precertification review. We will work with the requesting provider for the precertification request.
- **Maternity care** For childbirth admissions, Precertification is not required unless there is a complication and/or the mother and baby are not discharged at the same time.
- **What happens when you do not follow the precertifications rules when using non-network facilities** Since precertification is part of the prior approval process you would need approval to use a non-network facility. If you use a non-network facility without prior approval or precertification you may be financially responsible for the charges. It is always a good idea to ask the provider if the services have been precertified.

### **Circumstances beyond our control**

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

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

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

We call this review and approval process precertification.

Your physician must obtain precertification for the following services such as, but not limited to:

- All inpatient admissions (except maternity)
- Newborn stays beyond the discharge of the mother
- Transplants (Human Organ Tissue Transplants only)
- Inpatient hospice
- Uvulopalatopharyngoplasty, uvulopharyngoplasty surgery (UPPP)
- Plastic/Reconstructive surgeries such as but not limited to: Blepharoplasty, Rhinoplasty and Panniculectomy and Lipectomy/diastasis Recti Repair
- Durable Medical Equipment (DME) – specialized or motorized/powerd wheelchairs and accessories

- Prosthetics – electronically or externally powered and custom made and/or custom fitted prefabricated orthotics and braces
- Surgical treatment of morbid obesity
- Private duty nursing in a home setting
- Certain prescription drugs, such as Growth Hormones
- Diagnostic imaging such as, but not limited to: Computed Tomography (CT), Computed Tomographic Angiography (CTA), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Magnetic Resonance Spectroscopy (MRS), Nuclear Cardiology and Positron Emission Tomography (PET)

Precertification is a feature that requires an approval be obtained from us before incurring expenses for certain covered services. When care is evaluated, both medical necessity and appropriate length of stay will be determined. Medical necessity includes a review of both the services and the setting. For certain services you will be required to use the provider designated by Our Health Care Management staff. The care will be covered according to your benefits for the number of days approved unless our concurrent review determines that the number of days should be revised. If a request is denied, the provider may request a reconsideration. An expedited reconsideration may be requested when your health requires an earlier decision.

For emergency admissions, precertification is not required. However, you must notify us of your admission within 24 hours or as soon as possible within a reasonable period of time.

Predetermination is the process of requesting approval of benefits before the service or supply is rendered.

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## Section 4 Your costs for covered services

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This is what you will pay out-of-pocket for covered care.

### **Copayments**

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

Example: When you see your primary care physician you pay a copayment of \$15 per office visit and when you go in the hospital you pay \$200 per admission.

### **Deductible**

We do not have a deductible.

### **Coinsurance**

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

Example: In our Plan, you pay 20% of our allowance for durable medical equipment.

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

After your copayments and/or coinsurance 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 and/or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments and/or coinsurance for these services:

- Dental services
- Prescription drugs

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

### **Carryover**

If you changed to this Plan during Open Season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your old plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

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## Section 5 High Option Benefits

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See page 9 for how our benefits changed this year. Page 66 is a benefits summary. Make sure that you review benefits that are available to you.

Section 5 High Option Benefits Overview .....	17
Section 5(a) Medical services and supplies provided by physicians and other health care professionals.....	18
Diagnostic and treatment services .....	18
Lab, X-ray and other diagnostic tests .....	18
Preventive care, adult .....	19
Preventive care, children .....	19
Maternity care.....	20
Family planning.....	20
Infertility services.....	20
Allergy care .....	21
Treatment therapies .....	21
Physical and occupational therapies.....	22
Speech therapy .....	22
Hearing services (testing, treatment, and supplies).....	22
Vision services (testing, treatment, and supplies).....	22
Foot care.....	23
Orthopedic and prosthetic devices .....	23
Durable medical equipment (DME).....	23
Home health services.....	24
Chiropractic .....	25
Alternative treatments .....	25
Educational classes and programs.....	25
Section 5(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	26
Surgical procedures .....	26
Reconstructive surgery .....	27
Oral and maxillofacial surgery .....	27
Organ/tissue transplants .....	28
Anesthesia .....	31
Section 5(c) Services provided by a hospital or other facility, and ambulance services .....	32
Inpatient hospital .....	32
Outpatient hospital or ambulatory surgical center .....	33
Extended care benefits/Skilled nursing care facility benefits .....	33
Hospice care .....	33
Ambulance .....	33
Section 5(d) Emergency services .....	34
Emergency within our service area .....	35
Emergency outside our service area.....	35
Ambulance .....	35
Section 5(e) Mental health and substance abuse benefits.....	36
Mental health and substance abuse benefits.....	36
Preauthorization .....	38
Limitation .....	38
Section 5(f) Prescription drug benefits .....	38
Covered medications and supplies .....	40

Section 5(g) Special features.....41  
    Feature .....41  
Section 5(h) Dental benefits.....43  
    Accidental injury benefit .....43  
    Service .....43  
Summary of benefits for the High Option of Blue HMO - 2007 .....66

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## Section 5 High Option Benefits Overview

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This Plan offers High Option benefits. The benefit package is described in Section 5. Make sure that you review the benefits that are available under this option.

The High Option Section 5 is divided into subsections. Please read the important things you should keep in mind at the beginning of the subsections. 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 High Option benefits, contact us at 800-228-4375 or at our Web site at [www.anthem.com](http://www.anthem.com).

This option offers unique features.

<b>High Option</b>	
<ul style="list-style-type: none"> <li>• No referrals needed for Plan participating specialists</li> <li>• No deductibles</li> <li>• Office visits you pay a \$15 copayment</li> <li>• Mail order prescription drug program</li> <li>• Dental benefits               <ul style="list-style-type: none"> <li>Preventive services you pay nothing</li> <li>Restorative services you pay 80%</li> </ul> </li> <li>• Emergency and urgent care coverage while traveling</li> <li>• Guest memberships at affiliated HMO plans throughout the country when you or a family member is away from our service are for more than 90 days. You must contact the Plan for specific information concerning this program.</li> <li>• 24 hour Nurse line</li> <li>• A variety of discount programs which provide savings on selected health and wellness services</li> </ul>	

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

### Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay
<b>Diagnostic and treatment services</b>	
Professional services of physicians, physicians assistants or nurses <ul style="list-style-type: none"> <li>• In a primary care physician's office</li> <li>• In a specialty physician's office</li> <li>• Office medical consultations</li> <li>• Second surgical opinion</li> </ul>	\$15 per office visit
Professional services of physicians <ul style="list-style-type: none"> <li>• In an urgent care center</li> </ul>	\$25 per visit
Professional services of physicians <ul style="list-style-type: none"> <li>• At home</li> <li>• During a hospital stay</li> <li>• In a skilled nursing facility</li> </ul>	Nothing
<b>Lab, X-ray and other diagnostic tests</b>	
Tests, such as: <ul style="list-style-type: none"> <li>• Blood tests</li> <li>• Urinalysis</li> <li>• Non-routine Pap tests</li> <li>• Pathology</li> <li>• X-rays</li> <li>• Non-routine mammograms</li> <li>• CAT Scans/MRI</li> <li>• Ultrasound</li> <li>• Electrocardiogram and EEG</li> </ul>	\$15 per office visit; Nothing for Lab, X-ray and other diagnostic tests

Benefit Description	You pay
<b>Preventive care, adult</b>	
<p>Routine physical examination which includes:</p> <p>Routine screenings, such as:</p> <ul style="list-style-type: none"> <li>• Total Blood Cholesterol</li> <li>• Colorectal Cancer Screening , including <ul style="list-style-type: none"> <li>- Fecal occult blood test</li> <li>- Sigmoidoscopy, screening – starting at age 50</li> <li>- Double contrast barium enema (DCBE) – once every 5-10 years starting at age 50</li> <li>- Colonoscopy – once every 10 years starting at age 50</li> </ul> </li> <li>• Routine Prostate Specific Antigen (PSA) test – one annually for men</li> <li>• Routine Pap test</li> <li>• One routine mammogram, per calendar year, regardless of age</li> <li>• Fasting Lipoprotein profile (total cholesterol, LDL, HDL and triglycerides)</li> <li>• Bone density screening</li> <li>• Osteoporosis screening for women 65 and older and routine screening beginning at age 60 for women with increased risk</li> <li>• Abdominal Aortic Aneurysm screening – ultrasonography, one between the age of 65 and 75, for men with smoking history</li> </ul>	<p>\$15 per office visit; Nothing for routine screenings</p>
<p><i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i></p>	<p><i>All charges.</i></p>
<p>Routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC):</p> <ul style="list-style-type: none"> <li>• Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations)</li> <li>• Influenza vaccine, for pregnant women, and annually for men and women, age 50 and older</li> <li>• Pneumococcal vaccine, age 65 and older</li> </ul>	<p>\$15 per office visit; Nothing for immunizations</p>
<b>Preventive care, children</b>	
<ul style="list-style-type: none"> <li>• Childhood immunizations recommended by the American Academy of Pediatrics</li> </ul>	<p>\$15 per office visit; Nothing for immunizations</p>
<ul style="list-style-type: none"> <li>• Well-child care charges for routine examinations, immunizations and care (up to age 22)</li> <li>• Examinations, such as: <ul style="list-style-type: none"> <li>- Eye exams through age 17 to determine the need for vision correction</li> <li>- Hearing exams to determine the need for hearing correction</li> <li>- Examinations done on the day of immunizations (up to age 22)</li> </ul> </li> </ul>	<p>\$15 per office visit; Nothing for examinations</p>

Benefit Description	You pay
<b>Maternity care</b>	
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery</li> <li>• Postnatal care</li> <li>• One routine sonogram</li> </ul> <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> <li>• You do not need to precertify your normal delivery; see page 12 for other circumstances, such as extended stays for you or your baby.</li> <li>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery (you do not need to precertify the normal length of stay). We will extend your inpatient stay for you or your baby if medically necessary. See page 12 for other circumstances.</li> <li>• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care (including circumcision) of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits, apply to circumcision.</li> <li>• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits Section 5(c) and Surgery benefits Section 5(b).</li> </ul>	Nothing
<i>Not covered: Subsequent routine sonograms to determine fetal age, size or sex</i>	<i>All charges.</i>
<b>Family planning</b>	
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> <li>• Voluntary sterilization (See Surgical procedures Section 5(b) )</li> <li>• Surgically implanted contraceptives</li> </ul> <p>Note: See Prescription drug benefits (Section (5f) ) for oral and injectable contraceptives (such as Depo provera) when purchased through a retail pharmacy</p>	\$15 per office visit; Nothing for Family planning services
<ul style="list-style-type: none"> <li>• Intrauterine devices (IUDs)</li> <li>• Diaphragms (when provided in a physician's office)</li> </ul>	\$15 per office visit; 20% of our allowance for Birth control devices
<i>Not covered: Reversal of voluntary surgical sterilization</i>	<i>All charges.</i>
<b>Infertility services</b>	
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> <li>• Artificial insemination: <ul style="list-style-type: none"> <li>- Intravaginal insemination (IVI)</li> <li>- Intracervical insemination (ICI)</li> <li>- Intrauterine insemination (IUI)</li> </ul> </li> </ul>	\$15 per office visit; Nothing for infertility services
<ul style="list-style-type: none"> <li>• Fertility drugs</li> </ul>	\$15 per office visit; 50% of our allowance for Fertility drugs

*Infertility services - continued on next page*

Benefit Description	You pay
<b>Infertility services (cont.)</b>	
<p>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under Section 5(f) Prescription drug benefits</p>	\$15 per office visit; 50% of our allowance for Fertility drugs
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Assisted reproductive technology (ART) procedures, such as: <ul style="list-style-type: none"> <li>- In vitro fertilization</li> <li>- Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</li> </ul> </li> <li>• Services and supplies related to excluded ART procedures</li> <li>• Cost of donor sperm</li> <li>• Cost of donor egg.</li> </ul>	<i>All charges.</i>
<b>Allergy care</b>	
<ul style="list-style-type: none"> <li>• Testing</li> </ul>	\$15 per office visit; 20% of our allowance for Allergy testing
<ul style="list-style-type: none"> <li>• Treatment <ul style="list-style-type: none"> <li>- Allergy injections</li> <li>- Allergy serum</li> </ul> </li> </ul>	\$15 per office visit; Nothing for Allergy injections and serum
<p><i>Not covered:Provocative food testing and sublingual allergy desensitization</i></p>	<i>All charges.</i>
<b>Treatment therapies</b>	
<ul style="list-style-type: none"> <li>• Chemotherapy and radiation therapy</li> </ul> <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 28</p> <ul style="list-style-type: none"> <li>• Respiratory and inhalation therapy</li> <li>• Dialysis – hemodialysis and peritoneal dialysis</li> <li>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy</li> </ul>	\$15 per office visit; Nothing for Treatment therapies
<ul style="list-style-type: none"> <li>• Growth hormone therapy (GHT)</li> </ul> <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: Approval is based on our medical policy. We may ask you or your physician to submit, through our predetermination process, the following:</p> <ul style="list-style-type: none"> <li>- A letter of medical necessity</li> <li>- Laboratory results, and</li> <li>- A growth chart</li> </ul>	\$15 per office visit; 50% of our allowance for Growth hormone therapy (GHT)

Benefit Description	You pay
<b>Physical and occupational therapies</b>	
<p>60 visits, per calendar year, for the services by the following:</p> <ul style="list-style-type: none"> <li>• Qualified physical therapists</li> <li>• Qualified chiropractors (physical therapy only) and</li> <li>• Qualified occupational therapists</li> </ul> <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> <li>• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction</li> </ul>	<p>\$15 per visit</p> <p>Nothing per visit during a covered inpatient admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Long-term rehabilitative therapy</i></li> <li>• <i>Exercise programs</i></li> <li>• <i>Inpatient hospital stays for physical therapy purposes only</i></li> </ul>	<p><i>All charges.</i></p>
<b>Speech therapy</b>	
<p>60 visits, per calendar year</p>	<p>\$15 per visit</p> <p>Nothing per visit during a covered inpatient admission.</p>
<b>Hearing services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>• Hearing examinations to determine the need for hearing correction</li> <li>• Hearing testing for children through age 17 (see <i>Preventive care, children</i>)</li> </ul>	<p>\$15 per office visit; Nothing for Hearing services</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>All other hearing testing</i></li> <li>• <i>Hearing aids, testing and examinations for them</i></li> </ul>	<p><i>All charges.</i></p>
<b>Vision services (testing, treatment, and supplies)</b>	
<ul style="list-style-type: none"> <li>• One routine eye exam with refraction per year</li> </ul> <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p>	<p>\$15 per office visit</p>
<ul style="list-style-type: none"> <li>• First pair of prescribed contact or eyeglass lenses following cataract surgery</li> </ul> <p>Note: Contact lenses or glasses are often prescribed following intraocular lens implantation for the treatment of cataracts. See <i>Orthopedic and prosthetic devices</i> for internal device insertion benefits.</p>	<p>\$15 per office visit; 20% of our allowance for First pair of lenses</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Eyeglasses (frames and lenses)</i></li> <li>• <i>Contact lenses, contact fittings or contact examinations</i></li> <li>• <i>Eye exercises and vision training</i></li> <li>• <i>Radial keratotomy and other refractive surgery</i></li> <li>• <i>Photo-Refractive keratectomy (PRK)</i></li> </ul>	<p><i>All charges.</i></p>

Benefit Description	You pay
<b>Foot care</b>	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts</p>	\$15 per office visit
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i></li> <li>• <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i></li> </ul>	<i>All charges.</i>
<b>Orthopedic and prosthetic devices</b>	
<p>Externally worn orthopedic and prosthetic devices such as:</p> <ul style="list-style-type: none"> <li>• Artificial limbs and eyes; stump hose</li> <li>• Braces, slings, splints and certain orthotics</li> <li>• Externally worn breast prostheses and surgical bras, or necessary replacements, following a mastectomy</li> <li>• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.</li> </ul> <p>Note: See Section 5(b) for coverage of the medical treatment of TMJ pain dysfunction syndrome</p>	\$15 per office visit; 20% of our allowance for Orthopedic and prosthetic devices
<ul style="list-style-type: none"> <li>• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy.</li> </ul> <p>Note: Internal prosthetic devices are paid as hospital benefits; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b) for coverage of the surgery to insert the device.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Orthopedic shoes</i></li> <li>• <i>Foot support devices, such as arch supports and corrective shoes, unless they are an integral part of a leg brace</i></li> <li>• <i>Bionic, bioelectric, or computer programmed prosthetic devices unless authorized by the Plan</i></li> </ul>	<i>All charges.</i>
<b>Durable medical equipment (DME)</b>	
<p>We cover rental or purchase of durable medical equipment, at our option, including repair and adjustment. Covered items include:</p> <ul style="list-style-type: none"> <li>• Oxygen</li> <li>• Hospital beds</li> <li>• Wheelchairs</li> <li>• Crutches, walkers</li> <li>• Blood glucose monitors (when purchased at a participating medical supply provider)</li> <li>• Insulin pumps</li> </ul>	\$15 per office visit; 20% of our allowance for DME services rendered in a physician's office or from a medical supplier

*Durable medical equipment (DME) - continued on next page*

Benefit Description	You pay
<b>Durable medical equipment (DME) (cont.)</b>	
<ul style="list-style-type: none"> <li>• First pair of lenses following cataract removal</li> <li>• Wig (one per year following cancer treatment up to plan allowable)</li> <li>• Surgical stockings (30mm/hg) or supports when purchased by prescription or dispensed by a participating hospital not to exceed 4 pair per year</li> <li>• Hemodialysis and dialysis equipment</li> <li>• Traction and suspension equipment</li> <li>• Sleep apnea, cardiac and neonatal (high risk infant) monitors</li> <li>• Medical supplies, such as surgical dressings and colostomy bags and casting supplies</li> <li>• Manual breast pumps</li> <li>• Automatic blood pressure monitors</li> </ul> <p>Note: Rental cost must not be more than purchase price</p> <p>Note: Durable medical equipment is equipment which can withstand repeated use; primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home.</p>	<p>\$15 per office visit; 20% of our allowance for DME services rendered in a physician's office or from a medical supplier</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Devices and equipment used for environmental control or to enhance the environmental setting, such as air conditioners, humidifiers or air filters</i></li> <li>• <i>Supplies that can be used by other family members such as: adhesive tape, band-aids, alcohol and cotton balls</i></li> <li>• <i>Raised toilet seats</i></li> <li>• <i>Personal hygiene and convenience items</i></li> <li>• <i>Mechanical beds, such as Craftmatic Adjustable Beds</i></li> <li>• <i>Mattresses, sheets, pads, pillows, rubber sheets</i></li> <li>• <i>Therabath, hot tubs, Jacuzzis, saunas, portable whirlpool pumps</i></li> <li>• <i>Chair lifts and tub chairs</i></li> <li>• <i>Exercise equipment, including but not limited to exercise bikes and treadmills</i></li> <li>• <i>Ice bags and/or cold pack pump therapy</i></li> <li>• <i>Corsets or other articles of clothing</i></li> </ul>	<p><i>All charges.</i></p>
<b>Home health services</b>	
<ul style="list-style-type: none"> <li>• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or home health aide.</li> <li>• Services include oxygen therapy, intravenous therapy and medications.</li> </ul>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i></li> </ul>	<p><i>All charges.</i></p>

*Home health services - continued on next page*

Benefit Description	You pay
<b>Home health services (cont.)</b>	
<ul style="list-style-type: none"> <li>• Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</li> <li>• Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication</li> </ul>	All charges.
<b>Chiropractic</b>	
<p>Limited to:</p> <ul style="list-style-type: none"> <li>• 12 Spinal manipulations, per calendar year, provided by the following: <ul style="list-style-type: none"> <li>- Participating chiropractors</li> <li>- Doctors of Osteopathy</li> </ul> </li> </ul>	\$15 per visit
<b>Alternative treatments</b>	
No benefit	All charges.
<p><i>Not covered such as:</i></p> <ul style="list-style-type: none"> <li>• Naturopathic services</li> <li>• Hypnotherapy</li> <li>• Biofeedback</li> <li>• Acupuncture</li> </ul> <p>Note: Please contact the Plan at 800-228-4375 for further clarification</p>	All charges.
<b>Educational classes and programs</b>	
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> <li>• Diabetes self management</li> </ul>	\$15 per office visit
<ul style="list-style-type: none"> <li>• Smoking cessation (one smoking cessation program per member, per lifetime)</li> </ul> <p>Note: See Section 5(e) for individual or group counseling coverage</p>	Nothing up to \$100; All charges thereafter
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• Second and subsequent smoking cessation programs</li> <li>• Services or supplies primarily for educational, vocational, nutritional or training purposes, except as otherwise specified herein</li> </ul>	All charges.

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

**Important things you should keep in mind about these benefits:**

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

Benefit Description	You pay
<b>Surgical procedures</b>	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> <li>• Operative procedures</li> <li>• Treatment of fractures, including casting</li> <li>• Normal pre- and post-operative care by the surgeon</li> <li>• Correction of amblyopia and strabismus</li> <li>• Endoscopy procedures</li> <li>• Biopsy procedures</li> <li>• Removal of tumors and cysts</li> <li>• Correction of congenital anomalies (see <i>Reconstructive surgery</i>)</li> <li>• Surgical treatment of morbid obesity (bariatric surgery) – a condition:               <ul style="list-style-type: none"> <li>- In which an individual weights 100 pounds or 100% over his or her normal body weight according to current underwriting standards or Body Mass Index (BMI) of 35 or greater</li> <li>- For which physician monitored sanctioned non-surgical treatment has been unsuccessful</li> <li>- For eligible members, age 18 or over</li> </ul> </li> </ul> <p>Note: Approval is based on our medical policy through our predetermination process, see Section 3</p>	Nothing
<ul style="list-style-type: none"> <li>• Insertion of internal prosthetic devices, such as pacemakers and artificial joints . See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information</li> </ul> <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	Nothing

*Surgical procedures - continued on next page*

Benefit Description	You pay
<b>Surgical procedures (cont.)</b>	
<ul style="list-style-type: none"> <li>• Voluntary sterilization (e.g., tubal ligation, vasectomy)</li> <li>• Treatment of burns</li> </ul>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Reversal of voluntary sterilization</i></li> <li>• <i>Routine treatment of conditions of the foot; see Foot care in Section 5 (a)</i></li> <li>• <i>Non-surgical treatment of morbid obesity as set-forth by our predetermination process</i></li> </ul>	<i>All Charges.</i>
<b>Reconstructive surgery</b>	
<ul style="list-style-type: none"> <li>• Surgery to correct a functional defect</li> <li>• Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> <li>- the condition produced a major effect on the member's appearance and</li> <li>- the condition can reasonably be expected to be corrected by such surgery</li> </ul> </li> <li>• Surgery to correct a condition that existed at or from birth and is a significant deviation for the common form or norm</li> <li>• All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> <li>- Surgery to produce a symmetrical appearance on the other breast;</li> <li>- Treatment of any physical complications, such as lymphedemas;</li> </ul> </li> </ul>	Nothing
<ul style="list-style-type: none"> <li>- Breast prostheses and surgical bras and replacements (see Section 5 (a) <i>Prosthetic devices</i>)</li> </ul> <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	20% of our allowance
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Cosmetic surgery – any surgical procedure connected with or incidental to treatment that is primarily intended to improve appearance as set-forth by our predetermination process, except repair of accidental injury</i></li> <li>• <i>Surgeries related to sex transformation or the reversal thereof</i></li> </ul>	<i>All Charges.</i>
<b>Oral and maxillofacial surgery</b>	
<p>Oral surgical procedures, such as:</p> <ul style="list-style-type: none"> <li>• Excision of exostoses of the jaws and hard palate. (If pathology exists, generally done to prepare the mouth for dentures.)</li> <li>• Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth</li> <li>• External (extra-oral) incision and drainage of cellulitis</li> <li>• Incision of accessory sinuses, salivary glands or ducts, including removal of stones</li> </ul>	Nothing

*Oral and maxillofacial surgery - continued on next page*

Benefit Description	You pay
<b>Oral and maxillofacial surgery (cont.)</b>	
<ul style="list-style-type: none"> <li>• Reduction of dislocations and excision of the temporomandibular joints (TMJ)</li> <li>• Surgery for correction of accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth</li> <li>• Treatment of fractures of facial bones or jaw</li> <li>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion</li> <li>• Correction of orthognathic when severe handicapping malocclusion is present</li> <li>• Other surgical procedures that do not involve the teeth or their supporting structures</li> </ul> <p>Note: See Section 5(a), <i>Orthopedic and prosthetic devices</i>, for appliance cost</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Oral implants and transplants</i></li> <li>• <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i></li> <li>• <i>Dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction or syndrome</i></li> <li>• <i>Dentures and dental appliances</i></li> </ul>	<i>All charges.</i>
<b>Organ/tissue transplants</b>	
<p>Solid organ transplants limited to:</p> <ul style="list-style-type: none"> <li>• Cornea</li> <li>• Heart</li> <li>• Heart/lung</li> <li>• Single, double or lobar lung</li> <li>• Kidney</li> <li>• Liver</li> <li>• Pancreas</li> <li>• Simultaneous Pancreas-Kidney</li> <li>• Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis</li> <li>• Intestinal transplants <ul style="list-style-type: none"> <li>- Small intestine</li> <li>- Small intestine with the liver</li> <li>- Small intestine with multiple organs, such as the liver, stomach, and pancreas</li> </ul> </li> </ul>	Nothing
<p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity requirement is considered satisfied if the patient meets the staging description.)</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for</li> </ul>	Nothing

Benefit Description	You pay
<b>Organ/tissue transplants (cont.)</b>	
<ul style="list-style-type: none"> <li>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced Hodgkin's lymphoma</li> <li>- Advanced non-Hodgkin's lymphoma</li> <li>- Chronic myelogenous leukemia</li> <li>- Severe combined immunodeficiency</li> <li>- Severe or very severe aplastic anemia</li> <li>• Autologous transplants for <ul style="list-style-type: none"> <li>- Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced Hodgkin's lymphoma</li> <li>- Advanced non-Hodgkin's lymphoma</li> <li>- Advanced neuroblastoma</li> </ul> </li> <li>• Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer)</li> </ul>	Nothing
<p>Blood or marrow stem cell transplants for</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for <ul style="list-style-type: none"> <li>- Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)</li> <li>- Advanced forms of myelodysplastic syndromes</li> <li>- Advanced neuroblastoma</li> <li>- Infantile malignant osteopetrosis</li> <li>- Kostmann's syndrome</li> <li>- Leukocyte adhesion deficiencies</li> <li>- Mucopolysaccharidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy)</li> <li>- Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sannfilippo's syndrome, Maroteaux-Lamy syndrome variants)</li> <li>- Sickle cell anemia</li> <li>- Thalassemia major (homozygous beta-thalassemia)</li> <li>- X-linked lymphoproliferative syndrome</li> </ul> </li> <li>• Autologous transplants for <ul style="list-style-type: none"> <li>- Multiple myeloma</li> <li>- Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors</li> <li>- Amyloidosis</li> <li>- Ependymoblastoma</li> <li>- Ewing's sarcoma</li> <li>- Medulloblastoma</li> <li>- Pineoblastoma</li> </ul> </li> </ul>	Nothing

*Organ/tissue transplants - continued on next page*

Benefit Description	You pay
<b>Organ/tissue transplants (cont.)</b>	
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for.</p> <ul style="list-style-type: none"> <li>• Allogeneic transplants for <ul style="list-style-type: none"> <li>- Chronic lymphocytic leukemia</li> <li>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma</li> <li>- Multiple myeloma</li> </ul> </li> <li>• Nonmyeloablative allogeneic transplants for <ul style="list-style-type: none"> <li>- Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia</li> <li>- Advanced forms of myelodysplastic syndromes</li> <li>- Advanced Hodgkin's lymphoma</li> <li>- Advanced non-Hodgkin's lymphoma</li> <li>- Chronic lymphocytic leukemia</li> <li>- Chronic myelogenous leukemia</li> <li>- Early stage (indolent or non-advanced) small cell lymphocytic lymphoma</li> <li>- Multiple myeloma</li> </ul> </li> <li>• Autologous transplants for <ul style="list-style-type: none"> <li>- Breast cancer</li> <li>- Chronic myelogenous leukemia</li> <li>- Epithelial ovarian cancer</li> </ul> </li> <li>• Travel expenses related to covered transplants outside a 75 mile radius, subject to the Plan's procedures</li> <li>• National Transplant Program (NTP) - Blue Quality Centers for Transplant (BQCT) (See page 41 for a description of BQCT)</li> </ul> <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient, within six weeks of acquisition.</p> <p>Note: All transplants are subject to the Plan's medical policy through case management. When you or your provider become aware that a transplant is needed, you should contact us.</p> <p>Note: See Section 5(f), <i>Prescription drug benefits</i>, for related drug coverage</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Implants of artificial organs</i></li> <li>• <i>Transplants not listed as covered</i></li> <li>• <i>Transplants performed in a non-designated organ transplant facility except as authorized by the Plan</i></li> </ul>	<i>All Charges.</i>

Benefit Description	You pay
<b>Anesthesia</b>	
Professional services provided in: <ul style="list-style-type: none"> <li>• Hospital -- inpatient or outpatient department</li> <li>• Skilled nursing facility</li> <li>• Ambulatory surgical center</li> <li>• Office</li> </ul>	Nothing
<i>Not covered: Professional services provided in a dentist's office. See Section 5(h) for dental benefits.</i>	<i>All charges.</i>

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

**Important things you should 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 and you must be hospitalized in a Plan facility.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are 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.

Benefit Description	You pay
<b>Inpatient hospital</b>	
Room and board, such as <ul style="list-style-type: none"> <li>• Ward, semiprivate, or intensive care accommodations</li> <li>• General nursing care</li> <li>• Meals and special diets</li> <li>• Nursery charges</li> </ul> <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> <p>Note: Please see Section 3, page 12 for services that require prior approval</p>	\$200 per admission
Other hospital services and supplies, such as: <ul style="list-style-type: none"> <li>• Operating, recovery, maternity, and other treatment rooms</li> <li>• Prescribed drugs and medications</li> <li>• Diagnostic laboratory tests and X-rays</li> <li>• Administration of blood and blood products</li> <li>• Blood or blood plasma, if not donated or replaced</li> <li>• Dressings, splints, casts, and sterile tray services</li> <li>• Medical supplies and equipment, including oxygen</li> <li>• Anesthetics, including nurse anesthetist services</li> </ul>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Custodial care</i></li> <li>• <i>Personal comfort items, such as telephone, television, barber services, guest meals and beds</i></li> <li>• <i>Private nursing care</i></li> <li>• <i>Inpatient hospital stays for physical therapy purposes only</i></li> <li>• <i>Non-covered facilities; such as schools</i></li> </ul>	<i>All Charges.</i>

Benefit Description	You pay
<b>Outpatient hospital or ambulatory surgical center</b>	
<ul style="list-style-type: none"> <li>• Operating, recovery, and other treatment rooms</li> <li>• Prescribed drugs and medicines</li> <li>• Diagnostic laboratory tests, X-rays, and pathology services</li> <li>• Administration of blood, blood plasma, and other biologicals</li> <li>• Blood and blood plasma, if not donated or replaced</li> <li>• Pre-surgical testing</li> <li>• Dressings, casts, and sterile tray services</li> <li>• Medical supplies, including oxygen</li> <li>• Anesthetics and anesthesia service</li> </ul> <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p> <p>Note: Please see Section 3, page 12, for services that require prior approval</p>	\$100 Facility charge copay
<b>Extended care benefits/Skilled nursing care facility benefits</b>	
<p>Extended care/skilled nursing facility benefits:</p> <p>Up to 60 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically necessary as determined by a Plan doctor and approved by the Plan.</p>	Nothing
<i>Not covered: Custodial care, domiciliary or convalescent care</i>	<i>All Charges.</i>
<b>Hospice care</b>	
<ul style="list-style-type: none"> <li>• Home Health Care provided by Hospice nurses</li> <li>• Hospice facility care</li> </ul>	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All Charges.</i>
<b>Ambulance</b>	
Local professional ambulance service when medically appropriate	Nothing

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## Section 5(d) Emergency services

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### Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We 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.

### 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:** If you are in an emergency situation, you must contact your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are our member so they can notify us. You or a family member must notify your primary care doctor within 24 hours, unless it was not reasonably possible to do so. It is your responsibility to ensure that your primary care doctor has been timely notified.

If you need to be hospitalized, we must be notified within 24 hours or on the first working day following your admission, unless it was not reasonably possible to notify us within that time. If you are hospitalized in a non-Plan facility and our doctors believe care can be better provided in a Plan hospital, you will be transferred when medically feasible with ambulance charges covered in full.

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

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

**Emergencies outside our service area:** Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness.

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

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

Benefit Description	You pay
<b>Emergency within our service area</b>	
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office</li> </ul>	\$15 per office visit
<ul style="list-style-type: none"> <li>Emergency care at an urgent care center or in the outpatient urgent care department of a hospital, including doctors' services</li> </ul>	\$25 per visit
<ul style="list-style-type: none"> <li>Emergency care as an outpatient at a hospital, including doctors' services</li> </ul> <p>Note: Emergency Care-Observation setting without an inpatient admission – member emergency room copay applies.</p>	\$75 per visit; if visit results in an inpatient admission, you pay \$200
<i>Not covered: Elective care or non-emergency care</i>	<i>All Charges.</i>
<b>Emergency outside our service area</b>	
<ul style="list-style-type: none"> <li>Emergency care at a doctor's office</li> </ul>	\$15 per office visit
<ul style="list-style-type: none"> <li>Emergency care at an urgent care center or in the outpatient urgent care department of a hospital, including doctors' services</li> </ul>	\$25 per visit
<ul style="list-style-type: none"> <li>Emergency care as an outpatient at a hospital including doctors' services</li> </ul> <p>Note: Emergency Care-Observation setting without an inpatient admission – member emergency room copay applies.</p>	\$75 per visit; if visit results in an inpatient admission, you pay \$200
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li><i>Elective care or non-emergency care</i></li> <li><i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i></li> <li><i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i></li> </ul>	<i>All Charges.</i>
<b>Ambulance</b>	
<p>Professional land and air ambulance service when medically appropriate.</p> <p>Note: See 5(c) for non-emergency service.</p>	Nothing

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

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

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay
<b>Mental health and substance abuse benefits</b>	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<p>Professional services, including medication management, individual therapy or group therapy by providers such as psychiatrists, psychologists, or clinical social workers provided in:</p> <ul style="list-style-type: none"> <li>• Office</li> </ul>	\$15 per office visit
<p>Professional services by providers such as psychiatrists, psychologists, or clinical social workers provided the office for treatment of tobacco cessation.</p>	Nothing
<p>Professional services, including medication management, individual therapy or group therapy by providers such as psychiatrists, psychologists, or clinical social workers provided in:</p> <ul style="list-style-type: none"> <li>• Hospital (inpatient)</li> <li>• Hospital outpatient department</li> </ul>	Nothing
<ul style="list-style-type: none"> <li>• Diagnostic tests</li> </ul>	Nothing
<ul style="list-style-type: none"> <li>• Services provided by a hospital or other facility</li> <li>• Services in approved alternative care settings such as partial hospitalization, residential treatment, full-day hospitalization, facility based intensive outpatient treatment</li> </ul>	<p>\$200 per inpatient admission</p> <p>\$100 per outpatient visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Services we have not approved</i></li> </ul>	<i>All Charges.</i>

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

Benefit Description	You pay
<b>Mental health and substance abuse benefits (cont.)</b>	
<ul style="list-style-type: none"> <li>• <i>Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment</i></li> <li>• <i>Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition</i></li> <li>• <i>Services for marital counseling or personal growth</i></li> <li>• <i>Service, drugs, or supplies related to weight loss or treatment of obesity, except for surgical treatment of morbid obesity</i></li> </ul> <p><i>The same exclusions contained in this brochure that apply to other benefits apply to these mental health and substance abuse benefits, unless the services are included in a treatment plan that we approve.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<p><i>All Charges.</i></p>
<p>Preauthorization</p>	<p>To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes:</p> <ul style="list-style-type: none"> <li>• If you feel you need mental health or substance abuse services, you or your PCP should call Magellan Behavioral Health at 800/788-4003.</li> <li>• Magellan will work with you to determine your needs and begin the treatment planning process. Referrals for any necessary services will also be handled by Magellan.</li> <li>• Your mental health and substance abuse services must be provided by Plan providers.</li> </ul>
<p>Limitation</p>	<p>We may limit your benefits if you do not obtain a treatment plan.</p>

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## Section 5(f) Prescription drug benefits

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### Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Prior authorization is the process required to dispense certain drugs when the use of a drug is defined or limited by your medical condition.
- 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.

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

- **Who can write your prescription.** A plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill prescriptions at an Anthem Rx Network Plan pharmacy, or by mail for maintenance medication
- **We use a formulary.** Prescription drugs are prescribed by Plan doctors and dispensed in accordance with our prescription drug formulary. All prescription drugs on the formulary have been approved by the Food and Drug Administration (FDA). The formulary consists of medications that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their safety, quality and effectiveness. Coverage will be provided for both formulary and non-formulary medications when prescribed by a Plan doctor. However, when non-formulary drugs are dispensed, higher copays will apply. The formulary is subject to periodic review and amendment. We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs we selected to meet patient needs at a lower cost. To order a prescription drug listing, call 800-228-4375 or visit our web site at [www.anthem.com](http://www.anthem.com).
- **These are the dispensing limitations.** Prescriptions filled by a retail pharmacy or through our mail order pharmacy have a limit on days supply and different levels of copayments based on the days supply. You may obtain a 30-day supply or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin) at a Plan pharmacy, or up to a 90-day supply through our mail order program. Remind your doctor to write for the maximum days supply as your prescription will be dispensed for the quantity as written. Any continuous therapy medication presently covered by us within the limits of applicable State and Federal laws can be dispensed through the mail order program. Your prescriptions will be filled using FDA dispensing guidelines. Prior authorization may be required for certain drugs or the prescribed quantity of a particular drug. Certain drugs are subject to clinical authorization requirements based on age or sex. We may establish quantity limits for specific prescription drugs and establish clinical step therapy requirements. Covered Services will be limited based on Medical Necessity, quantity limits, and/or utilization guidelines. If a Member is called to active military duty, or in times of national or other emergency, call us to arrange for a medium-term supply of covered medications.

Your prescription claim history and patient profile information will be used by us to administer your pharmacy program and to identify possible drug interactions, duplications or other adverse events that may occur. This profile allows us to determine if you are trying to refill your prescription too soon, which could cause your claim to be rejected and require you to file again at a later date. If you receive a name brand drug, whether by mail order or from a Plan pharmacy, the copayment for the name brand applies regardless of whether:

- a generic equivalent is unavailable
- the prescription order specifies “Dispense as Written”
- or you choose the name brand drug instead of a generic drug

- **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 name brand copay.

- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive name brand drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original name brand product. Generics cost less than the equivalent name brand product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as name brand drugs. You can save money by using generic drugs. However, you and your physician have the option to request a name brand if a generic option is available. Using the most cost-effective medication saves money.
- **When you do have to file a claim.** Typically you will not have to file a claim for prescription drugs; however, if you have had to pay for a prescription due to some unforeseen circumstance, please contact us at 800-228-4375.

Benefit Description	You pay
<p><b>Covered medications and supplies</b></p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> <li>• Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>.</li> <li>• FDA-approved prescription drugs, injectable drugs (such as Depo Provera) and devices for birth control.</li> <li>• Insulin</li> <li>• Disposable needles and syringes needed to inject covered prescribed medications are covered at the name brand copayment.</li> <li>• Diabetic supplies including glucose test tablets and test tape, Benedict’s solution or equivalent, glucose monitors and acetone test tablets are covered at the name brand copayment. No copayment applies for insulin syringes.</li> <li>• Drugs for the treatment of impotence, such as but not limited to, Viagra: we require proof of medical necessity prior to approving benefits. Then, this Plan will cover a maximum of six tablets per month, subject to the following guidelines. The patient: <ul style="list-style-type: none"> <li>- Must be a male over age 18</li> <li>- Is being treated for erectile dysfunction (ED) regardless of cause, and</li> <li>- Is not on medication containing nitrates for 90 days prior.</li> </ul> </li> <li>• Smoking cessation prescription drugs and medications</li> <li>• The copay for off-label covered medication is subject to the Plan’s category assignment for the medication (generic, formulary name brand, non-formulary name brand or 50% of our allowance). The off-label use must be prescribed by a Plan doctor.</li> </ul> <p>Note: Intravenous fluids and medications for home use, implantable drugs, and some injectable drugs, such as Depo Provera, may also be covered under Medical and Surgical Benefits. See Section 5(a)</p>	<p><b>Up to a 30-day supply at a Plan pharmacy</b></p> <p>\$10 copay for generic drugs</p> <p>\$25 copay for formulary name brand drugs</p> <p>\$40 copay for non-formulary name brand drugs</p> <p><b>Up to a 90-day supply through the mail order program</b></p> <p>\$20 copay for generic drugs</p> <p>\$50 copay for formulary name brand drugs</p> <p>\$80 copay for non-formulary name brand drugs</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>
<ul style="list-style-type: none"> <li>• Immuno-Suppressive Agent</li> <li>• Fertility drugs</li> <li>• Human growth hormones</li> </ul>	<p>50% of our allowance</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <li>• <i>Drugs and supplies for cosmetic purposes</i></li> </ul>	<p><i>All Charges.</i></p>

*Covered medications and supplies - continued on next page*

Benefit Description	You pay
<b>Covered medications and supplies (cont.)</b>	
<ul style="list-style-type: none"> <li>• <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i></li> <li>• <i>Nonprescription medicines</i></li> <li>• <i>Drugs available without a prescription or for which there is a nonprescription equivalent available</i></li> <li>• <i>Drugs obtained at a Non-network pharmacy except for out-of-area emergencies</i></li> <li>• <i>Drugs to enhance athletic performance</i></li> <li>• <i>Drugs for weight loss purposes (except when authorized by the Plan doctor, through the predetermination process, for treatment of morbid obesity)</i></li> <li>• <i>Replacement prescriptions such as lost, stolen or spilled</i></li> <li>• <i>Drugs in connection with camp, travel, school or insurance exams</i></li> <li>• <i>Personal hygiene and convenience items</i></li> <li>• <i>Refills requested too soon (prior to 85% usage)</i></li> <li>• <i>Drugs in quantities exceeding the quantity prescribed</i></li> </ul>	<p><i>All Charges.</i></p>

## Section 5(g) Special features

Feature	Description
<b>Flexible benefits option</b>	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> <li>• We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit.</li> <li>• Alternative benefits are subject to our ongoing review.</li> <li>• By approving an alternative benefit, we cannot guarantee you will get it in the future.</li> <li>• The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits.</li> </ul> <p>Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.</p>
<b>24 hour nurse line</b>	<p>The Plan now offers Tel-a-Nurse. This free, 24-hour phone service is your link to non-emergency health information. Simply call the toll-free number day or night to speak to a registered nurse. So, the next time you have a health question or want some help making a health care decision, call:</p> <ul style="list-style-type: none"> <li>• 888-220-3891</li> <li>• 800-877-8044 (TDD for those with hearing impairments)</li> </ul> <p>You also have access, through the internet <a href="http://www.myanthem.com">www.myanthem.com</a>, to receive customized health information.</p>
<b>Reciprocity benefit</b>	<p><b>BlueCard® Program</b></p> <p>With the BlueCard® Program, Plan members have access to benefits when traveling outside the plan's service area for urgent care and emergency room services. To find a nearby health care provider, members can simply call BlueCard Access at 800-810-BLUE (2583).</p> <p><b>Guest Membership Program</b></p> <p>We offer guest memberships at affiliated HMO plans through the Guest Membership Program. Whenever you or a family member is away from our service area for more than 90 days, you may become a guest member at an affiliated HMO near your destination. Reasons to consider a guest membership include extended out-of-town business, children away at school, dependent children in another state, or a winter “snowbird” residency in the South. To determine if a guest membership is available at your destination, call 800-355-6414.</p>
<b>Centers of excellence</b>	<p>We use the Blue Quality Centers for Transplant Network (BQCT) as our transplant network. The network consists of leading medical facilities throughout the nation. For a list of transplant hospitals near you, call 800-824-0581.</p> <p>We also offer a network of institutions that have met stringent clinical standards for the following heart services:</p> <ul style="list-style-type: none"> <li>• Coronary artery bypass graft (CABG)</li> <li>• Percutaneous transluminal coronary angioplasty (PTCA)</li> </ul>

*Feature - continued on next page*

Feature	Description
<b>Feature (cont.)</b>	
	<ul style="list-style-type: none"> <li>• Heart valve procedures</li> <li>• Other major cardiovascular procedures</li> </ul> <p>You can refer to our provider directory for further information concerning our transplant and heart surgery centers of excellence.</p>
<b>Discount programs</b>	<p>SpecialOffers@Anthem</p> <p>You can receive negotiated savings on selected health and wellness services and programs simply by being an eligible Anthem Blue Cross and Blue Shield Blue HMO member. To obtain information about these programs please call us at 800-228-4375 or visit our Web site at <a href="http://www.anthem.com">www.anthem.com</a>. Services available through the SpecialOffers@Anthem program include but are not limited to:</p> <ul style="list-style-type: none"> <li>• <b>Jenny Craig</b> – Receive a free 30-day trial from Anthem and Jenny Craig</li> <li>• <b>Hearing</b> – Save on a wide variety of hearing aids and other products that help those with hearing problems. Your parents and grandparents are welcome to use this offer.</li> <li>• <b>Complementary Medicine</b> – Explore alternative paths to wellness with savings on everything from yoga videos to massage therapy to vitamins.</li> <li>• <b>Fitness Clubs</b> – Get fit for less. Save money at participating health clubs and get discounts on fitness equipment.</li> <li>• <b>Vision Savings</b> – Discounts on prescription eyeglasses and accessories.</li> <li>• <b>TruVision</b> – Get substantial savings on laser vision correction surgery from TruVision’s national network of providers. And discounts on contact lenses.</li> <li>• <b>Butt Out</b> – Extinguish a tobacco habit with discounts on smoking cessation programs and products.</li> <li>• <b>Books</b> – Peruse the Anthem bookrack for discounts on a vast collection of health and wellness books.</li> <li>• <b>Baby, Toddler and Maternity</b> – Save 15% at babystyle, the one stop shop for all your maternity and baby needs.</li> <li>• <b>Flowers</b> – Save 15% on floral arrangements, gourmet baskets and more.</li> <li>• <b>SeniorLink</b> – Access to eldercare specialists, savings on care management solutions and free trials to an emergency response system.</li> <li>• <b>Healthyroads</b> – Anthem offers you savings on vitamins, herbal supplements and sports nutrition products.</li> <li>• <b>Cosmetic dentistry</b> – Make your smile brighter with discounts on teeth whitening and dental veneers.</li> </ul>

## Section 5(h) Dental benefits

**Important things you should keep in mind about these benefits:**

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Plan dentists must provide or arrange your care, for a provider listing visit our web site at [www.anthem.com](http://www.anthem.com).
- 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.

Benefit Description	You Pay
<b>Accidental injury benefit</b>	
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth within three days of an accident. The need for these services must result from an accidental injury.	Nothing

**Dental benefits**

See benefit chart on the following pages.

We cover the following dental services when you use a participating Plan dentist and we have indicated when copayments apply. This benefit description does not list exclusions. Contact us for specific exclusions at 800-228-4375 or 513-872-8242 (in the local dialing area).

Dental Benefits	You Pay
<b>Service</b>	
<b>DIAGNOSTIC</b> X-rays including bite wings and panoramic; oral examinations and treatment plan; vitality test; and oral cancer exam	Nothing
<b>PREVENTIVE</b> Prophylaxis; annual topical application of fluoride to children age 12, preventive dental instructions	Nothing
<b>RESTORATIVE (Fillings)</b> Amalgam – one surface Amalgam – two surfaces Amalgam – three surfaces (Build up per tooth) Plastic or composite – single surface Plastic or composite – two surfaces	80% of our allowance
<b>ORAL SURGERY (Including preoperative and postoperative treatments under local anesthetics)</b>	80% of our allowance

*Service - continued on next page*

Dental Benefits	You Pay
<b>Service (cont.)</b>	
Extraction (simple) Alveolectomy per quadrant Impaction (soft tissue) Impaction (complete bony)	80% of our allowance
<b>PROSTHODONTICS</b> Complete upper or lower denture Cast chrome partial – upper or lower Acrylic partial – upper or lower (with clasps) Repair broken denture Denture adjustment Reline upper or lower complete denture or partial (office) Reline upper or lower complete denture or partial (laboratory) Space maintainers (for primary teeth) Stainless steel crown (for primary teeth) Bridge abutments or pontics	80% of our allowance
<b>PERIODONTICS (Under local anesthetics)</b> Examination, treatment plan Periodontal, root planing and curettage Gingivectomy or gingivoplasty Osseous surgery (per quadrant) Equilibration (entire mouth)	80% of our allowance
<b>ENDODONTICS (Under local anesthetics)</b> Pulpotomy (including restoration) Root canal filling – one canal Hemisection Each additional canal Apicoectomy, performed as separate surgical procedure	80% of our allowance
<b>ORTHODONTICS (Braces)</b> Initial Consultation Diagnosis and treatment plan <i>(Limited to one, two-year course of phase II treatment per eligible child up to age 19)</i>	80% of our allowance
Missed appointments without 24 hours prior notification	\$10.00
<b>ACCIDENTAL INJURY BENEFIT</b>	Nothing

*Service - continued on next page*  
 Section 5(h)

Dental Benefits	You Pay
<b>Service (cont.)</b>	
Restorative services and supplies necessary to promptly repair within three days of accident (but not replace) sound natural teeth.  <i>(The need for these services must result from an accidental injury)</i>	Nothing
<i>Not covered:</i> <ul style="list-style-type: none"> <li>• <i>All other dental services not shown as covered</i></li> </ul>	<i>All charges.</i>

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

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

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services*);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies 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 (see specifics regarding transplants);
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive without charge while in active military service;
- Services, drugs, or supplies for court ordered testing or care, unless Medically Necessary;
- Services, drugs, or supplies received from a member of your immediate family (parent, child, spouse, sister, brother, or corresponding in-laws);
- Services for completion of claim forms or charges for medical records or reports;
- Missed or canceled appointments;
- Mileage costs or other travel expenses, except as authorized by the plan;
- Services, or supplies at a health spa or similar facility;
- Services, drugs, or supplies for research studies or screening examinations, except as specified elsewhere in the brochure;
- Services, drugs, or supplies you receive from an individual or entity that is not a provider, as defined in this brochure; or
- Telephone consultations or consultations via electronic mail or internet/web except as required by law or authorized by us.

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## Section 7 Filing a claim for covered services

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

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. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 800-228-4375.

When you must file a claim – such as for services you received outside 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: Anthem Blue HMO**

**PO Box 37180**

**Louisville, KY 40233-7180**

### **Prescription drugs**

When you must file a claim for prescription drugs that you had to pay for, submit the original itemized Pharmacy receipt that comes with the prescription and the completed Prescription Drug Claim Form

**Submit your claims to: Anthem Prescription Management LLC**

**PO Box 145433**

**Cincinnati, OH 45250-5433**

### **Other supplies or services**

When you must file a dental claim, such as out-of-network care, submit a completed Standard ADA (American Dental Association) Claim Form

**Submit your claims to: Anthem Dental**

**555 Middle Creek Parkway**

**Colorado Springs, CO 80921-3624**

### **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 benefits for your claim if you do not respond.

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## Section 8 The disputed claims process

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Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for preauthorization/prior approval required by Section 3.

- 1** Ask us in writing to reconsider our initial decision. You must:
  - a) Write to us within 6 months from the date of our decision; and
  - b) Send your request to us at: Blue HMO, Mail No. OH0402-B014, 1351 William Howard Taft Road, Cincinnati, OH 45206-1775; 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** We have 30 days from the date we receive your request to:
  - a) Pay the claim (or, if applicable, arrange for the health care 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** You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.

We will write to you with our decision.

- 4** If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within

- 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.

Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 2, 1900 E Street, NW, Washington, DC 20415-3620.

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 800-228-4375 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
  - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
  - You may call OPM's Health Insurance Group 2 at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

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## Section 9 Coordinating benefits with other coverage

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### When you have other health coverage

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

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance and we will not waive our limits for services such as: chiropractic limits.

### What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has four 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. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) 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.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at [www.socialsecurity.gov](http://www.socialsecurity.gov), or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

### • Should I enroll in Medicare?

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

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

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

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

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

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, however, the referral or precertification process may be waived in some instances. We will not waive any of our copayments and/or coinsurance.

Note: If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

**Claims process when you have the Original Medicare Plan** – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 800-228-4375.

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

- **Medicare Advantage (Part C)**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at [www.medicare.gov](http://www.medicare.gov).

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

**This Plan and our Medicare Advantage plan:** You may enroll in our Medicare Advantage plan and also remain enrolled in our FEHB plan. When you are enrolled in our Medicare Advantage plan, along with this Plan, you still need to follow the rules in this brochure for us to cover your care, however, the referral or precertification process may be waived in some instances. In this case, we do not waive cost-sharing for your FEHB coverage.

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

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

- **Medicare prescription drug coverage (Part D)**

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan. We will not pay more than our Plan allowance or Plan benefits.

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

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

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

**TRICARE and  
CHAMPVA**

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

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

**Workers' Compensation**

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

**Medicaid**

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

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

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

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

**When others are  
responsible for injuries**

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

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

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

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<b>Calendar year</b>	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
<b>Coinsurance</b>	Coinsurance is the percentage of our allowance that you must pay for your care. See page 14.
<b>Copayment</b>	A copayment is a fixed amount of money you pay when you receive covered services. See page 14.
<b>Covered services</b>	Care we provide benefits for, as described in this brochure.
<b>Custodial care</b>	<p>Treatment or services primarily for the purpose of assisting you in the activities of daily living or in meeting personal rather than medical needs, and which is not specific treatment for an illness or injury. It is care which cannot be expected to substantially improve a medical condition and has minimal therapeutic value. Such care includes, but is not limited to:</p> <ul style="list-style-type: none"><li>• Personal care such as help in walking, getting in and out of bed, bathing, eating by spoon, tube or gastrostomy, exercising, dressing, oral hygiene, ordinary skin or nail care or using the toilet</li><li>• Homemaking such as preparing meals or special diets</li><li>• Moving the patient</li><li>• Acting as a companion or sitter</li><li>• Supervising medication that can usually be self administered</li><li>• Treatment services that any person may be able to perform with minimal instruction, including, but not limited to, recording temperature, pulse and respirations or administration and monitoring of feeding systems</li><li>• We determine which services are custodial.</li></ul>
<b>Experimental or investigational service</b>	<p>A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.</p> <p>A medical treatment or procedure, or biological product is experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.</p> <p>Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.</p>

**Group health coverage** Health care coverage that a member is eligible for because of employment, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies, or that pays a specific amount for each day or period of hospitalization.

**Medical necessity** Services, drugs, supplies or equipment provided by a hospital or covered provider of the health care services that the Carrier determines:

- Appropriate for and consistent with the symptoms and proper diagnosis or treatment of the Member's condition, illness, disease or injury;
- Were obtained from a Provider as defined in this brochure;
- Were provided in accordance with applicable medical and/or professional standards in the United States;
- Are known to be effective, as proven by scientific evidence, in materially improving health outcomes;
- In the case of inpatient care, cannot be provided safely on an outpatient basis;
- Are not Experimental/Investigative;
- Are not primarily for the convenience of the Member, the Member's family or the Provider;

The fact that a covered provider has prescribed, recommended or approved a service, supply, drug or equipment does not, in itself, make it medically necessary.

**Our allowance** Our allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:

- Amounts charged by other providers for the same or similar service
- Any unusual medical circumstances requiring additional time, skill or experience and
- Other factors we determine are relevant, including, but not limited to, a resource based relative value scale

**Provider** A duly licensed person or facility that provides services within the scope of an applicable license, a person or facility that the Plan approves and files claims using standard medical coding such as CPT, ICD-9, CDT, or DSM codes. Providers include, but are not limited to, the following persons and facilities:

- Alcoholism and Drug Abuse Treatment Facility
- Ambulatory Surgical Facility
- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist (C.R.N.A.)
- Dialysis Facility
- Home Health Care Agency
- Home Infusion Facility
- Hospitals
- Inpatient or Outpatient Psychiatric Facility, Residential Treatment Facility
- Laboratory (Clinical)
- Occupational, Physical, Speech Therapist or Chiropractor
- Pharmacy
- Physician or Physician Assistant
- Psychologist or Social Worker (licensed)
- Radiologist or Pathologist

- Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.)
- Respiratory Therapist
- Skilled Nursing Facility
- Supplier of Durable Medical Equipment, Prosthetic Appliances and/or Medical Supplies
- Urgent Care Center

**Us/We**

Us and We refer to Blue HMO

**You**

You refers to the enrollee and each covered family member.

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## Section 11 FEHB Facts

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### Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition 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/health](http://www.opm.gov/insure/health) for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

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

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

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

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

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including your marriage, divorce, annulment, or when your child under age 22 turns age 22 or has a change in marital status, divorce, or when your child under 22 marries.

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

- **Children's Equity Act**

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

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

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

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

• **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2007 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 2006 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.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

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

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage to you. However, you may be eligible for your own FEHB coverage under either 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](http://www.opm.gov/insure).

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

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

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

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

- **Converting to individual coverage**

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

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

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

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

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

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

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

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## Section 12 Three Federal Programs complement FEHB benefits

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### Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Long Term Care Insurance Program (FLTCIP)** helps cover long term care costs, which are not covered under the FEHB Program.

Second, the **Federal Flexible Spending Account Program**, also known as **FSAFEDS**, lets you set aside pre-tax money to pay for health and dependent care expenses. The result can be a discount of 20% to more than 40% on services you routinely pay for out-of-pocket.

Third, the new **Federal Employees Dental and Vision Insurance Program (FEDVIP)**, offers a variety of dental plans and vision plans to anyone who is eligible to enroll in the Federal Employees Health Benefits Program. Under **FEDVIP** you may choose self only, self plus one, or self and family coverage for yourself and any qualified dependents. Premiums are on an enrollee-pays-all basis

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

#### It's important protection

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

- **FEHB plans do not cover the cost of long term care.** Also called “custodial care,” long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. The need for long term care can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you options regarding the type of care you receive and where you receive it. With FLTCIP coverage, you won't have to worry about relying on your loved ones to provide or pay for your care.
- **It's to your advantage to apply sooner rather than later.** To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a future change in your health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums. 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 about your health. Newly married spouses of employees also have a limited opportunity to apply using abbreviated underwriting.
- **Qualified relatives are also eligible to apply.** Qualified relatives include spouses and adult children of employees and annuitants, and parents, parents-in-law, and stepparents of employees.
- **To request an Information Kit and application.** Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit [www.ltcfeds.com](http://www.ltcfeds.com).

### 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.

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** – Pays for eligible health care expenses for you and your dependents which are not covered or reimbursed by FEHBP coverage or other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents, which are not covered or reimbursed, by FEHBP or FEDVIP coverage or other insurance.
- **Dependent Care FSA (DCFSA)** – Pays for eligible dependent care expenses that allow you (and your spouse if married) to work, look for work (as long as you have earned income for the year), or attend school full-time.

**What expenses can I pay with an FSAFEDS account?**

For the HCFSA – Health plan copayments, deductibles, over-the-counter medications and products, sunscreen, eyeglasses, contacts, other vision and dental expenses (but not insurance premiums).

For the LEX HCFSA – Dental and vision care expenses including eligible over-the-counter medicines and products related to dental and vision care (but not insurance premiums)

For the DCFSA – Daycare expenses (including summer camp) for your child(ren) under age 13, dependent care expenses for dependents unable to care for themselves

AND MUCH MORE! Visit [www.FSAFEDS.com](http://www.FSAFEDS.com)

**Who is eligible to enroll?**

Most Federal employees in the Executive branch and many in non-Executive branch agencies are eligible. For specifics on eligibility, visit [www.FSAFEDS.com](http://www.FSAFEDS.com) or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., EST. TTY: 1-800-952-0450.

**When can I enroll?**

If you wish to participate, you must make an election to enroll each year by visiting [www.FSAFEDS.com](http://www.FSAFEDS.com) or calling the number above during the FEHB Open Season or within 60 days of employment (for new employees).

**Even if you enrolled for 2006, you must make a new election to continue participating in 2007. Enrollment DOES NOT carry over from year to year.**

**Who is SHPS?**

SHPS is the Third Party Administrator hired by OPM to manage the FSAFEDS Program. SHPS is responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

**Who is BENEFEDS?**

BENEFEDS is the name of the voluntary benefits portal hired by OPM to work with the FSAFEDS Program to set up payroll deductions for FSAFEDS allotments.

**The Federal Employees Dental and Vision Insurance Program – *FEDVIP***

**Important Information**

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a new program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004.

OPM has contracted with several insurance carriers to make supplemental dental and vision benefits available to eligible Federal and USPS employees, annuitants, and their eligible family members.

**Dental Insurance**

Dental plans will provide a comprehensive range of services, including the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.

- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with a 24-month waiting period

Please review the dental plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

**Vision Insurance**

Vision plans will provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Please review the vision plans' benefits material for detailed information on the benefits covered, cost-sharing requirements, and preferred provider listings.

**What plans are available?**

You can find a comparison of the plans available and their premiums on the OPM website at [www.opm.gov/insure/dentalvision](http://www.opm.gov/insure/dentalvision). This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

**Premiums**

The premiums will vary by plan and by enrollment type (self, self plus one, or self and family). There is no government contribution to the premiums. If you are an active employee, your premiums will be taken from your salary on a pre-tax basis when your salary is sufficient to make the premium withholding. If you are an annuitant, premiums will be withheld from your monthly annuity check when your annuity is sufficient. Pre-tax premiums are not available to annuitants. For information on each plan's specific premiums, visit [www.opm.gov/insure/dentalvision](http://www.opm.gov/insure/dentalvision).

**Who is eligible to enroll?**

Federal and Postal Service employees eligible for FEHB coverage (whether or not enrolled) and annuitants (regardless of FEHB status) are eligible to enroll in a dental plan and/or a vision plan.

**Enrollment types available**

- Self-only, which covers only the enrolled employee or annuitant;
- Self plus one, which covers the enrolled employee or annuitant plus one eligible family member specified by the enrollee; and
- Self and family, which covers the enrolled employee or annuitant and all eligible family members.

**Which family members are eligible to enroll?**

Eligible family members include your spouse, unmarried dependent children under age 22, and unmarried dependent children age 22 or over incapable of self-support because of a mental or physical disability that existed before age 22.

**When can I enroll?**

Eligible employees and annuitants can enroll in a dental and/or vision plan during this open season -- November 13 to December 11, 2006. You can enroll, disenroll, or change your enrollment during subsequent annual open seasons, or because of a qualified life event. New employees will have 60 days from their first eligibility date to enroll.

**How do I enroll?**

You enroll on the Internet at [www.BENEFEDS.com](http://www.BENEFEDS.com). BENEFEDS is a secure enrollment website sponsored by OPM where you enter your name, personal information like address and Social Security Number, the agency you work for (or retirement plan that pays your annuity), and the dental and/or vision plan you select. For those without access to a computer, call 1-877-888- FEDS (TTY number, 1-877-TTY-5680). If you do not have access to a computer or a phone, contact your employing office or retirement system for guidance on how to enroll.

You cannot enroll in a FEDVIP plan using the Health Benefits Election Form (SF 2809) or through an agency self-service system, such as Employee Express, MyPay, or Employee Personal Page. However, those sites may provide a link to BENEFEDS.

**When will coverage be effective?**

The new Program will be effective December 31, 2006. Coverage for those who enroll during this year's open season (November 13 – December 11, 2006) will be effective December 31, 2006. Coverage for any other enrollments will be effective on/or after December 31, 2006.

**How does this coverage work with my FEHB plan's dental or vision coverage?**

Some FEHB plans already cover some dental and vision services. When you are covered by more than one health/dental plan, federal law permits your insurers to follow a procedure called "coordination of benefits" to determine how much each should pay when you have a claim. The goal is to make sure that the combined payments of all plans do not add up to more than your covered expenses.

Coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

## Index

Accidental injury.....	43, 44	Fraud.....	4	Pre-existing.....	58
Alternative treatments.....	25	<b>General exclusions</b> .....	46	Preauthorization.....	37
Ambulance.....	33, 35	Growth hormones.....	13, 21, 39	Precertification.....	13
Anesthesia.....	31, 32, 33	<b>Hearing services</b> .....	19, 22	Predetermination.....	13
<b>Biopsy</b> .....	26	Home health services.....	24, 33	Prescription drugs.....	38, 66
Blood.....	32, 33	Hospice care.....	12, 33	Preventive care, adult.....	19
<b>Cardiac rehabilitation</b> .....	22	Hospital.....	11, 32, 33, 34, 35, 36, 43, 66	Preventive care, children.....	19
Casting.....	24, 26, 32, 33	<b>Immunizations</b> .....	19	Preventive services.....	7
Catastrophic protection (out-of-pocket maximum).....	14, 67	Infertility.....	20	Primary care.....	11, 66
Changes for 2007.....	9	Insulin.....	39	Prior approval.....	12, 13
Chemotherapy.....	21	Intravenous (IV)/Infusion therapy.....	21, 24	Prostate Specific Antigen (PSA).....	19
Chiropractic.....	25	<b>Laboratory/Pathological services</b> .....	32, 33	Prosthetic devices.....	23, 26
Cholesterol tests.....	19	<b>Magnetic Resonance Imaging</b> .....	13, 18	Provider.....	56
Circumcision.....	20	Mail order pharmacy.....	39, 66	Psychologist.....	36
Claims.....	47	Mammogram.....	18, 19	Psychotherapy.....	36
Clarifications for 2007.....	9	Maternity benefits.....	12, 20	<b>Radiation therapy</b> .....	21
Coinsurance.....	14, 55	Medicaid.....	54	Reconstructive surgery.....	12, 27
Colorectal cancer screening.....	19	Medical necessity.....	56	Respiratory and inhalation therapy.....	21
Congenital anomalies.....	26	Medical supplies.....	24, 32, 33	Room and board.....	32
Contraceptive drugs and devices.....	20, 39	Medically necessary.....	20, 32, 46	<b>Second surgical opinion</b> .....	18
Coordinating benefits.....	50	Medicare.....	50, 54	Service area.....	8
Copayment.....	14, 55	Original.....	51	Skilled nursing facility care.....	33
Covered services.....	55	Prescription drug.....	52	Smoking cessation.....	25, 36, 39
Crutches.....	23	Members.....		Social worker.....	36
<b>Deductible</b> .....	14	Associate.....	68	Special features.....	41, 67
Definitions.....	55	Family.....	58	Specialty care.....	11
Dental care.....	43, 66	Plan.....	10	Speech therapy.....	22
Diabetic supplies.....	39	Mental Health/Substance Abuse Benefits.....	36, 66	Splints.....	32
Diagnostic services.....	13, 18, 36, 66	Morbid obesity.....	13, 26, 40	Sterilization procedures.....	20, 27
Dialysis.....	21	<b>Newborn care</b> .....	20	Subrogation.....	54
Disputed claims process.....	48	Nurse.....		Surgery.....	
Donor expenses.....	30	Licensed Practical Nurse (LPN).....	24	Outpatient.....	33
Dressings.....	24, 32, 33	Nurse Anesthetist.....	32	Reconstructive.....	27
Durable medical equipment (DME).....	12, 23	Registered nurse (RN).....	24	Surgical procedures.....	26
<b>Educational classes and programs</b> .....	25	<b>Obstetrical care</b> .....	20	Syringes.....	39
Effective date of enrollment.....	55, 59	Occupational therapy.....	22	<b>Temporary Continuation of Coverage (TCC)</b> .....	59, 60
Emergency.....	13, 34, 46, 47, 66	Office visit.....	18, 19, 20, 21, 22, 23, 24, 25, 35, 36, 66	Transplant.....	12, 28
Experimental or investigational.....	46, 55	Oral and maxillofacial surgery.....	28	Treatment therapies.....	21
Extended care.....	33	Orthopedic.....	23	<b>Urgent care</b> .....	18, 35
Eyeglasses.....	22	Ostomy supplies.....	24	<b>Vision care</b> .....	19, 22, 66
<b>Family planning</b> .....	20	Oxygen.....	23, 24, 32, 33	<b>Well-child care</b> .....	19
Fecal occult blood test.....	19	<b>Pap test</b> .....	18, 19	Wheelchairs.....	12, 23
Fertility drugs.....	20, 39	Physical therapy.....	22	Workers Compensation.....	54
Foot care.....	23	Physician.....	26	<b>X-rays</b> .....	18, 32, 33, 43
Formulary drugs.....	39, 66				

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## Summary of benefits for the High Option of Blue HMO - 2007

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

High Option Benefits	You pay	Page
<b>Medical services provided by physicians:</b>		
Diagnostic and treatment services provided in the office	Office visit copay: \$15 primary care; \$15 specialist	18
<b>Services provided by a hospital:</b>		
• <b>Inpatient</b>	\$200 per visit	32
• <b>Outpatient</b>	\$100 per visit	33
<b>Emergency benefits:</b>		
• <b>In-area</b>	\$75 per visit	35
• <b>Out-of-area</b>	\$75 per visit	35
<b>Mental health and substance abuse treatment:</b>		
	Office visit copay: \$15 per visit	36
	Inpatient hospital: \$200 per visit	36
	Outpatient hospital: \$100 per visit	36
<b>Prescription drugs:</b>		
• Retail pharmacy	\$10 generic copay; \$25 formulary name brand copay; \$40 non-formulary name brand copay	39
• Mail order	\$20 generic copay; \$50 formulary name brand copay; \$80 non-formulary name brand copay	39
<b>Dental care:</b>		
• <b>Preventive Care</b>	Nothing	43
• <b>Other services</b>	80% of our allowance	43
<b>Vision care:</b>		
• One annual routine eye exam	\$15 per visit	22

**Special features:**

- Flexible benefits option 41
- 24-hour nurse line
- Centers of excellence for transplants/heart surgery
- Reciprocity benefit
- Discount programs

**Protection against catastrophic costs** (out-of-pocket maximum): Nothing after \$1,500/Self Only or \$3,000/Family enrollment per year. Some costs do not count toward this protection 14

## 2007 Rate Information for - Blue HMO

**Non-Postal rates** apply to most non-Postal employees. 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	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

### Most of Ohio

<b>High Option Self Only</b>	R51	141.92	92.39	307.49	200.18	167.54	66.77
<b>High Option Self and Family</b>	R52	321.89	213.86	697.43	463.36	380.01	155.74