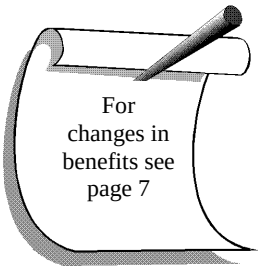
# Rocky Mountain HMO

http://www.rmhmo.org

# 2001

## A Health Maintenance Organization

**Serving:** *Most of Colorado*




**Enrollment in this Plan is limited; see page 5 for requirements.**

*This Plan has COMMENDABLE ACCREDITATION from the NCQA. See the 2001 Guide for more information on NCQA.*

**Enrollment codes for this Plan:**

**XJ1 Self Only**
**XJ2 Self and Family**

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

Federal Employees Health Benefits Program

**RI 73-027**

# Table of Contents

## Introduction

Rocky Mountain HMO
2775 Crossroads Boulevard
Grand Junction, CO 81506

This brochure describes the benefits of Rocky Mountain HMO under our contract (CS 1662) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page xx. Rates are shown at the end of this brochure.

## Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means Rocky Mountain HMO.

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

# Section 1. Facts about this HMO plan

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

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

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

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

**How we pay providers**

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

**Who provides my health care?**

Rocky Mountain Health Maintenance Organization is an individual practice prepayment plan that contracts with hospitals and health care professionals throughout Colorado.

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are coordinated. It is the responsibility of your primary care doctor to obtain any necessary authorization from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when there has been a referral by the member's primary care doctor: with the following exception: a woman may see her Plan gynecologist for her annual routine examination without a referral.

**Patients' Bill of Rights**

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Rocky Mountain HMO is an independent, non-profit organization
- In existence since 1974
- In 1975 Rocky Mountain HMO became the seventh HMO in the nation to be federally qualified

If you want more information about us, call 970-243-7050 or 1-800-346-4643, or write to 2775 Crossroads Boulevard, Grand Junction, CO 81506. You may also visit our website at http://www.rmhmo.org.

**What is this Plan's service area?**

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area is:

| | | | | |
|---|---|---|---|---|
| Adams | Custer | Hinsdale | Montezuma | San Miguel |
| Alamosa | Delta | Jefferson | Montrose | San Juan |
| Archuleta | Denver | Kiowa | Otero | Summit |
| Arapahoe | Dolores | Kit Carson | Ouray | Teller |
| Bent | Douglas | Lake | Park | Washington |
| Boulder | Eagle | La Plata | Pitkin | Yuma |
| Cheyenne | Elbert | Lincoln | Prowers | |
| Chaffee | El Paso | Logan | Pueblo | |
| Clear Creek | Fremont | Mesa | Rio Grande | |
| Conejos | Garfield | Mineral | Rio Blanco | |
| Costilla | Gilpin | Moffat | Saguache | |

## Section 2. How we change for 2001

**Program-wide changes**

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our *plan network* will be the same with regard to coinsurance and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed more limits on the number of visits and inpatient days for mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling our member services department 970-243-7050. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:

  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.

- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

**Changes to this Plan**

- Your share of the non-Postal premium will increase by 98.2% for self only and 103.3% for Self and family.

## Section 3. How you get care

### Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 970-253-7050.

### Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay co-payments 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.

- **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

### What you must do

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

- **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.

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

• **Specialty care**

Your primary care physician will refer you to a specialist for needed care.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  •• terminate our contract with your specialist for other than cause; or

  •• drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  •• reduce our service area and you enroll in another FEHB Plan,

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 970-243-7050. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

## 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. If a service is not approved, we will notify you in writing.

We call this review and approval process pre-authorization. Your physician must obtain pre-authorization for the following services

- Hospital admission's
- Surgery
- Home health services
- Invasive diagnostic tests
- transplants
- Skilled nursing facility admission's
- Mental health services
- Alcohol and substance abuse treatment
- Some diagnostic procedures such as MRI's and CT scans
- Durable medical equipment, orthotic and prosthetic devices and home oxygen
- Hospice services

# Section 5. Benefits -- OVERVIEW

***(See page 7 for how our benefits changed this year and page 59 for a benefits summary.)***

**NOTE**: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 970-243-7050 or 1-800-346-4643 or by e-mail at RMHMO-Member-Service@rmhmo.org

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

IMPORTANT

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

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

IMPORTANT

| Benefit Description | You pay |
|---|---|
| **Diagnostic and treatment services** | |
| Professional services of physicians<br>• In physician's office | $10 per office visit |
| Professional services of physicians<br>• During a hospital stay<br>• In a skilled nursing facility<br>• Initial examination of a newborn child covered under a family enrollment<br>• Office medical consultations<br>• Second surgical opinion | $10 per office visit<br>You pay nothing for professional services during a hospital or skilled nursing facility stay. |
| At home | Nothing |
| | |

| Lab, X-ray and other diagnostic tests | |
|---|---|
| Tests, such as:<br>• Blood tests<br>• Urinalysis<br>• Non-routine pap tests<br>• Pathology<br>• X-rays<br>• Non-routine Mammograms<br>• Cat Scans/MRI<br>• Ultrasound<br>• Electrocardiogram and EEG | Nothing in addition to the office visit copay |
| **Preventive care, adult** | |
| Routine screenings, such as<br>• Blood lead level – one annually<br>• Total Blood Cholesterol – once every three years, ages 19 through 64<br>• Colorectal Cancer Screening, including<br>  • Fecal occult blood test<br>  • Sigmoidoscopy, screening every five years starting at age 50 | $10 per office visit |
| Prostrate Specific Antigen (PSA test) – one annually for men age 40 and older | Nothing |
| Routine pap test<br>Note: The office visit is covered if pap test is received on the same day; see *Diagnosis and Treatment*, above. | Nothing |

| **Preventive care, adult** *(Continued)* | **You pay** |
|---|---|
| Routine mammogram –covered for women age 35 and older, as follows:<br>• From age 35 through 39, one during this five year period<br>• From age 40 through 64, one every calendar year<br>• At age 65 and older, one every two consecutive calendar years | Nothing |
| *Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel, unless it is the only physical examination obtained during the calendar year.* | *All charges.* |
| Routine Immunizations, limited to:<br>• Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations)<br>• Influenza/Pneumococcal vaccines, annually, age 65 and over | Nothing in addition to the office visit co-pay |
| **Preventive care, children** | **You pay** |
| • Childhood immunizations recommended by the American Academy of Pediatrics | Nothing in addition to the office visit co-pay |
| • Examinations, such as:<br>••Eye exams through age 17 to determine the need for vision correction.<br>••Ear exams through age 17 to determine the need for hearing correction<br>••Examinations done on the day of immunizations ( through age 22) | $10 per office visit |
| • Well-child care charges for routine examinations, immunizations and care (through age 22) | Nothing |

| Maternity care | You pay |
|---|---|
| Complete maternity (obstetrical) care, such as:<br>• Prenatal care<br>• Delivery<br>• Postnatal care<br>Note: Here are some things to keep in mind:<br>• You do not need to precertify your normal delivery; see page xx for other circumstances, such as extended stays for you or your baby.<br>• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.<br>• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment.<br>• We pay hospitalization and surgeon services | $10 for the initial visit only, nothing thereafter for prenatal care and delivery. |
| *Not covered: Routine sonogram or amniocentesis to determine fetal age, size or sex* | *All charges* |
| **Family planning** | |
| • Voluntary sterilization<br>• Surgically implanted contraceptives<br>• Injectable contraceptive drugs<br>• Intrauterine devices (IUDs) | $10 per office visit |
| *Not covered: reversal of voluntary surgical sterilization, genetic counseling,* | *All charges.* |

| Infertility services | You pay |
|---|---|
| Diagnosis and treatment of infertility, such as:<br>• Artificial insemination, up to four attempts per pregnancy:<br>••*intravaginal insemination (IVI)*<br>••*intracervical insemination (ICI)*<br>••*intrauterine insemination (IUI)*<br>• Fertility drugs<br>Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit when pre-authorized. | $10 per office visit |
| *Not covered:*<br>• *Assisted reproductive technology (ART) procedures, such as:*<br>••*in vitro fertilization*<br>••*embryo transfer and GIFT*<br>• *Services and supplies related to excluded ART procedures*<br>• *Cost of donor sperm* | *All charges.* |
| **Allergy care** | |
| Testing and treatment<br>Allergy injection | $10 per office visit |
| Allergy serum | Nothing |
| *Not covered: provocative food testing and sublingual allergy desensitization* | *All charges.* |

| Treatment therapies | You pay |
| --- | --- |
| • Chemotherapy and radiation therapy<br>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page xx.<br>• Respiratory and inhalation therapy<br>• Dialysis – Hemodialysis and peritoneal dialysis<br>• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy<br>• Growth hormone therapy (GHT)<br>Your physician will contact us for pre-authorization. We will send you a letter if pre-authorization is denied. | $10 per office visit |

| Rehabilitative therapies | You pay |
|---|---|
| Physical therapy, occupational therapy and speech therapy<br>• 60 consecutive days or<br>• 20 visits per condition for the services of each of the following:<br>••qualified physical therapists;<br>••speech therapists; and<br>••occupational therapists.<br>Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury.<br>***Phase I and II*** Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction is covered | $10 per office visit |
| *Not covered:*<br>• *long-term rehabilitative therapy*<br>• *exercise programs*<br>• *Phase III cardiac rehabilitation* | *All charges.* |
| **Hearing services (testing, treatment, and supplies)** | |
| *Not covered:*<br>• *Hearing testing*<br>• *hearing aids, testing and examinations for them*<br>• *Cochlear implants and communication devices* | *All charges.* |

| Vision services (testing, treatment, and supplies) | You pay |
|---|---|
| • One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)<br>• Diagnosis and treatment of diseases of the eye.<br>No referral required to plan provider. | $10 per office visit |
| • Annual eye refractions may be obtained from any licensed optometrist or ophthalmologist with the plan's service area.<br>No referral required to plan provider. | $10 per office visit |
| *Not covered:*<br>• *Eyeglasses or contact lenses*<br>• *Eye exercises and orthoptics*<br>• *Radial keratotomy and other refractive surgery* | *All charges.* |
| **Foot care** | |
| Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.<br>See orthopedic and prosthetic devices for information on podiatric shoe inserts. | $10 per office visit |
| *Not covered:*<br>• *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*<br>• *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)* | *All charges.* |

| Orthopedic and prosthetic devices | You pay |
|---|---|
| • Artificial arms and legs. | 20% of all charges |
| • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy.<br>• Artificial eyes and orthotic devices such as braces, splints and collars. | 50% of all charges |
| • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. | Nothing |
| *Not covered:*<br>• *orthopedic and corrective shoes*<br>• *arch supports*<br>• *foot orthotics*<br>• *heel pads and heel cups*<br>• *lumbosacral supports*<br>• *corsets, trusses, elastic stockings, support hose, and other supportive devices*<br>• *prosthetic replacements provided less than 3 years after the last one we covered*<br>• *cochlear implants* | *All charges.* |

| Durable medical equipment (DME) | You pay |
|---|---|
| Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:<br>• hospital beds;<br>• Non motorized wheelchairs<br>• crutches<br>• walkers<br>• blood glucose monitors<br>• insulin pumps.<br>Durable medical equipment, such as wheelchair and hospital beds, on loan from the plan.<br>Durable medical equipment must be pre-authorized by the plan and provided by a participating vendor. | Nothing |
| *Not covered:*<br>• *Motorized wheel chairs* | *All charges.* |
| **Home health services** | |
| • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide.<br>• Services include oxygen therapy, intravenous therapy and medications. | Nothing |
| **Home health services** *(Continued)* | **You pay** |
| *Not covered:*<br>• *nursing care requested by, or for the convenience of, the patient or the patient's family;*<br>• *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.* | *All charges.* |

| Alternative treatments | |
|---|---|
| **Not covered:**<br><br>• *Acupuncture*<br>• *Chiropractic services*<br>• **naturopathic services**<br>• **hypnotherapy**<br>• *biofeedback* | *All charges.* |
| **Educational classes and programs** | |
| Coverage is limited to:<br><br>• Diabetic Education Services, provided by a plan approved diabetic educator or education program. | $10 per office visit |

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

IMPORTANT

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

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

IMPORTANT

| Benefit Description | You pay |
|---|---|
| **Surgical procedures** | |
| • Treatment of fractures, including casting<br>• Normal pre- and post-operative care by the surgeon<br>• Correction of amblyopia and strabismus<br>• Endoscopy procedure<br>• Biopsy procedure<br>• Removal of tumors and cysts<br>• Correction of congenital anomalies (see reconstructive surgery)<br>• Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over.<br>• Insertion of internal prosthetic devices. See 5 (a) – Orthopedic braces and prosthetic devices for device coverage information. | $10 per office visit or nothing for hospital visits |

*Surgical procedures continued on next page.*

| **Surgical procedures** *(Continued)* | **You pay** |
|---|---|
| • Voluntary sterilization<br>• Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a).<br>• Treatment of burns<br><br>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. | $10 per office visit or nothing for hospital visits |
| *Not covered:*<br>• *Reversal of voluntary sterilization*<br>• *Routine treatment of conditions of the foot; see Foot care.* | *All charges.* |
| **Reconstructive surgery** | |
| Surgery to correct a functional defect<br>• Surgery to correct a condition caused by injury or illness if:<br>•• the condition produced a major effect on the member's appearance and<br>•• the condition can reasonably be expected to be corrected by such surgery<br>• Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. | $10 per office visit |

| **Reconstructive surgery** *(Continued)* | **You pay** |
|---|---|
| • All stages of breast reconstruction surgery following a mastectomy, such as:<br>•• surgery to produce a symmetrical appearance on the other breast;<br>•• treatment of any physical complications, such as lymphedemas;<br>•• breast prostheses and surgical bras and replacements (see Prosthetic devices)<br>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 | See above. |
| *Not covered:*<br>• *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury*<br>• *Surgeries related to sex transformation* | *All charges* |
| **Oral and maxillofacial surgery** | |
| Oral surgical procedures, limited to:<br>• Reduction of fractures of the jaws or facial bones;<br>• Surgical correction of cleft lip, cleft palate or severe functional malocclusion;<br>• Removal of stones from salivary ducts;<br>• Excision of leukoplakia or malignancies;<br>• Excision of cysts and incision of abscesses when done as independent procedures; and<br>• Other surgical procedures that do not involve the teeth or their supporting structures. | $10 per office visit or nothing for hospital visits |
| *Not covered:*<br>• *Oral implants and transplants*<br>• *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*<br>• *Dental care involved in treatment of temporomandibular joint dysfunction syndrome, (TMJ) pain.* | *All charges.* |

| Organ/tissue transplants | You pay |
|---|---|
| Limited to:<br>• Cornea<br>• Heart<br>• Heart/lung<br>• Kidney<br>• Kidney/Pancreas<br>• Liver<br>• Lung: Single –Double<br>• Pancreas<br>• Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors<br>• Allogeneic bone marrow transplants<br><br>Note: We cover related medical and hospital expenses of the donor when we cover the recipient on this plan | $10 per office visit |
| *Not covered:*<br>• *Donor screening tests and donor search expenses, except those performed for the actual donor*<br>• *Implants of artificial organs*<br>• *Transplants not listed as covered* | *All charges* |
| **Anesthesia** | **You pay** |
| Professional services provided in –<br>• Hospital (inpatient) | nothing |
| Professional services provided in –<br>• Hospital outpatient department<br>• Skilled nursing facility<br>• Ambulatory surgical center<br>• Office | Nothing |

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

IMPORTANT

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

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

IMPORTANT

| Benefit Description | You pay |
|---|---|
| **Inpatient hospital** | |
| Room and board, such as<br>• ward, semiprivate, or intensive care accommodations;<br>• general nursing care; and<br>• meals and special diets.<br><br>NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate. | Nothing |

*Inpatient hospital continued on next page.*

| **Inpatient hospital** *(Continued)* | **You pay** |
|---|---|
| Other hospital services and supplies, such as:<br>• Operating, recovery, maternity, and other treatment rooms<br>• Prescribed drugs and medicines<br>• Diagnostic laboratory tests and X-rays<br>• Administration of blood and blood products<br>• Dressings, splints, casts, and sterile tray services<br>• Medical supplies and equipment, including oxygen<br>• Anesthetics, including nurse anesthetist services<br>• Take-home items<br>• Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home | Nothing |
| *Not covered:*<br>• *Blood or blood plasma, if not donated or replaced*<br>• *Custodial care*<br>• *Non-covered facilities, such as nursing homes, extended care facilities, schools*<br>• *Personal comfort items, such as telephone, television, barber services, guest meals and beds*<br>• *Private nursing care* | *All charges.* |
| **Outpatient hospital or ambulatory surgical center** | |
| • Operating, recovery, and other treatment rooms<br>• Prescribed drugs and medicines<br>• Diagnostic laboratory tests, X-rays, and pathology services<br>• Administration of blood, blood plasma, and other biologicals<br>• Pre-surgical testing<br>• Dressings, casts, and sterile tray services<br>• Medical supplies, including oxygen<br>• Anesthetics and anesthesia service<br><br>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. | Nothing |
| *Not covered: blood and blood derivatives not replaced by the member* | *All charges* |

| Extended care benefits/skilled nursing care facility benefits | You pay |
|---|---|
| Extended care or skilled nursing facility: up to 100 days per calendar year. | Nothing |
| *Not covered: custodial care* | *All charges* |
| **Hospice care** | |
| Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. A maximum of ten (10) days of respite care are provided. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less | Nothing |
| *Not covered: Independent nursing, homemaker services* | *All charges* |
| **Ambulance** | |
| • Local professional ambulance service when medically appropriate | Nothing |

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

### 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. If you use the emergency room for something that is not a true emergency, you may have to pay for the service yourself.

### What to do in case of emergency:

**Emergencies within our service area:** Contact your primary care doctor or in extreme emergency call the local emergency system (e.g., the 911) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Rocky Mountain HMO plan member so they can notify the plan..

**Emergencies outside our service area:** Go to the nearest emergent or urgent care center for treatment. If you need to be hospitalized, the plan must be notified at 1-800-346-4643. 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. Follow-up care recommended by non-plan providers must be approved by the plan or provided by plan providers. You pay 50% of charges for follow-up care up to a maximum plan payment of $250.

| Benefit Description | You pay |
|---|---|
| **Emergency within our service area** | |
| • Emergency care at a doctor's office<br>• Emergency care at an urgent care center<br>• Emergency care as an outpatient or inpatient at a hospital, including doctors' services | $10 per office visit.<br>$50 per visit<br>$50 for outpatient visit, waived if you are admitted to the hospital. |
| *Not covered: Elective care or non-emergency care* | *All charges.* |
| **Emergency outside our service area** | |
| • Emergency care at a doctor's office<br>• Emergency care at an urgent care center<br>• Emergency care as an outpatient or inpatient at a hospital, including doctors' services | Reasonable charges for emergency care services to the extent the services would have been covered if received from plan providers. |
| *Not covered:*<br>• *Elective care or non-emergency care*<br>• *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*<br>• *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area* | All charges. |
| **Ambulance** | |
| Professional ambulance service and air ambulance when medically appropriate.<br>See 5(c) for non-emergency service. | Nothing |

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

IMPORTANT

**Parity**

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

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

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- 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.

IMPORTANT

| Benefit Description | You pay |
|---|---|
| **Mental health and substance abuse benefits** | |
| 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.<br><br>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. You must complete the entire treatment program for services to be covered. | Your cost sharing responsibilities are no greater than for other illness or conditions. |
| • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers<br>• Medication management | $10 per office visit if the program is completed. All charges if the program is not completed. |

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

| **Mental health and substance abuse benefits** *(Continued)* | **You pay** |
|---|---|
| • Diagnostic tests | Nothing in addition to office visit copay |
| • Services provided by a hospital or other facility<br>• Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment | Nothing if the program is completed, you pay all charges if the program is not completed |
| **Not covered: Services we have not approved.**<br>**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.** | *All charges.* |

## Preauthorization

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

Your physician is responsible for getting our approval before you receive any of the listed services. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice. It is important that you use plan providers for all services. You can get a directory by calling 800-346-4643. If we do not approve a service for you we will notify you in writing.

*Special transitional benefit*

***If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following conditions:***

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

***If this conditions applies to you, we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.***

*Limitation*

***We may limit your benefits if you do not follow your treatment plan.***

## Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a plan pharmacy
- **We use a formulary.** A formulary is a list of prescription drugs we will pay for. We will not pay for drugs not on the formulary even if your doctor prescribes the drug.
- **These are the dispensing limitations.** Prescription drugs listed on the plan's formulary and certain medical supplies prescribed by a plan doctor or referral doctor will be dispensed for up to a 30-day supply or 100 doses, whichever is greater. You pay a $10 co-pay for generic drugs, $15 copay for preferred brand name drugs and $25 for non-preferred drugs. If you choose a brand name drug when a generic substitution is permissable, you pay the price difference between the generic and brand name drug in addition to the brand name co-pay. A dose is defined as a single pill , regardless of the number of pills to be taken at a single time. For inhalers and medicines available in patch formulation, the maximum quantity dispensed shall be a 30-day supply. You may check with your doctor or call member services to determine which drugs or medicines are listed on the formulary.

*Prescription drug benefits begin on the next page.*

| Benefit Description | You pay |
|---|---|
| **Covered medications and supplies** | |
| We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy.<br><br>• Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below.<br>• Insulin<br>• Disposable needles and syringes for the administration of covered medications<br>• Drugs for sexual dysfunction<br>• Contraceptive drugs and devices | $10 copay for generic drugs<br>$15 for preferred brand drugs<br>$25 for non-preferred brand drugs<br>Note: If there is no generic equivalent available, you will still have to pay the brand name copay.<br><br>If you choose the brand name when a generic is available, you will pay the brand name copay and the difference in cost between the generic and the brand name |
| Viagra is covered only when pre-authorized and is limited to 5 pills per month. | $25 |

| **Covered medications and supplies** *(continued)* | **You pay** |
|---|---|
| Here are some things to keep in mind about our prescription drug program:<br><br>• A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.<br><br>• We have a closed 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 that we selected to meet patient needs at a lower cost. | |
| *Not covered:*<br>• *Drugs and supplies for cosmetic purposes*<br>• *Vitamins, nutrients and food supplements even if a physician prescribes or administers them*<br>• *Nonprescription medicines*<br>• *Drugs not included on the plan formulary*<br>• *Weight loss drugs* | *All Charges* |

## Section 5 (g). Dental benefits

IMPORTANT

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

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

IMPORTANT

| Accidental injury benefit | You pay |
|---|---|
| We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth The need for these services must result from an accidental injury not from biting or chewing. Treatment must be completed within 24 months from the date of the injury.<br><br>Note: A tooth is not considered sound and natural if it has more than one surface restoration, a crown or root canal, and/or the tooth is a partial, a denture or implant. | $10 per office visit |
| Plan provides preventive dental services to children under age 12. This benefit is limited to two visits per child per calendar year. The following dental services are covered.<br><br>• Oral Exams<br><br>• Prophylaxis (Cleaning)<br><br>• Topical application of fluoride (if drinking water is not fluoridated<br><br>• Sealants | $10 per office visit |

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

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

### Expanded Dental Benefits

| | First Year | Second Year | Third Year |
|---|---|---|---|
| Diagnostic & Preventive | 80% | 100% | 100% |
| Basic Services | 50% | 65% | 80% |
| Major Services | 25% | 40% | 50% |
| Annual Program Maximum | $1,000.00 | $1,000.00 | $1,000.00 |
| Deductible: | $50/$150 | $50/$150 | $50/$150 |

- Deductible does not apply to Diagnostic and Preventive services
- No claim forms with participating providers
- Over 50,000participating providers nationally
- With Concordia select, benefits gradually increase over a three year period
- The percentages shown are the percent of the maximum allowance amount for covered service's

For more information call customer service at 1-800-332-0366

***Benefits on this page are not part of the FEHB contract***

**Rocky Mountain HMO**

# Federal Employees Health Benefits – Medicare 2001

# This page applies only to Medicare members

## How Your Medicare Plan is Different From the Rocky Mountain HMO Health Plan Brochure for Federal Employees

(Please refer to page 67, Summary of Benefits)

### Inpatient Care

| | |
|---|---|
| Mental Conditions | Inpatient care in a participating or approved Psychiatric hospital shall be provided for 30 days Per calendar year above Medicare's covered days of 190 per lifetime. You pay nothing. |
| Substance Abuse | Services are provided for rehabilitation according to Medicare provisions. Rocky Mountain HMO will assume liability for deductible and co-insurance. |

### Outpatient Care

| | |
|---|---|
| Mental Conditions | Covered in accordance with Medicare requirements. You pay a $10 co-payment for each visit. |

### Emergency Care

All treatment required for medical emergencies is Provided. You pay a $10 co-payment for each emergency room visit and any charges for services that are not covered by this Plan.

### Prescription Drugs

Drugs prescribed by a plan doctor and obtained at a plan pharmacy are provided. You pay an $8 co-payment for each prescription.

### Out-Of-Pocket Limit

Does not apply.

***Benefits on this page are not part of the FEHB contract***

# Medicare Enrollment Information

Rocky Mountain HMO offers Medicare recipients the opportunity to enroll in the plan through Medicare. As indicated on page 57 of the 2001 Federal Employees Health Benefits Program brochure, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later re-enroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB program, call 1-800-346-4643 for information on the benefits available under the FEHB Medicare HMO plan.

***Benefits on this page are not part of the FEHB contract***

## Section 4. Your costs for covered services

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

| | |
|---|---|
| • **Copayments** | A copayment is a fixed amount of money you pay when you receive services.<br><br>Example: When you see your primary care physician you pay a copayment of $10 per office visit and when you go in the hospital, you pay nothing. |
| •**Deductible** | We do not have a deductible. |
| **Coinsurance** | We do not have coinsurance. |

### Your out-of-pocket maximum for copayments

After your co-payments total $750 per person or $1500 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services.

- *Prescription drugs*

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

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

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies that were authorized by another plan before you enrolled in this plan;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel unless such examination is the only physical examination obtained during the calendar year.
- Surgery primarily for cosmetic purposes
- Hearing aids
- Chiropractic services
- Homemaker services
- Blood and blood derivative not replaced by the member or,
- Transplants not specified as covered.

## Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card. Rocky Mountain HMO will bill you for any co-payments due.

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

### Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 970-243-7050 or 1-800-346-4643.

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

- Covered member's name and ID number;
- Name and address of 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:** **Rocky Mountain HMO,**
**2775 Crossroads Blvd.**
**Grand Junction, CO 81506**

### Prescription drugs

Drugs and supplies must be obtained by a plan pharmacy, except for medical emergencies.

**Submit your claims to:** **Rocky Mountain HMO**
**2775 Crossroads Blvd.**
**Grand Junction, CO 81506**

**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 within 30 days when we ask for additional information. We may delay processing or deny your claim if you do not respond.

## Section 8. The disputed claims process

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

| Step | Description |
|---|---|
| 1 | Ask us in writing to reconsider our initial decision. You must:<br>(a) Write to us within 6 months from the date of our decision; and<br>(b) Send your request to us at: 2775 Crossroads Blvd, Grand Junction CO, 81506<br>(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and<br>(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:<br>(a) Pay the claim if applicable or arrange for the health care provider to give you the care); or<br>(b) Write to you and maintain our denial -- go to step 4; or<br>(c) Ask you or your medical provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3. |
| 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.<br>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.<br>We will write to you with our decision. |
| 4 | If you do not agree with our decision, you may ask OPM to review it.<br>You must write to OPM within:<br>• 90 days after the date of our letter upholding our initial decision; or<br>• 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or<br>• 120 days after we asked for additional information.<br>Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division IV, P.O. Box 436 Washington, D.C. 20044-0436.<br>Send OPM the following information:<br>• A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;<br>• Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;<br>• Copies of all letters you sent to us about the claim;<br>• Copies of all letters we sent to you about the claim; and<br>• Your daytime phone number and the best time to call.<br>Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim. |

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

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

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

**6** If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies. 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 pre-authorization then call us at 970-243-7050 or 1-800-346-4643 and we will expedite our review; or We denied your initial request for care or pre-authorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division IV at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

## Section 9. Coordinating benefits with other coverage

**When you have other health coverage**

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

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

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

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

**•What is Medicare?**

Medicare is a Health Insurance Program for:

•• People 65 years of age and older.

•• Some people with disabilities, under 65 years of age.

•• People with End-Stage Renal Disease

Medicare has two parts:

•• Part A (Hospital Insurance). Most people do not have to pay for Part A.

•• Part B (Medical Insurance). Most people pay monthly for Part B.

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

**•The Original Medicare Plan**

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

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. See page 45 for a list of differences between the benefits of this plan and the Medicare plan.

**(Primary payer chart begins on next page.)**

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

**Claims process --** You probably will never have to file a claim form when you have both our Plan and Medicare.

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

- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 970-243-7050 or 1-800-346-4643.

**We waive some costs when you have Medicare --** When Medicare is the primary payer, we will waive some out-of-pocket costs, as follows:

- Emergency room visits are $10 per visit
- Prescription drugs are $8 per prescription

- **Medicare managed care plan**

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

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

**This Plan and another Plan's Medicare managed care plan:** You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments

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

- **Enrollment in Medicare Part B**

**Note:** If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program. We cannot require you to enroll in Medicare.

## TRICARE

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

## Workers' Compensation

We do not cover services that:

- you need because of a workplace-related disease 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 benefits. You must use our providers

## Medicaid

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

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

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

**When others are responsible**

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

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

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

**Calendar year**

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

**Copayment**

A copayment is a fixed amount of money you pay when you receive covered services.

**Covered services**

Care we provide benefits for, as described in this brochure.

**Custodial care**

Care which is furnished mainly to assist a person in the activities of daily living, and for which professional skill or training is not required.

**Experimental or investigational services**

The plan will determine the experimental/investigational nature of a service, supply or drug through its Medical Department and Medical Director. The plan, in its discretion, may review material from, or seek input from, the following groups: The Food and Drug Administration, The National Institutes of Health and the American Medical Association. The Plan may also consider any local community standard with respect to each service in question, and inquire as to the coverage of such service by group health insurance companies an other health maintenance organizations in the Plan's service area.

**Medical necessity**

Services that are necessary to preserve a member's health according to the standards of medical practice in the community. Services provided only as a convenience are not considered necessary. The fact that a plan provider prescribes, recommends or orders a service or supply does not make it medically necessary.

**Us/We**

Us and we refer to Rocky Mountain HMO

**You**

You refers to the enrollee and each covered family member.

## Section 11. FEHB facts

### No pre-existing condition limitation

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

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

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

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

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

### Types of coverage available for you and your family

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

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry. Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

## When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

## Your medical and claims records are confidential

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

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

## When you retire

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

## When you lose benefits

**•When FEHB coverage ends**

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

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

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

**• Spouse equity coverage**

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

**•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.

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

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.

**•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

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.

## Inspector General Advisory

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 970/243-7050 or 1-800-346-4643 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

## Penalties for Fraud

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

## TCC eligibility

See Section 11, FEHB Facts; it explains temporary continuation of coverage (TCC). Under this DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

## Other features

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration Project.

# Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

**NOTES:**

## Summary of benefits for the Rocky Mountain HMO – 2001

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

| Benefits | You Pay | Page |
|---|---|---|
| Medical services provided by physicians:<br>• Diagnostic and treatment services provided in the office..... | Office visit copay: $10 primary care; $10 specialist | 13 |
| Services provided by a hospital:<br>• Inpatient.....<br>• Outpatient..... | Nothing | 28<br>28 |
| Emergency benefits:<br>• In-area .....<br>• Out-of-area ..... | $10 per office visit<br>$50 per emergency room or urgent care visit | 32<br>32 |
| Mental health and substance abuse treatment ..... | Regular benefits | 33 |
| Prescription drugs..... | $10 generic<br>$15 preferred<br>$25 brand name | 35 |
| Dental Care..... | $10 per visit for preventive services to children under age 12 | 38 |
| Vision Care..... | $10 per visit, plan pays for one annual refraction to provide a written lens prescription only | 15 |
| Protection against catastrophic costs (your out-of-pocket maximum) ..... | Nothing after $750 Self Only or $1500 Family enrollment per year<br>Some costs do not count toward this protection | 11 |

# 2001 Rate Information for
# The Rocky Mountain Health Maintenance Organization

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

**Postal rates** apply to most career U.S. Postal Service employees. Different rates apply if you are a Postal Service nurse or tool and die employee. Refer to the FEHB Guide (for Postal Service nurses and tool and die employees), RI 70-2B. If you are a Postal Service Inspector or Office of Inspector General (OIG) employee, refer to FEHB Guide RI 70-2IN.

*Postal rates do not apply to non-career postal employees, postal retirees or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable FEHB Guide.*

| | | Non-Postal Premium | | | | Postal Premium | |
|---|---|---|---|---|---|---|---|
| | | Biweekly | | Monthly | | Biweekly | |
| Type of Enrollment | Code | Gov't Share | Your Share | Gov't Share | Your Share | USPS Share | Your Share |
| Most of Colorado | | | | | | | |
| Self | XJ1 | $86.59 | $50.23 | $187.61 | $108.83 | $102.22 | $34.60 |
| Self and Family | XJ2 | $195.82 | $124.18 | $424.28 | $269.05 | $231.17 | $88.83 |