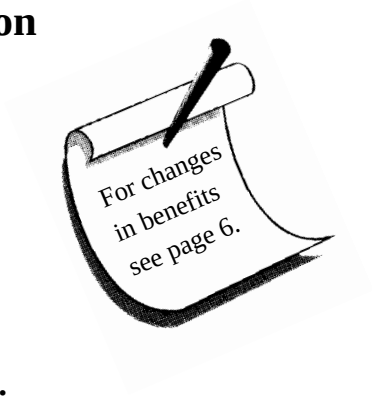
CIGNA HealthCare of Virginia, Inc.

CIGNA HealthCare

http://www.cigna.com/healthcare

2001

A Health Maintenance Organization



Serving: Central and Southeastern Virginia

Enrollment in this Plan is limited; see page 4 for requirements.

This Plan has commendable accreditation from the NCQA. See the 2001 Guide for more information on NCQA.

Enrollment codes for this Plan:

Central Virginia

W31 Self Only
W32 Self and Family

Southeastern Virginia

W21 Self Only
W22 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 73-270

Table of Contents

Introduction

CIGNA HealthCare of Virginia, Inc.
7501 Boulders View Drive, Suite 600
Richmond, Virginia 23225

This brochure describes the benefits of CIGNA HealthCare of Virginia, Inc. under our contract (CS 2094) 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 6. 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 CIGNA HealthCare of Virginia, Inc.

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 copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. We compensate our participating providers in ways that are intended to emphasize preventive care, promote quality of care, and assure the most appropriate use of medical services. You can discuss with your provider how he is compensated by us. The methods we use to compensate participating providers are:

Discounted fee for service – payment for service is based on an agreed upon discounted amount for the services provided.

Capitation **–** Physicians, provider groups and physician/hospital organizations are paid a fixed amount at regular intervals for each Member assigned to the physician, provider group or physician/hospital organization, whether or not services are provided. This payment covers the physician and/or, where applicable, hospital or other services covered under the benefit plan. Medical groups and physician/hospital organizations may in turn compensate providers using a variety of methods.

Capitation offers health care providers a predictable income, encourages Physicians to keep people well through preventive care, eliminates the financial incentive to provide services that will not benefit the patient, and reduces paperwork.

Providers paid on a "capitated" basis may participate with us in a risk sharing arrangement. They agree upon a target amount for the cost of certain health care services, and they share all or some of the amount by which actual costs are over target. Provider services are monitored for appropriate utilization, accessibility, quality and Member satisfaction.

We may also work with third parties who administer payments to Participating Providers. Under these arrangements, we pay the third party a fixed monthly amount for these services. Providers are compensated by the third party for services provided to Healthplan participants from the fixed amount. The compensation varies based on overall utilization.

Salary – Physicians and other providers who are employed to work in our medical facilities are paid a salary. The compensation is based on a dollar amount, decided in advance each year, that is guaranteed regardless of the services provided. Physicians are eligible for any annual bonus based on quality of care, quality of service and appropriate use of Medical Services.

Bonuses and Incentives – Eligible Physicians may receive additional payments based on their performance. To determine who qualifies, we evaluate Physician performance using criteria that may include quality of care, quality of service, accountability and appropriate use of Medical Services.

Per Diem – A specific amount is paid to a hospital per day for all health care received. The payment may vary by type of service and length of stay.

Case Rate – A specific amount is paid for all the care received in the hospital for each standard service category as specified in our contract with the provider (e.g., for a normal maternity delivery).

Who provides my health care?

We contract with a group of doctors and hospitals to provide your health care. You will select a primary care physician who supervises your total health care needs. You may see a Plan gynecologist for 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.

- CIGNA HealthCare of Virginia is in compliance with all State and Federal licensing and certification requirements and has received its three year certification by the National Committee on Quality Assurance (NCQA) in February 1998.
- CIGNA HealthCare of Virginia is a Health Maintenance Organization licensed in the Commonwealth of Virginia since 1984.

If you want more information about us, call 1-800-832-3211, or write to CIGNA HealthCare of Virginia, Inc., 7501 Boulders View Drive, Suite 600, Richmond, Virginia 23225. You may also visit our website at www.cigna.com/healthcare.

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:

Central Virginia Area

The **Cities** of Richmond, Petersburg, Colonial Heights and Hopewell; and the **Counties** of Amelia, Caroline, Charles City, Chesterfield, Cumberland, Dinwiddie, Gouchland, Hanover, Henrico, King William, Louisa, New Kent, Nottaway, Powhatan, Prince George, Surry and Sussex.

Southeastern Virginia Area

The **Cities** of Chesapeake, Hampton, Newport News, Norfolk, Poquoson, Portsmouth, Smithfield, Suffolk, Virginia Beach, and Williamsburg; and the **Counties** of Gloucester, Isle of Wight, James City, King & Queen, Mathews, Middlesex, and York.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care. We will not pay for any other health care services.

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

Section 2. 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 deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed higher patient cost sharing and shorter day or visit limitations on 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 Customer Service Department at 1-800-832-3211, **or** checking our website www.cigna.com/healthcare. 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

- **W2** – Your share of the non-Postal premium will increase by 17.7% for Self Only or 17.9% for Self and Family.
- **W3** – Your share of the non-Postal premium will increase by 2.6% for Self Only or 2.8% for Self and Family.
- Durable Medical Equipment is covered subject to a maximum Plan payment of $3,500 per member per contract year. Previously, DME was covered subject to no maximum Plan payment. Members continue to pay no copayment for this benefit.
- Infertility benefit office visit copay is now $10 instead of $20.
- Self Only out-of-pocket maximum is $1,000 and Self and Family out-of-pocket maximum is $2,000. Previously, Self Only out-of-pocket maximum was $1,500 and Self and Family out-of-pocket maximum was $3,000.
- Outpatient short-term rehabilitative therapy benefits are covered up to 60 visits per condition subject to a member copay of $20 per visit. Previously, the benefit was covered for 60 consecutive days subject to a member copay of $10 per visit.
- Prescription drugs per prescription unit or refill are covered subject to a member copayment of $5 for generics, $15 for preferred brand name drugs and $35 for non-preferred drugs. Previously, the copays were $5 for generic drugs and $10 for brand name drugs.
- Mail Order prescription drugs are covered for up to a 90 day supply subject to a member copayment of $10 for generics, $40 for preferred brand name drugs and $100 for non-preferred brand name drugs. Previously, the copays were $10 for generics drugs and $20 for brand name drugs.
- Urgent care copay is now $25 instead of $50.

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 1-800-832-3211.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims unless you receive emergency services from a provider who does not have a contract with us.

- **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 website.

- **Plan facilities**

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

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. This decision is important since your primary care physician provides or arranges for most of your health care. When you enroll, you choose a Primary Care Physician (PCP). Each family member also chooses a PCP. Your PCP is your personal doctor and serves as your health care manager. If you do not select a PCP, we will assign one for you. If your PCP leaves our network, you will be able to choose a new PCP. You may voluntarily change your PCP for other reasons but not more than once in any calendar month. We reserve the right to determine the number of times during a year that you will be allowed to change your PCP. If you select a new PCP before the fifteenth day of the month, the designation will be effective on the first day of the month following your selection. If you select a new PCP on or after the fifteenth day of the month, the designation will be effective on the first day of the month following the next full month. For example, if you notify us on June 10, the change will be effect on July 1. If you notify us on June 15, the change will be effective on August 1.

Some Primary Care Physicians belong to provider organizations which usually refer to a network of Specialty Care Physicians and Hospitals that are in the provider organization. Your choice of Primary Care Physician may affect the Hospital(s) and Specialty Care Physicians to which you may be referred. Therefore, you may not have access to every specialist or Participating Provider in your Service Area. Before you select a PCP, you should check to see if that PCP is associated with the specialist or facility you prefer to use.

• Primary care

Your primary care physician can be a general practitioner, 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. However, you may see an OB/GYN for well-woman care or go to a hospital for emergency care without a referral.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will work with the Plan to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. 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 1-800-832-3211. 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 benefit of the hospitalized person.

Circumstances beyond our control

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

Services requiring our prior approval

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

A referral or Prior Authorization must be obtained prior to receiving services performed by any health care provider EXCEPT:

For services provided by

- Your Primary Care Physician;
- OB/GYN Services; and
- Emergency Services or Urgently Needed Care.

A Referral must be obtained directly from your Primary Care Physician. Your Primary Care Physician must provide a referral if you receive services and benefits such as Specialty Care Physician services. If you receive services which require a referral without a referral from your Primary Care Physician, you will be obligated to pay for the unauthorized Services. **We will not pay for such unauthorized Services.**

Certain benefits and services require Prior Authorization from us. Prior Authorization must always be obtained through your Plan Provider. If Prior Authorization is required from us, your Primary Care Physician or Specialty Care Physician will make arrangements with our Medical Department Staff. Prior Authorization is required for the following types of benefits and services such as: Inpatient and Outpatient Hospital Services, Rehabilitative Therapy, Skilled Nursing Facility Services, Home Health Services, Second Surgical Opinions, Services provided by a Non-Plan Provider, Durable Medical Equipment and Prosthetic Devices.

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

Section 4. Your costs for covered services

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

- **Copayments**

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

Example: When you see your primary care physician you pay a copayment of $10 per office visit.

- **Deductible**

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. We do not have a deductible.

NOTE: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

- **Coinsurance**

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

Example: In our Plan, you pay 50% of our allowance for infertility surgical procedures.

Your out-of-pocket maximum for copayments

After your copayments total $1,000 per person or $2,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services:

- prescription drugs
- vision services
- mental health/substance abuse
- external prosthetic appliances
- office visits

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

Section 5. Benefits – OVERVIEW

(See page 6 for how our benefits changed this year and page 48 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. Please read the important things you should keep in mind at the beginning of each subsection. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-832-3211 or at our website at www.cigna.com/healthcare.

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 • In physician's office • Office medical consultations • Second surgical opinion	$10 per office visit
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment Note: You pay nothing for the physician's service, however a facility copayment may apply. Refer to the facility charges identified in this Section 5.	Nothing
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Pap tests • Pathology • X-rays • Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG Note: You pay nothing for Lab, X-rays and other diagnostic tests, however a provider or facility copayment may apply. Refer to the provider/facility charges identified in this Section 5.	Nothing

Preventive care, adult	You pay
Routine screenings, such as: • Blood lead level – One annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including •• Fecal occult blood test •• Sigmoidoscopy, screening – every five years starting at age 50 Prostate Specific Antigen (PSA test) – one annually for men age 40 and older Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnostic and treatment services*, above. Note: You pay nothing for routine screenings, however a provider or facility copayment may apply. Refer to the provider/facility charges identified in this Section 5.	Nothing
Routine mammogram – Covered once annually. In addition to routine screenings, mammograms are covered when prescribed by the doctors as medically necessary to diagnose or treat your illness.	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	Nothing
Preventive care, children	
• Childhood immunizations and injections recommended by the American Academy of Pediatrics Note: You pay nothing for childhood immunizations, however a provider or facility copayment may apply. Refer to the provider/facility charges identified in this Section 5.	Nothing
• Examinations, such as: •• Eye exams through age 17 to determine the need for vision correction •• Ear exams through age 17 to determine the need for hearing correction •• Examinations done on the day of immunizations (through age 22) • Well-child care charges for routine examinations, immunizations and care (through age 22) • Early intervention services (through age 2)	$10 per office visit

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to obtain prior authorization for your normal delivery; see page 9 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$10 for the first office visit to confirm pregnancy; no copay for all pre-/post-delivery visits thereafter.
Not covered: Routine sonograms to determine fetal age, size or sex .	*All charges.*
Family planning	
• Voluntary sterilization Note: You pay nothing for Voluntary sterilization, however a provider or facility copayment may apply. Refer to the provider/facility charges identified in this Section 5.	Nothing
• Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per office visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling.	*All charges.*
Infertility services	
Diagnosis of infertility	$10 per office visit
Treatment of infertility, such as: • Artificial insemination: •• *intravaginal insemination (IVI)* •• *intracervical insemination (ICI)* •• *intrauterine insemination (IUI)* • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	50% per procedure/surgery
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* •• *in vitro fertilization* •• *embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm*	*All charges.*

Allergy care	You pay
Testing and treatment Allergy injection	$10 per office visit
Allergy serum	Nothing
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 21. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: We will only cover GHT when your PCP has received our prior authorization – Prior approval must be received before you begin treatment; otherwise, we will only cover GHT services from the date your PCP receives prior authorization. If prior authorization is not received or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. GHT is covered under the prescription drug benefit. See *Services requiring our prior approval* in Section 3.	Nothing, however a provider or facility copayment may apply.
Rehabilitative therapies	
Physical therapy, occupational therapy and speech therapy • 60 visits total per condition for the services of each of the following: •• qualified physical therapists; •• speech therapists; •• occupational therapists; and •• chiropractors. 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.	$20 per office visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs* • *cardiac and pulmonary rehabilitation programs*	*All charges.*
Hearing services (testing, treatment, and supplies)	
• Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit
Not covered: • *all hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*

Vision services (testing, treatment, and supplies)	You pay
One pair of eyeglasses or contact lenses for treatment of keratoconus or post-cataract surgery	$10 per office visit
Eye exam to determine the need for vision correction for children through age 17 (see preventive care)	$10 per office visit
Not covered: • *Eyeglasses or contact lenses and examinations for them* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Routine refractions*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for medical conditions such as diabetes; fungal infection of the nail beds, circulatory impairment; immunocomprimised patients. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; hands or hooks.	First $200 up to a maximum Plan benefit of $1,000 per member per calendar year.
• Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device.	Nothing
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *prosthetic replacements due to wear and tear, loss, theft or destruction.* • *Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome* • *Biomechanical devices* • *Penile prosthetics*	*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 and received from a vendor approved by the Plan, such as oxygen tents and dialysis equipment. Under this benefit, we also cover: • Hospital beds; • Wheelchairs (limited to the lowest cost alternative to satisfy medical necessity); • Crutches; • Walkers; • blood glucose monitors and blood glucose monitors for the legally blind; • insulin pumps and infusion devices; • respirators; and • oxygen tents. Note: Your PCP will prescribe and arrange for a participating health care provider to rent or sell you the durable medical equipment. We will not cover equipment received from a non-participating health care provider unless your PCP has received our prior authorization.	Nothing up to a maximum Plan benefit of $3,500.
Not covered: • *Hygienic or self-help items or equipment, or item or equipment that are primarily for comfort or convenience, such as bathtub chairs, safety grab bars, stair gliders or elevators, over-the-bed tables, saunas or exercise equipment;* • *Environmental control equipment, such as air purifiers, humidifiers, and electrostatic machines;* • *Institutional equipment such as air fluidized beds and diathermy machines;* • *Consumable medical supplies including, but not limited to, bandages and other disposable supplies, skin preparations, test strips, ostomy supplies, surgical leggings, elastic stockings and wigs.*	*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. • Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication;* • *services primarily for rest, domiciliary or convalescent care.*	*All charges.*

Alternative treatments	You pay
No benefit	*All charges.*
Educational classes and programs	
Coverage for classes/programs upon referral of the Plan such as: • Diabetes self-management at a participating American Diabetes Association facility • Asthma well aware classes • Nutritional classes	$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.).
- YOUR PLAN PROVIDER MUST GET PRIOR AUTHORIZATION OF SOME SURGICAL PROCEDURES. Please refer to the prior authorization information shown in Section 3 to be sure which services require prior authorization and identify which surgeries require prior authorization.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity – a condition in which an individual weighs 200% of his or her normal weight according to the 1983 Metropolitan Life Insurance Company height-weight chart with a history of morbid obesity for at least 5 years and has complied with more conservative methods of weight loss • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information	Nothing
• Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a) • Treatment of burns 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.	Nothing

Surgical procedures continued on next page.

Surgical procedures *(Continued)*	**You pay**
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.* • *Cosmetic therapy or surgery primarily for the purpose of altering appearance.*	*All charges.*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery. • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices). Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Not covered: • *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* • *Surgeries related to sex transformation*	*All charges.*
Oral and maxillofacial surgery	
Oral surgical procedures, with the prior approval of Plan Medical Director, such as: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung • Pancreas • Small bowel/liver • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • National Transplant Program (NTP) please see Section 5(g), Special Features Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's Medical Director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges.*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

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

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.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).
- Your Primary Care Physician must obtain our Prior Authorization for Hospital Stays, except for emergencies.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as: • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood, blood products and other biologicals • Blood or blood plasma • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics and anesthesia services	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, skilled nursing facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*

Outpatient hospital or ambulatory surgical center	You pay
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood products and other biologicals • Blood and blood plasma • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia services 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	
Covered for up to 60 days per contract year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. Covered services include: • Skilled and general nursing services • Physicians visits • Physiotherapy • X-rays • Administration of drugs, medications and fluids	Nothing
Not covered: • *Personal comfort items, such as television and telephone* • *Custodial care, rest cures, domiciliary or convalescent care*	*All charges.*

Hospice care	You pay
Hospice care for a patient who as certified by a Plan doctor is in the terminal stages of illness and who has a life expectancy of six months or less. Hospice care services include: • Inpatient care • outpatient care • physician services • psychologist, social worker or family counselor services for individual or family counseling	Nothing
Not covered: • *Independent nursing* • *homemaker services, including services and supplies that are primarily to aid you or your dependent in daily living* • *services of a person who is a member of your family who normally resides in your house* • *services or supplies not listed in the Hospice Care Program* • *services for curative or life-prolonging procedures* • *services for respite care* • *nutritional supplements, non-prescription drugs or substances, medical supplies, vitamins or minerals* • *bereavement counseling*	*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.

What to do in case of emergency:

Emergencies inside or outside our service area: Emergency Services are defined as the medical, surgical, hospital and related health care services and testing, including ambulance service, that are rendered by participating or non-participating providers and are required to treat a sudden unexpected onset of a bodily injury or a serious illness that manifests itself by symptoms of sufficient severity, including severe pain, and which could reasonably be expected, by a prudent layperson who possesses an average knowledge of health and medicine, to result, in the absence of immediate medical attention, in (i) serious jeopardy to the mental or physical health of the individual, (ii) loss of life or serious impairment to bodily functions, (iii) serious dysfunction of any of the individual's bodily functions, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Included are conditions which produce loss of consciousness or excessive bleeding; or which may otherwise be determined by the Plan Medical Director in accordance with generally accepted medical standards, to have been a condition requiring immediate medical attention. The presenting symptoms, as coded by the provider and recorded by the Hospital on the UB92 claim form or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency.

In the event of an emergency, go to the closest emergency room or to the nearest Participating Hospital or call 911 for help. Whenever possible, contact your Primary Care Physician for direction. Participating Providers are on call twenty-four (24) hours a day, seven (7) days a week, to assist Members needing Emergency Services.

For Emergency Services rendered outside the Service Area, Members must notify Plan as soon as reasonably possible. We may, at our option, arrange to have Member transferred to a Participating Provider for continuing or follow-up care whenever medically prudent to do so.

Continuing or follow-up treatment, whether in or out of the Service Area, is not covered unless rendered by a Participating Provider or authorized in advance by the Plan Medical Director.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a Plan doctor's office • Emergency care at a Plan urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$10 per office visit $25 per office visit $50 per office visit. Copayment waived if admitted to hospital
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$10 per office visit $25 per office visit $50 per office visit. Copayment waived if admitted to hospital
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*	*All charges.*
Ambulance	
Professional ambulance service when medically appropriate. 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.
- 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.

IMPORTANT

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. 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.	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 • Medication management	$10 per office visit
• Diagnostic tests	Nothing
• Inpatient Services provided by a hospital or other facility • Outpatient Services in approved alternative care settings such as partial hospitalization, residential treatment, facility based intensive outpatient treatment	Nothing Nothing, however a provider copayment may apply.
Not covered: Services we have not approved. *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.*

Mental health and substance abuse benefits continued on next page.

Preauthorization

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

Mental Health and Substance Abuse Services are provided by CIGNA Behavioral Health, Inc. You do not need a referral to receive these services. However, to obtain these services, you **must** call CIGNA Behavioral Health directly, their phone number can be found on your ID Card, to get more information or speak with someone about a specific problem. A representative is available to assist you twenty-four (24) hours a day, seven (7) days a week. The representative will provide you with a choice of providers in your area and will authorize an appropriate number of visits.

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 condition:

- 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 condition 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.
- 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

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 the prescription at a plan retail pharmacy, or by plan mail-order pharmacy. You must fill the prescription at a plan retail pharmacy. You may fill your maintenance medications by mail through a plan mail-order pharmacy.
- **We use a formulary.** A formulary is a listing of approved drug products. The drugs and medications included have been approved in accordance with parameters established by us. This list is subject to periodic review and is amended as required.

These are the dispensing limitations. –

- Your copayment for generic retail prescription drugs that are on the formulary is $5. Your copayment for name brand retail prescription drugs that are on the formulary but do not have a generic equivalent is $15. Your copayment for name brand drugs that are on the formulary but do have a generic equivalent OR for drugs that are not on the formulary is $35. Each prescription order or refill is limited to a consecutive thirty (30) day supply at a retail participating pharmacy, unless limited by the drug manufacturer's packaging.
- Maintenance medications prescribed by Plan doctors may also be obtained through our mail order program. Your copayment for generic mail order prescription drugs that are on the formulary is $10. Your copayment for name brand mail order prescription drugs that are on the formulary but do not have a generic equivalent is $40. Your copayment for name brand mail order drugs that are on the formulary but do have a generic equivalent OR for mail order drugs that are not on the formulary is $100. Each prescription order or refill is limited to a consecutive ninety (90) day supply at a mail order participating pharmacy, unless limited by the manufacturer's packaging.

Each prescription order or refill is further limited to:

- "generic" drugs unless a generic alternative does not exist or substitution is not permitted by state law.
- Coverage for prescription drugs are subject to a Copayment. In no event will the Copayment exceed the cost of the drug.
- **When you have to file a claim.** Please refer to Section 7 "Filing a claim for covered services".

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 or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below • Insulin, copay charge applies to each vial • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (contact Plan for dose limits) • Oral and injectable contraceptive drugs and contraceptive devices (such as diaphragms) • Intravenous fluids and medication for home use, implantable drugs, including Norplant, and some injectable drugs are covered under Medical and Surgical Benefits. • Diabetic supplies such as test strips • Oral agent for controlling blood sugar Here are some things to keep in mind about our prescription drug program: • 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.	**Retail Pharmacy** $5 per generic formulary drug. $15 per name brand formulary drug with no generic equivalent. $35 per name brand formulary drug with generic equivalent OR per non-formulary drug. **Mail Order** $10 per generic formulary drug. $40 per name brand formulary drug with no generic equivalent. $100 per name brand formulary drug with generic equivalent OR per non-formulary drug. Note: If there is no generic equivalent available, you will still have to pay the brand name copay
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins (except for prenatal vitamins), and fluoride products, nutrients and food supplements even if a physician prescribes or administers them* • *Non-prescription medicines* • *Over the counter drugs* • *Drugs obtained from a non-Plan pharmacy except for out-of-area emergencies* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Smoking cessation drugs and medications, including nicotine patches* • *Diet pills or appetite suppressants (except when used in the treatment of morbid obesity)* • *Replacement of drugs due to loss or theft* • *Prescriptions more than one year from the original date of issue* • *Injectable fertility drugs (see Infertility benefit under Medical and Surgical Benefits for limited coverage)*	*All charges.*

Section 5 (g). Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call 1-800-832-3211 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	Deaf/Hearing impaired individuals may access the member services department by calling their state relay line.
High risk pregnancies	Healthy Babies is a program that provides guidance and support to women from pre-pregnancy through post-partum care. This program is designed to promote better maternity care, reduce the number of premature births and educate expectant parents.
Centers of Excellence for transplants/heart surgery/etc.	CIGNA HealthCare members have access to the CIGNA Lifesource Organ Transplant Network® which is an organization of participating hospitals which provides organ transplant services. As part of the rigorous credentialing program, each hospital's transplant program is evaluated for patient outcome, as well as waiting period, housing arrangements, "patient friendly" environment and the availability of transportation, before it is included in the CIGNA Lifesource Organ Transplant Network®.
Travel benefit/ services overseas	We cover you for emergency services anywhere in the world.

Section 5 (h). 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.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when prior authorized by the Plan Medical Director and 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

Dental benefits	
Service	**You pay**
The following preventive dental services are covered by participating Plan dentists once every six months, or twice per member per year except as shown below: • Consultations • Oral examination (two per year) • Preventive care training • Prophylaxis (cleaning) with fluoride for children through age 18 • Prophylaxis (cleaning) for adults (per two year) • X-rays (single, bitewing, panoramic) Exceptions: Complete series of X-rays is available once every three years. Topical application of fluoride is available one per year for children through age 18.	Nothing

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

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

Guest Privileges

If you or a covered family member temporarily moves outside of the service area for at least 90 days, you may be eligible for the Plan's "guest privileges" program. The "guest privileges" program allows participants to enroll as "guests" in another CIGNA HealthCare site. This program is only available when you or your covered family member is temporarily relocating to an approved CIGNA guest site. Guest privileges is an ideal way to arrange for benefits in situations such as: a temporary job transfer/work assignments; college child attending school away from home, etc. You should be aware that your FEHBP benefits will NOT follow you to the guest site. You will be covered by the CIGNA HealthCare "guest privileges" program plan of benefits. Contact member services at 1-800-832-3211 for more information.

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 and we agree, as discussed under *Services Requiring Our Prior Approval* on page 9.**

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical, hospital and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-800-832-3211.

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 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: Please refer to your ID card for the address to mail any claims.

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. Write to us at: CIGNA HealthCare of Virginia, Inc., 7501 Boulders View Drive, Suite 600, Richmond, Virginia 23225. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: CIGNA HealthCare of Virginia, Inc., 7501 Boulders View Drive, Suite 600, Richmond, Virginia 23225; 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: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call.

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must 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 preauthorization/prior approval, then call us at 1-800-832-3211 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division III 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 (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- 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. Your care must continue to be authorized by your Plan PCP, or recertified as required.

We will not waive any of our copayments or coinsurance.

(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. Please note, if your Plan physician does not participate in Medicare, you will have to file a claim with 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 1-800-832-3211, or write to CIGNA HealthCare of Virginia, Inc., 7501 Boulders View Drive, Suite 600, Richmond, Virginia 23225. You may also visit our website at www.cigna.com/healthcare. In this case we do not waive any out-of-pocket costs.

• Medicare managed care plan

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

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

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related 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 for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 10.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 10.

Covered services

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

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 10.

Experimental or investigational services

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by our Medical Director to be:

- not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified by The United States Pharmacopoeia Dispensing Information, or the American Hospital Formulary Service;
- the subject of review or approval by an Institutional Review Board for the proposed use;
- the subject of an ongoing clinical trial that meets the definition of a phase I, II or III Clinical Trial as set forth in the FDA regulations, regardless of whether the trial is subject to FDA oversight (except as set forth in the "Clinical Trials for Treatment Studies on Cancer and Life-threatening Conditions" provision of "Section IV. Covered Services and Supplies"); or
- not demonstrated, through existing peer-reviewed literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.

Medical necessity

Medically necessary covered Services and Supplies are those Services and Supplies that are determined by our Medical Director to be:

- No more than required to meet your basic health needs; and
- consistent with the diagnosis of the condition for which they are required; and
- consistent in type, frequency and duration of treatment with scientifically based guidelines as determined by medical research; and
- required for purposes other than the comfort and convenience of the patient or his Physician; and
- rendered in the least intensive setting that is appropriate for the delivery of health care; and
- of demonstrated medical value.

Us/We

Us and we refer to CIGNA HealthCare of Virginia, Inc.

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 1-800-832-3211 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.

Index

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

NOTES:

Summary of benefits for CIGNA HealthCare of Virginia, Inc. – 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:		
• Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care or specialits. Copays are waived after the first prenatal visit for maternity care.	12
Services provided by a hospital:		
• Inpatient	Nothing per admission	22
• Outpatient	Nothing	23
Emergency benefits:		
• In-area	Office visit: $10 per visit; $25 per urgent care visit; $50 per hospital emergency room visit.	26
• Out-of-area		26
Mental health and substance abuse treatment	Regular cost sharing.	27
Prescription drugs	**<u>Retail Pharmacy</u>:** $5 per generic formulary; $15 per name brand formulary; $35 per name brand non-formulary. **<u>Mail Order</u>:** $10 per generic formulary; $40 per name brand formulary; $100 per name brand non-formulary. Note: If there is no generic equivalent available, you will still have to pay the brand name copay	29
Dental Care	Preventive dental care; you pay nothing	32
Vision Care	No benefit	16
Special features: Flexible benefits option; 24 hour nurse line; Services for deaf and hearing impaired; High risk pregnancies; Centers of Excellence for transplants/heart surgery/etc.; Travel benefit/ services overseas		31
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $1,000/Self Only or $2,000/Family enrollment per calendar year. This copay maximum does not include Prescription Drugs, Prosthetics, vision services, Mental Health/Substance Abuse or office visits.	10

2001 Rate Information for
CIGNA HealthCare of Virginia, Inc.

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

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization. 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**
Southeastern Virginia							
Self Only	**W21**	**$73.94**	**$24.65**	**$160.21**	**$53.40**	**$87.50**	**$11.09**
Self and Family	**W22**	**$165.71**	**$55.23**	**$359.03**	**$119.67**	**$196.08**	**$24.86**
Central Virginia							
Self Only	**W31**	**$69.10**	**$23.03**	**$149.72**	**$49.90**	**$81.77**	**$10.36**
Self and Family	**W32**	**$156.20**	**$52.07**	**$338.44**	**$112.81**	**$184.84**	**$23.43**