Arnett HMO Health Plan

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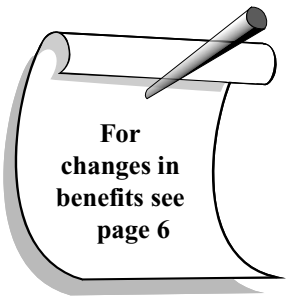
ARNETT HMO

2001

A Health Maintenance Organization



Serving: The Lafayette, Indiana Area

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

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

Enrollment codes for this Plan:

G21 Self Only
G22 Self and Family

Authorized for distribution by the:

OPM

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
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FEHB
Federal Employees
Health Benefits Program

R1 73-288

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Introduction

Arnett HMO
415 N. 26th Street, Suite 101
Lafayette, IN 47903-6108

This brochure describes the benefits of Arnett HMO under our contract (CS 2171) 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 11. 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 Arnett HMO.

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

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

Section 1. Facts about this HMO plan

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

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

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

Arnett HMO is a group model HMO. There are over 250 participating physicians. Plan members may select their primary care physicians among the participating family practice physicians, internists, pediatricians, or obstetrician/gynecologists.

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 healthcare 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.

If you want more information about us, call 888-448-7440, or write to Arnett HMO P.O. Box 6108, Lafayette, IN 47903-6108. You may also contact us by fax at 765-448-7700, or visit our website at www.arnettplans.com.

Service Area

To enroll in this Plan, you must reside in, or within 30 miles of one of our counties, or within 30 miles of any Plan Primary Care Physician in our network. This is where our providers practice. Our services area for this Plan are available in the following area: The Greater Lafayette, Indiana area; including the counties of Benton, Boone, Carroll, Cass, Clinton, Fountain, Fulton, Howard, Jasper, Montgomery, Newton, Pulaski, Tippecanoe, Warren, and White counties.

Ordinarily you must get your care from our 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. In this plan, the family member would only be covered for emergency care. For routine, maintenance, or illness they would need to be seen in plan. 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 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 Arnett HMO at 888-448-7440, or checking our website, www.arnettplans.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five easy 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 reference only women.

Changes to this Plan

- Your share of the non-Postal premium will increase by 25.4% for Self Only or 18.4% for Self and Family.

- The Plan has a limit of 90 days with no dollar limit for Extended Care or Skilled Nursing Care.

- You pay a 20% copayment with up to $10,000 annual limit for Durable Medical Equipment/Prosthetic Devices.

- You pay a $75 copayment for In or Out of Service Area Emergency Care. The emergency copayment is waived if you are admitted.

- You pay a $25 copayment for Urgent Care visits.

- The Plan covers Rehabilitative Therapy (physical/occupational/speech) up to 60 consecutive day limit.

- You pay a $50 copayment for outpatient MRI and CAT scans.

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 toll free at 888-448-7440 or 765-448-7440.

Where you get covered care

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

• Plan Providers

Plan providers are physicians and other 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

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 healthcare.

• Primary Care

Your primary care physician can be a family practitioner, internist, pediatrician, or obstetrician–gynecologist. 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. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation. All follow-up care must be provided or arranged by the primary care physician. Do not go to the specialist unless your primary care physician has arranged for and the Plan has issued an authorization for the referral in advance.

Here are other things you should know about specialty care:

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

- 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 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 765-448-7440 or 888-448-7440. 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 alternate care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the hospital benefit of the hospitalized person; we cover your other non-hospital care

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.

Your physician must obtain prior approval by the Plan for the following service, but not limited to:

- All Inpatient Admissions
- Same Day Surgeries
- Outpatient Mental Health and Substance Abuse visits
- Home Health Care
- Skilled Nursing Facilities
- Rehabilitation Therapies
- Some Durable Medical Equipment and Prosthetics
- Out of Plan Network Referrals

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	We do not have a deductible with this Plan.
• Coinsurance	Coinsurance is the percentage of our negotiated fee that you must pay for your care. In our Plan, you pay 20% of our fees for durable medical equipment and prosthetics. You pay 50% of our allowance for infertility services by a non-primary care physician in our plan.
• Your out-of-pocket maximum	We do not have an out-of-pocket maximum for coinsurance and copayments.

Section 5. Benefits – OVERVIEW

(See page 6 for how our benefits changed this year and page 45 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also, read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims filing advice, or more information about our benefits, contact us at 765-448-7440 or at our website at www.arnettplans.com.

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.
- 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	**You pay**
Professional services of physicians • In physician's office	$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 • Office medical consultations • Second surgical opinion	Nothing (Copays may apply to associated visits)
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine mammograms • Ultrasound • Electrocardiogram and EEG	Nothing (Copays may apply to associated visits)
• CAT scans and MRI	$50 copay

Preventative care, adult — Continued on next page

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 • Routine mammogram — covered from age 35 and older as follows: •• From age 35 through 39, one during this five year period •• From age 40 through 64, one every calendar year •• At age 65 and older, one every two consecutive calendar years	Nothing (Copays may apply to associated visits)
Not covered: *Physical exams required for obtaining or continuing employment or insurance, attending schools, camp, travel, or sports are not covered.*	*All charges*
Routine Immunizations	Nothing (Copays may apply to associated visits)
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics • Well-child care charges for routine examinations (through age 17)	Nothing (Copays may apply to associated visits)
• Examinations, such as: •• Eye exams through age 17 to determine the need for vision correction. •• Ear exams through age 17 to determine hearing correction. •• Examinations done on the day of immunizations (through age 17)	Nothing (Copays may apply to associated visits)
Maternity care	
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 precertify your normal delivery; see page 8 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 impatient 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 or injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$10 for the initial office visit and nothing therafter.
Routine sonograms to determine fetal age, size, or sex are not covered.	*All charges*

Family planning	You Pay
• Voluntary sterilization • Norplant implantations • Injectable contraceptives drugs • Intrauterine devices (IUD's)	Nothing (Copays may apply to associated visits)
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling* • *Voluntary abortion*	*All charges*
Infertility services	
Diagnosis and treatment of infertility, such as: • Artificial insemination: • Intravaginal insemination (IVI) • Intracervical insemination (ICI) • Intrauterine insemination (IUI)	$10 per office visit with primary care physician and 50% coinsurance for non primary care physician and services.
• Fertility drug Clomiohene citrate (Clomid) See Section 5(f)	Covered under the prescription benefit.
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* •• *In vitro fertilization* •• *Embyo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm*	*All charges*
Allergy care	
Testing and treatment Allergy injection Allergy serum	Nothing (Copays may apply to associated visits)
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*
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 20. • 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 we preauthorize the treatment from your physician's referral.	Nothing (Copays may apply to associated visits)

Rehabilitative therapies	You Pay
Physical therapy, occupational therapy, speech therapy, and cardiac rehabilitation— Note: 60 consecutive days of treatment	Nothing (Copays may apply to associated visits)
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges*
Hearing services (testing, treatment, and supplies)	
• Hearing tests are covered for diagnosis or treatment of disease or injury. • Hearing exams are covered for diagnosis or treatment of disease or injury.	Nothing (Copays may apply to associated visits)
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
• Annual eye exam and refraction through age 17. (See preventive care, children) • Diagnosis and treatment of disease or injury of the eyes. • Refractions following cataract surgery.	Nothing (Copays may apply to associated visits)
Not covered: • *Eyeglasses or contact lenses, and examinations for them* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. • Podiatry care including bunions, spurs, ingrown toe nails, etc.	$10 per office visit
Not covered: • *Shoe inserts and orthotics.* • *Cutting, trimming of toenails, and similar routine treatment of conditions of feet, except as stated above.* • *Treatment of weak, strained or flat feet and of instability, imbalance or subluxation of the foot.*	*All charges*

Orthopedic and prosthetic devices	You Pay
• Artificial limbs and eyes, stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See 5(b) for coverage of surgery to insert the device. • Orthopedic braces • Corrective orthopedic aplliance for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	20% coinsurance
Not covered: • *Orthopedic devices* • *Corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices.*	*All charges*
Durable Medical Equipment	
Rental or purchase at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds • Standard wheelchairs • Crutches • Walkers • Blood glucose monitors • Insulin pumps • Nebulizers Note: Our provider for our durable medical equipment is Lincare. They can be contacted directly once the physician has prescribed the equipment through them. You can reach them at 800-487-0001 to make arrangements for pick up or delivery. If you would like to know more about this service, please call us at 888-448-7440.	20% coinsurance
Not covered: • *Personal comfort or convenience items.* • *Single patient use, self-administered dressings and other disposable supplies*	*All charges*

Home health services	You Pay
• 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 aid. • 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.*	*All charges*
Alternative treatments	
Not covered: • *Acupuncture;* • *Chiropractic services;* • *Naturopathic services;* • *Hypnotherapy;* • *Biofeedback*	*All charges*
Educational Classes and programs	
• Smoking Cessation — The reimbursement is based upon completion of an approved stop smoking class and includes prescription, class fees, etc. Call us at 888-448-7440 for more information.	100% reimbursement up to $200 per member per lifetime.

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.
- Be sure to read Section 4. Your costs for covered services for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- YOU MUST GET PRECERTIFICATION ON ALL SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3.

IMPORTANT

Benefit Description	You pay
Surgical procedures	**You pay**
• 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 constructive surgery) • Surgical treatment of morbid obesity — which is defined in our Plan as •• A weight of at least two (2) times the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables; •• A body mass index of at least thirty-five (35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes; •• A body mass index of at least forty (40) kilograms per meter squared without comorbidity •• Morbid obesity that has persisted for at least five (5) years; •• For which non-surgical treatment that is supervised by a physician has been unsuccessful for at least eighteen (18) consecutive months. Note: For purposes of this section, body mass index equals weight in kilograms divided by height in meters squared. • Insertion of internal prosthetic devices. See 5(a) — Orthopedic braces and prosthetic device coverage information. • Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a). • Treatment of burns	Nothing (Copays may apply to associated visits)

Surgical procedures — Continued on next page

Surgical procedures *(Continued)*	You pay
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.	
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care*	*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 for the common form or norm. Examples of congenital anomalies are: protruding ear deformities, cleft lip, cleft palate, birth marks, webbed fingers, 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 prosthesis and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have this procedure on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • 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 teeth or their supporting structures.	Nothing

Oral and maxillofacial surgery — Continued on next page

Oral and maxillofacial surgery *(Continued)*	You pay
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as periodontal membrane, gingiva, and alveolar bone.* • *Any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.*	*All charges*
Organ/tissue transplants	
Limited to: • Cornea • Heart • Heart/Lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neurpblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • National Transplant Program (NTP) Limited Benefits – Treatment of 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 as long as the recipient is enrolled into our Plan.	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 • 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.
- 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 5(b).
- **YOU MUST GET PRECERTIFICATION ON ALL SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	**You pay**
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 and it is not medically necessary, you pay the additional charge above the semiprivate room rate. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines given while admitted. • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home supplies • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Take-home drugs.*	*All charges*

Outpatient hospital or ambulatory surgical center	You Pay
• Operating, recovery, and other treatment rooms • Drugs and medications given at the facility • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood or blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service 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
CAT Scans and MRIs	$50 copay
Not covered: • *Take home drugs*	*All charges*
Extended care benefits/skilled nursing facility benefits	
Extended care/skilled nursing benefit (90 day annual limit)	Nothing
Not covered: • *Custodial care*	*All charges*
Hospice Care	
Care for a terminally ill member is covered in the home or skilled facility as long as there are skilled components medically necessary. Services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing
Ambulance	
• Local professional ambulance service when medically appropriate	Nothing

Section 5(d). Emergency services/accidents

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.
- 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 if 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, poisoning, 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:

Benefits are provided for urgent and emergency medical services whether rendered inside or outside of the Plan's Service Area.

- ***Urgent Care:*** Medical direction and advice is available through your primary care physician, seven (7) days a week, twenty four (24) hours a day. All urgent care services whether inside or outside of the service area must be referred ***in advance*** by your primary care physician.
- ***Emergency Care:*** Benefits are not provided for the use of an emergency room except for emergency care. In the event of an Emergency, you should go to a participating practitioner, unless the condition requires you to go to the nearest emergency room. If you are admitted, the applicable copay would be waived. If admitted in an out of area facility, please notify the Plan within 48 hours of admitting, unless it is not reasonably possible to do so. If this is the case, notify the Plan as soon as possible.

Benefit Description	You pay
Emergency within our service area	**You pay**
• Emergency care at doctor's office	$10 copay
• Emergency care at an approved urgent care center	$25 copay
• Emergency care at a hospital, and not admitted.	$75 copay
• Emergency care at a hospital, and admitted.	Nothing
Not covered: • *Elective care or non-emergency care*	*All charges*

Emergency outside our service area	You pay
• Emergency care at an urgent care center	$25 copay
• Emergency care at a hospital, and not admitted.	$75 copay
• Emergency care at a hospital, and admitted.	Nothing
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area is the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside 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.

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.
- Be sure to read Section 4. *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay
Network 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 isclinically 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 copay per office visit
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered: • *Services we have not approved* Note: OPM's review of disputes about the network treatment plans will be based on the treatment plan's clinical appropriateness. OPM will generally not order one clinically appropriate treatment plan in favor of another.	*All charges*

Network mental health and substance abuse benefits — Continued on next page

Mental health and substance abuse benefits (*Continued)*

Preauthorization

To be eligible to receive these enhanced mental health and substance abuse benefits you must follow your treatment plan and all of our network authorization processes.

Note: You primary care physician will make the referral for the treatment plan for you. Please contact your physician if you have questions, or call us at 765-448-7440 or toll free at 888-448-7440.

Special transitional benefit

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

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

If this condition applies to you, we will allow you reasonable time to transfer your care to a network mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider. This transitional period will last for up to 90 days from the date you receive notice of the change. You may receive this notice prior to January 1, 2001, and the 90-day period begins with receipt of the notice.

Network limitation

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

How to submit network claims

Our network providers should bill us directly, but if by chance you receive a bill of charges, you may contact us at 765-448-7440 or mail them to us:

Arnett Health Plans, Attn HMO Claims Department, P.O. Box 6108, Lafayette, IN 47903

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

IMPORTANT

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

- **Who can write your prescription**. A plan physician must write the prescription.

- **Where can you obtain them.** Prescriptions must be dispensed by a participating pharmacy, In order to receive this benefit you must present your Arnett HMO membership card at the time the prescription is filled. The participating pharmacy will then charge you the applicable copayment amount. There are some specific drugs that require prior authorization by Arnett HMO. Your ordering physician or the participating pharmacy will then charge you the applicable copayment amount. Take-home prescriptions dispensed from a hospital facility will not be covered.

- **We use a formulary.** The Arnett Prescription Drug Formulary is based on the recommendations of our Pharmacy and Therapeutics (P&T) Committee and from the input we receive from our physicians. The P&T Committee is made up of pharmacists and physicians who make decisions regarding the formulary. They review medications on an ongoing basis to decide which are the safest and most effective. The Committee meets every four months to develop and update the formulary. Many medications have the same chemical structure but are packaged differently. The formulary limits the number of similar drugs from which providers may choose. This allows us to purchase drugs in volume at greater discounts. This cost savings is passed on to our members in the form of reduced premiums and increased benefits.

- **These are the dispensing limitations.** All prescriptions are filled for up to a one month supply. We offer three levels of copayments for this prescription:
  - Generic Drugs . . . . . $ 5 copay (up to a one month supply)
  - Formulary Brand Name Drugs . . . . . $15 copay (up to a one month supply)
  - Non-Formulary Brand Name Drugs . . . . . $30 copay (up to a one month supply)

Note: If a generic drug is available and the prescription is filled with a brand name drug, (formulary or non-formulary) member pays the difference in cost between the generic and brand name drug in addition to the copayment. Drugs that require prior authorization must be authorized prior to the prescription being filled in order to be considered for payment.

- **When you have to file a claim.** Our network providers should bill us directly, but if by chance you receive a bill of charges, you may contact us at 765-448-7440 or mail them to us:

  Arnett Health Plans, Attn HMO Claims Department, P.O. Box 6108, Lafayette, IN 47903

Prescription drug benefits begin on 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: • Drugs for which a prescription is required by Federal law • Insulin, with a copay charge applied to each visit. • Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape, Benedict's solution or equivalent, and acetone test tablets • Disposable needles and syringes needed for injecting covered prescribed medication • Oral contraceptive drugs; contraceptive devices	$ 5 copay — Generic Drugs $15 copay — Formulary Brand Name Drugs $30 copay — Non-Formulary Brand Name Drugs Note: Copays cover for up to a one-month supply. If there is no generic available, you will still have to pay the brand name copay.
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies where the network does not extend.* • *Vitamins, nutrients, and food supplements even if a physician prescribes or administers them* • *Medical supplies such as dressings and antiseptics* • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athlete performance* • *Smoking cessation drugs and medications, including nicotine patches* • *Fertility drugs except for Chomiphene (Clomid)*	*All charges.*

Section 5(g). Dental benefits

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 providers must arrange your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure.
- Be sure to read Section 4. *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit

We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Services must be received within 72 hours of the injury.

Service	You Pay
In physician's or referral specialist's office	$10 copay
In an urgent care center	$25 copay
In a hospital emergency room	$75 copay

We have no other dental benefits.

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

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

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs, or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; 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, such as emergency care services. 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 765-448-7440 or toll free at 888-448-7440.

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

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

Submit your claims to:

Arnett Health Plans
Attn: HMO Claims Department
P.O. Box 6108
Lafayette, IN 47903

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. You must; (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Arnett HMO, Member Services Department, P.O. Box 6108, Lafayette, IN 47903 (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, 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. 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 provider a copy of your specific written consent with the review request.

The disputed claims process *(Continued)*

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 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 765-448-7440 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 they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 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 medical 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 if 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 managed care plan 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.

(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 our enrollment 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 a 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 re-employed 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	✓	
b) Are an active employee		✓

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

- When we are the primary payer, we process the claim first.
- When Original medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically, and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 765-448-7440 or toll free at 888-448-7440.

We do not waive any out-of-pocket cost when you have Medicare.

• Managed Care Plan

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

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 premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care plan 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 and 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 enrollees, the calendar year begins on the effective date of their enrollment and ends in 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

Drugs, devices, services, supplies, medical treatments or procedures which are experimental or investigational in nature. The Plan will apply the following criteria in determining whether services or supplies are experimental or investigational:

a. Any medical device, drug or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition.

b. Conclusive evidence from the published peer-review medical literature must exist that over time the technology has a definite positive effect on health outcomes; such evidence must include well-designed investigations that have been reproduced by nonaffiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding the efficacy and rationale.

c. Demonstrated evidence as reflected in the published peer-review literature must exist that over time the technology leads to improvements in health outcomes, *i.e.,* the beneficial effects outweigh the harmful effects.

d. Proof as reflected in the published peer-reviewed literature must exist that the technology is at least as effective in improving health outcomes as established technology, or is usable in appropriate clinical contexts in which established technology is not employable.

e. Proof as reflected in the published peer-reviewed medical literature must exist that improvements in health outcomes, as defined in paragraph c, is possible in standard conditions of medical practice, outside clinical investigatory settings.

Us/We

Us and we refer to Arnett HMO.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under 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 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 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 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 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 765-448-7440 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 are 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 benefit coverage.

Summary of Benefits for Arnett HMO Health Plan – 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; $10 specialist	12
Services provided by a hospital:		
• Inpatient	Nothing	21
• Outpatient	Nothing	22
CAT scans and MRI tests (Outpatient)	$50 copay	12
Emergency benefits:		
In- and Out-of-area		
• Urgent Care	$25 copay	23
• Hospital	$75 copay	23, 24
Mental health and substance abuse treatment	Regular cost sharing	25
Prescription drugs:		
• Generic drugs	$5 copay	27
• Formulary brand name drugs	$15 copay	27
• Non-formulary brand name drugs	$30 copay	27
Dental care: Accidental injury only	Nothing	29
Vision care	Nothing	15

2001 Rate Information for
Arnett HMO Health Plan

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

Postal rates apply to most career U.S. 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 70-21N).

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 A	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Our services for this Plan are available in the following area: The Greater Lafayette, Indiana area; including the counties of Benton, Boone, Carroll, Cass, Clinton, Fountain, Fulton, Howard, Jasper, Montgomery, Newton, Pulaski, Tippecanoe, Warren, and White counties.

Self Only	**G21**	**$86.59**	**$34.61**	**$187.61**	**$74.99**	**$102.22**	**$18.98**
Self and Family	**G22**	**$195.82**	**$119.32**	**$424.28**	**$258.52**	**$231.17**	**$83.97**