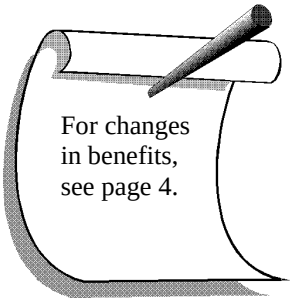
BlueCross BlueShield of Utica-Watertown
An Excellus Company

HMOBlue®
http://www.bcbsuw.com

2001

A Health Maintenance Organization



Serving: **North Central New York and Utica/Rome area**

Enrollment in this Plan is limited; see page 3 for requirements.

This Plan has excellent accreditation from NCQA.

Enrollment codes for this Plan:

AH1 Self Only
AH2 Self and Family

Authorized for distribution by the:

United States
Office of Personnel Management
Retirement and Insurance Service
http://www.opm.gov/insure

FEHB
Federal Employees Health Benefits Program

RI 73-460

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Introduction

BlueCross BlueShield of Utica-Watertown Inc., d.b.a. HMOBlue
Utica Business Park, 12 Rhoads Drive
Utica, NY 13502-6398

This brochure describes the benefits of HMOBlue under our contract (CS2294) 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 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 50. 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 HMOBlue.

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.

Who Provides My Healthcare

BlueCross BlueShield of Utica-Watertown, d.b.a. HMOBlue, is a division of Excellus Health Care, Inc. HMOBlue is an individual practice association HMO. You, and each member of your family, must select a primary care doctor to coordinate all medical needs. There are over 1200 primary care doctors to choose from, representing family practice, general practice, internal medicine, OB/GYN and pediatrics. The Plan also contracts with an additional 3000 specialists throughout the service area.

Benefits for urgent care outside of this Plan's may be covered. This Plan is affiliated with HMO-USA, a network of BlueCross and BlueShield HMOs that can coordinate your medical care. If you need more information, this Plan can tell you more about its reciprocity benefits.

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 your health plan, its 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:

- BlueCross BlueShield of Utica-Watertown has been serving our community for 64 Years with the finest health care insurance
- HMOBlue is a Non-Profit organization

You can obtain additional information by calling Member Services at 1-800-722-7884. This includes:

- Consumer satisfaction, clinical quality and service performance measures
- Whether facility has been excluded from any Federal health programs
- Cancellation, suspension, or exclusion from participation in Federal programs or sanctions.
- Number of primary care and specialty providers
- Methods of compensation, ownership or interest in health care facilities that the plan has.

There is information that we do not track and you should able to get the following information from your doctor and/or hospital. If you are not able to get this information we will assist you in obtaining it.

Doctor:

- Language(s) spoken and availability of interpreters, facilities are accessible to the disabled
- Corporate form of providers
- Names of hospitals where physicians have admitting privileges
- Years in practice as a physician and as a specialist if so identified
- Experience with performing certain medical or surgical procedures

Hospitals:

- Corporate form
- Consumer satisfaction, clinical quality and service performance measures
- Whether facility specialty programs meet guidelines established by specialty societies or other bodies
- Complaint procedures
- Volume of certain procedures performed
- Numbers and credentials of providers of direct patient care
- Whether the facility's affiliation with a provider network would make it more likely that a consumer would be referred to health professionals or other organizations in that network.

If you want more information about us, call 800-722-7884, or write to 12 Rhoads Dr., Utica, NY, 13502.. You may also contact us by fax at 315-733-2830 or visit our website at http://www.bcbsuw.com.

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: The New York counties of Chenango, Clinton, Delaware, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, ***Oswego***, Otsego and St. Lawrence.

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. However, you may also contact HMO-USA at 1-800-4-HMOUSA for urgent care and they will set up an appointment with a doctor in the area where you are visiting or instruct you to go to the emergency room. We will not pay for health care services that are not emergency care or authorized by HMO-USA.

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. Guest Membership is available in most parts of the United States from HMO-USA. Contact HMOBlue for more information regarding Guest Membership. 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 HMOBlue 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 and 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 1-800-722-7884. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:

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

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

Changes to this Plan

- Your share of the non-Postal premium will increase by 53% for Self Only or 94.8% for Self and Family
- We are introducing a three tier prescription drug benefit for retail prescriptions, this includes a $5 copay for generic drug for up to a 30 day supply, a $20 copay for a value preferred brand name drug for up to a 30 day supply, and a $35 copay for a non-preferred brand name drug for up to a 30 day supply.
- We are introducing a three tier prescription drug benefit for mail order prescriptions, this includes a $15 copay for a generic drug for up to a 90 day supply, a $60 copay for a value preferred brand name drug for up to a 90 day supply, and a $105 copay for a non-preferred brand name drug for up to a 90 day supply.
- We are introducing a three tier prescription drug benefit. The copay for maintenance drugs ordered by mail has been increased to a $10 copay per prescription unit or refill for generic drugs or a $40 copay per prescription unit or refill for brand name drugs. Previously, there was no copay for generic drugs and a $20 copay for brand name drugs.

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 800-722-7884.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance. You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us.. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

• 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 at http://www.bcbsuw.com.

• Plan facilities

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

What you must do

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. To determine if a physician is a participating provider and accepting new patients, you can refer to our Provider Directory or contact us at 800-722-7884.

•Primary care

Your primary care physician can practice family medicine, internal medicine, pediatrics, and general medicine. 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 at 800-722-7884. 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 optometrist once a year for a routine exam, and a woman may see an OB-GYN twice a year for routine exams 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 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 800-722-7884. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

Circumstances beyond our control

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

Services requiring our prior approval

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

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

1. Air Ambulance,
2. All Inpatient Admissions,
3. All Referrals to Non-Participating Providers,
4. Ambulatory Surgery,
5. Chemotherapy & Radiation Treatment,

6. Colonoscopy & Endoscopy Procedures,
7. Diabetic Equipment,
8. Home Health Care,
9. Home Infusion Therapy,
10. Inpatient Physical Rehabilitation,
11. Kidney Dialysis,
12. Magnetic Resonance Imaging (MRI) and Magnetic Resonance Angiography (MRA),
13. Mental Health Services,
14. Nutritional Counseling,
15. Organ & Bone Marrow Transplants,
16. Outpatient Alcohol or Drug Abuse,
17. Pain Management,
18. Short Term Therapy,
19. Skilled Nursing Facility Care, and
20. Sleep Apnea Studies.

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 and when you go in the hospital, Y**ou Pay** nothing.
• **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 services and 20% of our allowance for durable medical equipment.
Your out-of-pocket maximum	We do not have an out-of-pocket maximum.

Section 5. Benefits -- OVERVIEW

(See page 4 for how our benefits changed this year and page 50 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 800-722-7884 or at our website at www.bcbsuw.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	
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	$10 per office visit
At home	$10 per home visit
Lab, X-ray and other diagnostic tests	**You pay**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing

Preventive care, adult	You pay
Routine screenings such as: • Blood lead level • Total Blood Cholesterol • Colorectal Cancer Screening, including ••Fecal occult blood test ••Sigmoidoscopy, screening – every five years starting at age 50	Nothing
Prostate Specific Antigen (PSA test) • One routine annual exam for men age 50 and older • One annually for mem age 40 and older who are symptomatic and at high risk	Nothing
Routine pap test	Nothing
Routine mammogram –covered for women age 35 and older, as follows: • Upon recommendation of a physician, one mammogram each calendar year at any age, if the Member, the Member's mother, or the Member's sister has a prior history of breast cancer. • A single, baseline mammogram if the Member is between the ages of 35 and 39, inclusive. • From age 40 or older, one every calendar year	Nothing
Routine Immunizations, Innoculations and Boosters for Adults:	Nothing The Plan will not pay for inoculations for adults or children that are required for employment.
Annual Physical Exams	Nothing
Routine Gynecological Exams • Primary and preventive obstetric and gynecological services including two annual exams.	Nothing
Allergy Injections	Nothing
Vision Exams • The annual exam may include physical exam of the eyes, refraction tests, and assessment of binocular vision.	$10 per office visit
Hearing Exams – 1 exam per year	$10 per office visit
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*

Preventive care, children	You pay
Well Child Care/Immunizations. Childhood immunizations and exams for children thru age 22 at a frequency recommended by the American Academy of Pediatricians. Such exams may cover: a medical history, complete physical exam, developmental assessment, anticipatory guidance, necessary and appropriate immunizations, and lab tests ordered at the time of the visit.	Nothing
• Examinations, such as:	
•Routine Eye Exams	$10 per office visit
•Routine Hearing Exams	$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 need to pre-authorize your normal delivery; see page 6 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 require pre-authorization. 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).	Nothing
Not covered: Routine sonograms to determine sex	*All charges*
Family planning	**You pay**
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	Nothing
Not covered: reversal of voluntary surgical sterilization.	*All charges*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: ••*intravaginal insemination (IVI)* ••*intracervical insemination (ICI)* ••*intrauterine insemination (IUI)*	50% coinsurance
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	$10 per office visit
Allergy injection	Nothing
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*
Treatment therapies	**You pay**
• 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. • 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 pre-authorize the treatment. Have your physician call for pre-authorization. We will ask your physician to submit information that establishes that the GHT is medically necessary. Ask physician to have us authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If your physician do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	Nothing

Treatment therapies *(Continued)*	**You pay**
Respiratory and inhalation therapy • Inhalers are covered under pharmacy benefits, see page 29. • Inhalation therapy equipment is covered under DME, see page 16. Note: Medications used with inhalation therapy equipment are covered under pharmacy benefits.	See Pharmacy See DME
Rehabilitative therapies	**You pay**
• Physical therapy • Occupational therapy • Speech therapy • Pulmonary/cardiac therapy: • 2 consecutive months of short term therapy per acute condition which in the judgement of the Plan's Medical director can be expected to result in significant improvement through short term therapy: 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.	$10 per office visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges*
Hearing services (testing, treatment, and supplies)	**You pay**
• First Hearing Aid and testing only when necessitated by accidental injury, disease, or illness • Hearing testing	$10 per office visit
Not covered: • *hearing aids, testing and examinations for them not connected with injury, disease, or illness*	*All charges*
Vision services (testing, treatment, and supplies)	**You pay**
Routine annual exam *(See Preventive Care)*	$10 per office visit
Initial prescription lenses and frames after cataract surgery	Nothing
• Annual eye refractions	$10 per office visit

Vision services (testing, treatment, and supplies) *(Continued)*	**You pay**
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	**You pay**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. 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	**You pay**
• Artificial limbs and eyes • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	20% coinsurance
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 provided less than 3 years after the last one we covered*	*All charges*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds; • wheelchairs; • braces and crutches; • walkers; • blood glucose monitors; • insulin pumps; • casts; • trusses; and • apnea monitor. Note: Call us at 800-722-7884 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	20% Coinsurance
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 aide. Services include: • oxygen therapy, • intravenous therapy and medications.	$10 per office visit
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;*	*All charges*
Alternative treatments	**You pay**
Chiropractic Services	$10 per office visit
Not covered: • *Naturopathic services* • *Hypnotherapy* • *Biofeedback*	*All charges*

Educational classes and programs	You pay
Coverage is limited to: • Smoking Cessation Packets – including committed quitters program and "Clear the Air" smoking cessation resource guide. • Managing Your Diabetes – Includes a comprehensive study guide for patients and their health care professionals; diabetes resource list and standards of care. • Nutritional Counseling – One visit per year • Healthy Choice – Valued added programs offered to HMOBlue members. • Healthy Life Self-Care Guide Series – Healthy life self-care guides gives up to date information on 25 of the most common ailments. • Mind Set – This completely confidential program includes a too-free number and free educational videos on anxiety disordered such as social phobia and obsessive-compulsive behavior. • Asthma Community and Education Resource Guide • Environmental Control: Avoiding Exposure In and Around Your Home • Wealth of Health Community Wellness Calendar – Free or low cost HMOBlue sponsored events where you live or work. • Connection Book Series – This informative 3-book series explains the communication process of people who suffer from depression and provides insights into how significant these relationships are affected.	Nothing

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 5c for changes associated with the facility.

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 – upper and lower • 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 100 pounds or 100% over his or her normal weight according to current medical policy; eligible members must be age 18 or over • 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	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges*

Reconstructive surgery	You pay
• 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.	Nothing
• 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	**You pay**
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 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)* • *Any service determined to be dental in nature*	*All charges*

Organ/tissue transplants	You pay
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 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 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. The Plan will cover transportation costs for the recipient and one other individual to and from the site of a covered human organ or bone marrow transplant surgery. If the recipient is a minor, The Plan will cover transportation costs for two individuals to accompany the recipient. Transportation costs include all reasonable and necessary lodging and meal expenses incurred, up to a daily maximum of $150. Transportation costs are limited to $10,000 for each covered transplant procedure. The Plan will only pay benefits that are unavailable or not provided to the donor from any other source. The Plan will pay for covered Hospital and surgical services, storage, and transportation costs incurred by the donor that are directly related to the donation of a human organ or bone marrow used in a covered transplant procedure. Donor transportation costs include all reasonable and necessary lodging and meal expenses incurred by the donor, up to a daily maximum of $150. Our Payments for all donor benefits are limited to $25,000 for each covered transplant procedure. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	$10 per office visit

Organ/tissue transplants *(Continued)*	**You pay**
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* • *The Plan does not provide benefits for the Member to be a human organ or bone marrow donor.* • *The Plan will not pay benefits for any human organ or bone marrow donation or related costs that are covered for the donor under another health benefits plan.* • *The Plan will not pay for services that would be covered for a human organ donor, if those services are provided more than 5 days before a covered human organ transplant.* • *The Plan will not pay for services that would be covered for a bone marrow donor, if those services are provided more than 30 days before a covered bone marrow transplant.*	*All charges*
Anesthesia	**You pay**
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.
- 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).

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 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 • 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 and 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 plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service 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
Skilled nursing care facility benefits	**You pay**
Skilled nursing facility (SNF)*:* The Plan provides a comprehensive range of benefits for 45 days per calendar year when medically necessary when in a Skilled Nursing Facility (SNF) and are subject to the following terms: • Services are furnished by a facility as defined under Section 2801 of the Public Health Law, or which qualifies as an Extended Care Facility under Medicare which provides therapeutic services to patients needing skilled nursing care. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility or facility for the aged. • Coverage is limited to services provided by a Participating Provider. • A Skilled Nursing Facility which is licensed by the State to provide inpatient medical and nursing care, is recognized as such by Medicare, and which has an agreement with Blue Cross and Blue Shield to provide such services. • Care in a Skilled Nursing Facility is provided only if hospitalization would otherwise be required as determined by The Plan's Medical Director and the Member's PCP.	Nothing
Not covered: custodial care	*All charges*
Hospice care	**You pay**
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility for up to 210 days. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stage of illness.	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	**You pay**
• 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.
- 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 within our service area: If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member must notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been timely notified.

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

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

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

If the emergency results in admission to a hospital, the emergency care copay is waived.

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

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

To be covered by this Plan, Any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

If the emergency results in admission to a hospital, the emergency care copay is waived.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office other than the primary care physician • Emergency care at an urgent care center	$10 per visit
Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$35 per visit
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	**You pay**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$10 per visit
Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$35 per visit
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	**You pay**
• Professional ambulance service when medically appropriate. • Air Ambulance See 5(c) for non-emergency service.	Nothing

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

IMPORTANT

Parity

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

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

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

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

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. 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 copay per office visit

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits *(Continued)*	**You pay**
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full day hospitalization, facility based intensive outpatient treatment.	Nothing
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.* MENTAL HEALTH • Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate SUBSTANCE ABUSE Treatment that is not authorized by a Plan doctor. • Benefits for days of care that consist primarily of participation in programs of a social, recreational, or companionship nature.	*All charges.*

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. These include:

- The Pre-authorization procedure must be followed regardless whether the Member is within The Plan's Service Area or not. Pre-authorization need not be obtained for Emergency care. In making the determination to issue Pre-authorization The Plan will examine the circumstances surrounding the Member's condition and the care provided; including reasons for providing or prescribing the care; and any unusual circumstances. However, the fact that the Member's Doctor prescribed the care does not automatically mean that the care qualifies for The Plan's payments under this Certificate. The provider, prior to recommending or ordering any pre-authorized services, must call the Medical Management Department at (800) 926-2357. For obtaining provider directories, call Member Service Department at (315) 798-4384 or (800) 722-7884.

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, or if a Member's Provider is terminated from The Plan's network, the Member may continue a course of treatment for up to ninety (90) days from the date the Member receives notice from The Plan that the Provider is no longer a Participating Provider. • If these conditions apply 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 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. This transitional period 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.
Network Limitation	We may limit your benefits if you do not follow your treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

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

IMPORTANT

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

- **Who can write your prescription.** A licensed physician must write the prescription – or – A plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a participating retail pharmacy, a non-participating pharmacy, or by mail.

  •• Non participating pharmacy – If you use a non-participating pharmacy you must submit a claim to us for the Prescription Drug. Our payment will be made directly to you, and will be limited to the Allowed Amount less Copayment and Ancillary Charge. You will not be reimbursed for the difference between our Allowed Amount and the Non-Participating Pharmacy's charge for the Prescription Drug when the charge exceeds our Allowed Amount.
- **We use a formulary.** (A formulary is a list of plan recommended drugs for provider to prescribe. This list is for provider recommendations only and does not restrict the member from receiving prescriptions.)
- **These are the dispensing limitations.**

  • If you have your prescription filled at a retail pharmacy you will get up to a 30 day supply.

  • If you use the mail order program you will get up to a 90 day supply.

  •Because federal law will not allow you fill a controlled substances prescription through mail order you will have to use a retail pharmacy.

  • You may want to fill your prescription early. Normally we would not allow you do so. It is only taking 10 business days to refill a mail order prescription. However, if you are going on vacation, call our member services at 800-722-7884 and ask them for an exception.

  • If there is no generic drug you will have to pay the brand name copay.

  • Some brand name drugs are listed on the Plan's Maximum Allowable Cost (MAC) list. For drugs on this list, **you pay** the brand name copay plus the difference in cost between the brand name drug on the MAC list and its generic equivalent. If your doctor proscribes a drug that does not have a generic you will still have to pay one of the brand name copays.
- **When you have to file a claim.** You will have no claims to file unless you use non-participating pharmacies.

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 when obtained from a Plan pharmacy or through our mail order program: Covered medications and accessories include: • Drugs for which a prescription is required by law • Insulin with a copay charge applied to each vial • All FDA approved contraceptive drugs and devices • The Member must submit a claim to us for the Prescription Drug. Our payment will be made directly to the Member, and will be limited to the Allowed Amount less any applicable Deductible, Coinsurance or Copayment, and Ancillary Charge. Members will not be reimbursed for the difference between our Allowed Amount and the Non-Participating Pharmacy's charge for the Prescription Drug when the charge exceeds our Allowed Amount. • Fertility drugs • Intravenous fluids and medication for home use, and some injectable drugs are covered under Medical and Surgical Benefits. • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. • Disposable needles and syringes for the administration of covered medications • Drugs for the treatment of sexual dysfunction have dosage limitations. Contact the plan for the dosage limitations.	PLAN PHARMACY $ 5 copay per prescription or refill for up to a 30 day supply of generic. Drugs; $ 20 copay per prescription or refill for up to a 30 day supply of brand name formulary drugs; $ 35 copay for non-formulary drugs for up to a 30 day supply MAIL ORDER $5 Copay will be applied for each separate prescription filled for up to a 30 day supply of an approved Generic maintenance medication through our designated mail order facility. $10 Copay will be applied for each prescription filled in quantities sufficient for a 31-60 day supply, and $15 copay will be applied for each prescription filled in quantities sufficient for a 61-90 day supply.

Covered medications and supplies *(Continued)*	**You pay**
• Covered smoking cessation drugs are limited as to which are covered, and are limited to one course of treatment per lifetime. Contact the plan for which drugs are covered. • Contraceptive drugs and devices	**Brand Name Drugs:** $20 Copay will be applied for each separate prescription filled for up to a 30 day supply of an approved Preferred Brand Name maintenance medication through our designated mail order facility. $40 Copay will be applied for each prescription filled in quantities sufficient for a 31-60 day supply, and $60 copay will be applied for each prescription filled in quantities sufficient for a 61-90 day supply. **Non-Formulary Drugs:** $35 Copay will be applied for each separate prescription filled for up to a 30 day supply of a Non-formulary brand name maintenance medication through our designated mail order facility. $70 Copay will be applied for each prescription filled in quantities sufficient for a 31-60 day supply, and $105 copay will be applied for each prescription filled in quantities sufficient for a 61-90 day supply. For those Prescription drugs on the Maximum Allowable Cost (MAC) list, the Member must pay their Copay and the Ancillary Charge as well.
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. • We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call Member Service Department at (315) 798-4384 or (800) 722-7884.	

Not Covered medications and supplies	You pay
Not covered: • Drugs available without a prescription or for which there is a nonprescription equivalent available • Vitamins and nutritional substances that can be purchased without a prescription • Medical supplies such as dressings and antiseptics • Drugs for cosmetic purposes • Drugs to enhance athletic performance • Implanted time-release medications other than Norplant • Drugs for weight loss	*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.
	• Healthy Choices is a value-added program, a package of health-related savings. Through a variety of special discounts, Healthy Choice encourages you to take advantage of resources dedicated to promoting a healthy life-style. All products, services, and wellness programs offer substantial savings.
	  • Fitness Clubs
	  • Golf Passes
	  • Fitness Clothing and Equipment
	  • Weight Loss Programs
	  • Wellness Programs
	  • Therapeutic Massage
	  • Smoking Cessation Programs
	  • Health & Beauty
	  • Wellness Books and Audio
	  • Health & Safety
	  • Vision & Eye Care
	  • Discount Coupons

Reciprocity benefit	**HMOBlue USA** **Away from Home Care & Guest Membership** **From BlueCross BlueShield of Utica-Watertown** **Enjoy the comforts of your HMO wherever you go.** Now the benefits you enjoy from your HMO at home, are with you where ever you happen to be. *Away From Home Care* coverage puts you in touch with HMO health care from qualified physicians in nearly every state across the country, wherever you need it. You'll receive the same health care coverage you enjoy at home, through the country's largest HMO network, HMO Blue USA. The benefits of *Away From Home Care* coverage are yours automatically – and at no extra cost – when you join our HMO. **The HMO that stays with you whenever you're away from home.** Should you ever come down with an unexpected illness or injury while traveling, which can't wait to be treated at home, you can rest assured knowing that you have a place to turn. We call it *Urgent Care*, because it delivers just that: the help you need, whenever you need it. **No paperwork whatsoever.** You're not feeling well to begin with. The last thing you need is a big expense to make things worse. With *Away From Home Care*, you can take comfort knowing you'll have no claims to file, no paperwork and no payment at the time of service. **Far-reaching comforts no other HMO provides.** HMOBlue USA offers health care coverage in more than 200 major cities across the country. It's also reassuring to know HMOBlue USA's *Away From Home Care* program is sponsored by the BlueCross and BlueShield Association. You know how important the right HMO coverage is when you're at home. Choose HMOBlue from BlueCross and BlueShield of Utica-Watertown and keep the benefits of your local coverage wherever you go. **Even your follow-ups follow you.** Should your travel schedule require that you miss a scheduled follow-up appointment at home, our *Follow-Up Care* lets you conveniently schedule an appointment for ongoing care near your travel destination. Like every *Away From Home Care* service, you'll receive the same quality you enjoy at home.
Centers of excellence for transplants/heart surgery/etc	BlueCross BlueShield Utica-Watertown works with other BlueCross plans to identify centers of excellence which offer quality care in specialized areas. When necessary the plan's Medical Director will recommend, members with diseases and conditions that can not be handled by our providers, to be sent to centers of excellence.

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

IMPORTANT

Accidental injury benefit

These services are limited to those required for injury to sound natural teeth as a result of an accident. Inpatient or outpatient Hospital services, Physician services, and other costs will not be Covered for any non-Covered dental services. If you have a medical condition, which makes the service of a Hospital and/or Physician Medically Necessary then Hospital, Physician, and related Hospital services will be Covered. The services of the dentist or oral surgeon will NOT be covered. **You Pay** nothing.

Dental benefits

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 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, 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, coinsurance, or deductible.

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, Drug and Other Supplies or Services 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 800-722-7884.

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: **12 Rhoads Drive**
Utica Business Park
Utica, NY 13502

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: 12 Rhoads Drive, Utica Business Park, Utica, NY 13502; 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 2, 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 800-722-7884 and we will expedite our review; or

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 2 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you 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 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.

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.

(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……	……..	……✓

• 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 and coinsurance.

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

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your benefits. You must use our providers.

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible 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 8.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 8.

Covered services

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

Custodial care

Custodial Care includes any service that can be provided by an average individual who has little or no medical training. Examples of Custodial Care include: (a) assistance in meeting activities of daily living such as feeding, dressing, and personal hygiene, (b) administration of oral medications, routine changing of dressings or preparation of special diets, (c) assistance in walking or getting out of bed, (d) care when it is primarily for the purpose of meeting personal needs and could be provided by persons without professional skills or training.

Experimental or investigational services

Experimental/investigational procedures are defined as any procedure, treatment, drug, biological product or device (hereinafter referred to as technology) that, in the sole discretion of the Plan, are determined to be experimental or investigational in nature.
Experimental or investigational means that the technology is determined not to:

- have final approval from the appropriate government regulatory body;
- be proven benefit for the particular diagnosis or treatment of the member's condition;
- be recognized by the medical community, as reflected in the published peer-reviewed literature, as effective or appropriate for the particular diagnosis or treatment of the member's condition; or
- be as beneficial as any established alternative.

Your primary care physician will work with our medical director and medical staff to determine if a service is experimental or investigational.

Medical necessity

Medically Necessary Care is care which, according to The Plan's criteria is: (a) Consistent with the symptoms or diagnosis and treatment of the Member's condition, disease, ailment or injury, (b) in accordance with standards of acceptable medical practice, (c) not solely for the Member's convenience, or that of the Member's Doctor or other Provider, (d) the most appropriate supply, place of service, or level of service which can safely be provided to the Member, (e) provided for the diagnosis or the direct care and treatment of the Member's condition, illness, disease or injury, and (f) when applied to hospitalization, the Member requires acute care as a bed patient due to the nature of the services rendered, or the Member's condition, and the Member could not have received safe or adequate care in any other setting (e.g. as an outpatient).

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. We determine our allowance as follows:

We use many different forms of Plan Allowance. Our contract with your providers allows us to change Plan Allowance with a 60 days notice. We believe that by listing Plan Allowances it would jeopardize our contracting ability with our providers. In addition, with our merger with the other two BlueCross plans, we are focused on one platform for the plan allocation at this time we do not know how that will effect our current Plan Allocation with providers.

Us/We

Us and we refer to HMOBlue

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.

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; benefits will not be available to your spouse until you marry.

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 an 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 800-722-7884 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 HMOBlue – 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	10
Services provided by a hospital: • Inpatient..... • Outpatient.....	Nothing	22 18
Emergency benefits: • In-area ..... • Out-of-area	$35 per incident $35 per incident	24 24
Mental health and substance abuse treatment	Regular cost sharing.	26
Prescription drugs.....	Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $5 copay for generic drugs, a $20 copay for preferred brand name drugs or a $35 copay for non-preferred brand name drugs per prescription unit or refill. Mail order maintenance drugs. **You pay** a $15 copay for generic drugs, a $60 copay for preferred brand drugs or a $105 copay for non-preferred brand name drug per prescription unit or refill.	29
Dental Care.....	Accidental injury benefit; you pay nothing.	35
Vision Care.....	One refraction annually. You pay a $10 copay per visit.	11
Protection against catastrophic costs (your out-of-pocket maximum)	No Maximum	8

2001 Rate Information for
HMO Blue

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

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and 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
Fill In Location Here							
Self Only	AH1	$86.59	$34.39	$187.61	$74.51	$102.22	$18.76
Self and Family	AH2	$195.82	$111.47	$424.28	$241.52	$231.17	$76.12