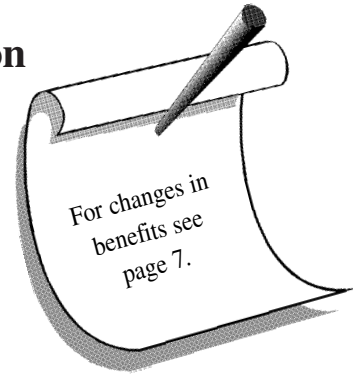
BlueCHiP, Coordinated Health Partners, Inc.

http://www.bcbsri.com

2001

A Health Maintenance Organization with a Point of Service Product



Serving: Rhode Island and portions of Southeastern Massachusetts
Enrollment in this Plan is limited; see page 5 for requirements.

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

Enrollment code for this plan:
DA1 Self Only
DA2 Self and Family

Authorized for distribution by the:

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

Federal Employees Health Benefits Program

RI 73-489

Table of Contents

Introduction

BlueCHiP, Coordinated Health Partners, Inc.
15 LaSalle Square
Providence, RI 02903

This brochure describes the benefits of BlueCHiP, Coordinated Health Partners under our contract (CS 2328) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

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

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 7. 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 BlueCHiP, Coordinated Health Partners.

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, 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.

We also have Point-of-Service (POS) benefits:

Our HMO offers Point-of-Service (POS) benefits. This means you can receive covered services from a participating provider without a required referral, or from a non-participating provider. These out-of-network benefits have higher out-of-pocket costs than our in-network benefits.

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. BlueCHiP, Coordinated Health Partners is affiliated with Blue Cross & Blue Shield of Rhode Island. BlueCHiP, Coordinated Health Partners provides care through over 900 primary care doctors (internists, pediatricians and family practitioners) and over 1,900 specialists, along with a full range of hospitals and other health care providers across the state. When specialist services are needed, your primary care doctor will refer you to a BlueCHiP, Coordinated Health Partners specialist. All participating primary care doctors practice out of offices in the community. Each member selects a primary care doctor who acts as a personal doctor working with you to coordinate all of your health care needs.

BlueCHiP, Coordinated Health Partners has a POS product which offers members the flexibility of obtaining services outside of the primary care doctor system and receiving an allowance for services. For more information regarding this benefit, see page 32.

Patients' Bill of Rights

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

If you want more information about us, call 401-274-3500 or toll-free 1-800-564-0888, or write to 15 LaSalle Square, Providence, RI 02903. You may also contact us by fax at 401-459-5089 or visit our website at www.bcbsri.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 State of Rhode Island and the following cities and towns in the state of Massachusetts: Acushnet, Attleboro, Bellingham, Blackstone, Dartmouth, Dighton, Fall River, Fairhaven, Foxborough, Franklin, Mansfield, Medway, Mendon, Millville, New Bedford, North Attleboro, Norton, Plainville, Raynham, Rehoboth, Seekonk, Somerset, Swansea, Taunton, Uxbridge, Westport, Wrentham.

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

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. BlueCHiP, Coordinated Health Partners offers the HMO USA Away from Home Care Guest Membership Program. To enroll in this program, please contact Customer Service at 401-274-3500 or toll-free at 1-800-564-0888. If you or a family member move, you do not have to wait until the Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our Plan network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed shorter day or visit limitatons on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many health care organizations have turned their attention this past year to improving health care 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 Customer Service at 401-274-3500 or toll-free at 1-800-564-0888, or checking our website at www.bcbsri.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your health care, 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 BlueCHiP, Coordinated Health Partners' non-postal premium will increase by 28.4% for Self Only or 34.2% for Self and Family.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card. 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 401-274-3500 or toll-free at 1-800-564-0888.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance, and you will not have to file claims. If you use our Point-of-Service program, you can also get care from non-Plan providers, or from participating providers without a required referral, but it will cost you more. You may have to file claims when you use the Point-of-Service option or when you receive emergency services from a provider who doesn't contract with us.

• Plan providers

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

• Plan facilities

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

What you must do

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. You will select a primary care physician for you and each covered member of your family when you enroll by completing the primary care physician selection card provided by the Plan. If you want to change your primary care physician at any time, you must contact Customer Service at 401-274-3500 or toll-free at 1-800-564-0888 prior to receiving any services. The change will not become effective until the first day of the following month.

• Primary care

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

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

• Specialty care

Your primary care physician will refer you to a specialist for needed care. However, you may see your OB-GYN, go for your annual eye exam and receive up to six (6) chiropractic visits per year without a referral.

Here are other things you should know about specialty care:

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

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

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

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

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

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

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

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

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

• Hospital care

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

If you are in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at 401-274-3500 or toll-free at 1-800-564-0888. 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 the authorization process. Your physician must obtain authorization for the following services: hospital admissions, referrals to specialists and follow-up care. You may be responsible for payment of services that are not Plan authorized.

Services requiring Plan authorization under the Plan's Standard HMO benefits continue to require authorization under the POS benefit. When utilizing non-Plan participating providers, you are responsible for assuring that Plan authorization is obtained in advance for such services.

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 to the emergency room, you pay a copayment of $25 per visit.
• Deductible	We do not have a deductible.
• Coinsurance	We do not have coinsurance.
Your out-of-pocket maximum	After your copayments and deductibles total $2,294 per person or $5,874 per family enrollment in any calendar year, you do not have to pay any more for covered services. Charges over the usual and customary allowance cannot be applied to the out-of-pocket maximum. Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the maximum.

Section 5. Benefits -- OVERVIEW

(See page 4 for how our benefits changed this year and page 49 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. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 401-274-3500 or toll-free at 1-800-564-0888 or at our website at www.bcbsri.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.
- We have no calendar year deductible for services received by Plan participating providers. Please see Section 5(i) regarding your Point-of-Service benefits.
- 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 • At home	$10 per visit
Professional services of physicians • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion	$10 per visit
Professional services of physicians • In an urgent care center	$20 per visit
Professional services of physicians • During a hospital stay • In a skilled nursing facility	Nothing
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing

Diagnostic and treatment services -- Continued on next page

Preventive care, adult	You pay
Routine screenings, such as: • Blood lead level – one annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including • • Fecal occult blood test • • Sigmoidoscopy, screening – every five years starting at age 50	Nothing
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	Nothing
Routine Pap test Note: The office visit is covered if Pap test is received on the same day; *see Diagnosis and Treatment on previous page.*	Nothing
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing
Not covered: • *Physical exams and/or immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel* • *Weight Reduction Programs, including laboratory tests related to programs designed for the purposes of weight reduction*	*All charges*
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	Nothing
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Examinations, such as: • • Eye exams through age 17 to determine the need for vision correction. • • Ear exams through age 17 to determine the need for hearing correction • • Examinations done on the day of immunizations (through age 22) • Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per visit
Not covered: • *Physical exams and/or immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel* • *Weight Reduction Programs, including laboratory tests related to programs designed for the purposes of weight reduction* • *Examinations, evaluations or services performed solely for educational or developmental purposes*	*All Charges*

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify 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 hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; in addition, coverage of injury or sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities will be covered for the first 31 days of a newborn's life; all care after the first 31 days will be covered only if the infant is covered under a Self and Family enrollment • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b)	$10 for initial visit, you pay nothing thereafter
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	
• Voluntary sterilization • Surgically implanted contraceptives • Intrauterine devices (IUDs)	Nothing
• Injectible contraceptive drugs	20%
Not covered: • *Reversal of voluntary surgical sterilization, genetic counseling*	*All charges*
Infertility services	
Diagnosis and treatment of infertility, such as: • Artificial insemination: • • intravaginal insemination (IVI) • • intra-cervical insemination (ICI) • • intrauterine insemination (IUI) • Fertility drugs • *Assisted reproductive technology (ART) procedures, such as:* • • *in vitro fertilization* • • *embryo transfer and GIFT* • *Services and supplies related to ART procedure* Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit.	20%

Infertility Services (continued)	You pay
Not covered: • *Cost of donor sperm* • *Treatment for infertility when the cause of the infertility was a previous sterilization*	*All charges*
Allergy care	
Testing and treatment Allergy injection	$10 per visit
Allergy serum	Nothing
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 21. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: We will only cover GHT when we preauthorize the treatment.	Nothing
Rehabilitative therapies	
Physical therapy, occupational therapy and speech therapy for services by each of the following: • • qualified physical therapists; • • speech therapists; and • • occupational therapists. • You must show significant improvement within 60 days to receive authorization for additional treatment. 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 visit on an outpatient basis Nothing on an inpatient basis
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 32 sessions	Nothing

Rehabilitative therapies (continued)	You pay
Not covered: • *long-term rehabilitative therapy* • *exercise programs* • *massage therapy* • *recreational therapy*	*All charges*
Hearing services (testing, treatment, and supplies)	
• Hearing exams when referred by the primary care doctor	$10 per visit
Not covered: • *hearing aids, testing and examinations*	*All charges*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by intraocular surgery (such as for cataracts)	Nothing
• Eye exam to determine the need for vision correction for children through age 17 (see preventive care) • Annual eye refractions	$10 per visit
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	
• Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes	$10 per 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 other routine foot care*	*All charges.*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome	$20 per item

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)	
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 (the type of wheelchair we allow depends on your medical condition) • crutches • walkers • blood glucose monitors • insulin pumps	$20 per item
Not covered: • *Power Operated Vehicles*	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide • Services include oxygen therapy, intravenous therapy and medications	Nothing
Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family* • *nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication*	*All charges*
Alternative treatments	
• Chiropractic Services – 6 self-referred visits per calendar year	$10 per visit
Not covered: • *Acupuncture* • *Naturopathic services* • *Hypnotherapy* • *Biofeedback* • *Christian Science services*	*All charges*
Educational classes and programs	
• Diabetes self-management	$10 per visit
• Asthma self-management	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.
- We have no calendar year deductible for services received by Plan participating providers. Please see Section 5(i) regarding your Point-of-Service benefits.
- Be sure to read Section 4, "Your costs for covered services" for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information. • Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a). • Treatment of burns • Surgical treatment of morbid obesity Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$10 per office visit; nothing for surgery
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 • All stages of breast reconstruction surgery following a mastectomy, such as: • • surgery to produce a symmetrical appearance on the other breast • • treatment of any physical complications, such as lymphedemas • • breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, 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 • Other surgical procedures that do not involve the teeth or their supporting structures; • Treatment of tumors or cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of mouth	$10 per office visit Nothing for surgery
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: 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. Note: We cover the donor's related medical and hospital expenses that are strictly related to the donation when we cover the recipient.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in: • Hospital (inpatient)	Nothing
Professional services provided in: • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- 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 • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*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
Not covered: *• Blood and blood derivatives not replaced by the member*	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Extended care/skilled nursing facility (SNF) benefit: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor	Nothing
Not covered: *• Custodial care*	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include: • Inpatient care (21-day limit per calendar year) • outpatient care • family counseling Hospice services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing
Not covered: *• Independent nursing, homemaker services*	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate and authorized by the Plan	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT	**Here are some important things to keep in mind about these benefits:** • Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure. • We have no calendar year deductible for services received by Plan participating providers. Please see Section 5(i) regarding your Point-of-Service benefits. • 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:

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 should notify the Plan within 48 hours unless it is not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized in a non-Plan facility, 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 (except as shown on page 25)

To be covered by this plan, any follow-up care recommended by non-Plan providers must be approved by Plan providers except as covered under POS benefits.

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 Plan providers except as covered under POS benefits.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$10 per visit
• Emergency care at an urgent care center	$20 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctor's services	$25 per hospital emergency room visit. If emergency results in an admission to a hospital, the copay is waived.
Not covered: • *Elective care or non-emergency care*	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office	$10 per visit
• Emergency care at an urgent care center	$20 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctor's services	$25 per hospital emergency room visit. If emergency results in an admission to a hospital, the copay is waived.
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* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges.*
Ambulance	
• Professional ambulance service when medically appropriate • Air ambulance Note: 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	
Diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per visit
• 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.*	*All charges*

Preauthorization

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

Treatment for mental health conditions and substance abuse may be obtained directly from Continuum Behavioral Care or other mental health administrator, as determined by the Plan; you must call 1-800-544-5977 or 401-276-4052 prior to services being rendered. Continuum Behavioral Care will determine and authorize the appropriate number of visits and determine the appropriate specialist. A referral from your PCP is not required.

Special transitional benefit

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

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

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

Limitation

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

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible for services received by Plan participating providers. Please see Section 5(i) regarding your Point-of-Service benefits.
- Be sure to read Section 4, "Your costs for covered services" for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

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

- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy. Plan pharmacies include CVS and Brooks pharmacies as well as additional independent pharmacies. Prescriptions filled at non-participating pharmacies will be covered at 80% of BlueCHiP, Coordinated Health Partners' allowance after a $30 copay.

- **We use a formulary.** BlueCHiP, Coordinated Health Partners uses a drug formulary, which is a listing of quality, cost effective medications that are covered under your prescription drug benefit for a lower copay. You are still covered for medications that are not on the Plan's formulary; however, you will be responsible for a higher copay. If your physician prescribes a medication that is not listed on the Plan's formulary, there is a two-month grace period for non-formulary drugs, during which you will only be charged a generic or brand name copay, whichever applies. If you meet the pre-established medical criteria for the non-formulary drug, you will only be required to pay the applicable generic or brand name copay. If you do not meet the pre-established medical criteria or your physician does not submit the necessary information for medical necessity to be determined, you will be responsible for the non-formulary copay after the two-month grace period has ended.

- **These are the dispensing limitations.** Prescription drugs prescribed by a Plan or referral doctor will be dispensed for up to a 34-day supply for non-maintenance drugs or the greater of a 34-day supply or 100 units for maintenance drugs. If there is no generic equivalent available, you will still have to pay the brand name copay.

- **When you have to file a claim.** You will be required to submit a claim for prescriptions purchased from a non-Plan pharmacy. You will be required to pay the non-Plan pharmacy directly and the Plan will reimburse you once you have submitted the receipt, your name and identification number to BlueCHiP, 15 LaSalle Square, Providence, RI 02903.

Prescription drug benefits begin on the next page

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. • Insulin • Disposable needles and syringes for the administration of covered medications • Fertility drugs (non-injectibles) • Implanted time-released medications, such as Norplant (included with office visit copay covered under Medical/Surgical benefits) • All FDA approved contraceptive drugs and devices • Prenatal vitamins • **Limited Benefit:** Drugs to treat sexual dysfunction are subject to dosage limitations. Contact the Plan for specific dosage limitations.	$5 per prescription unit or refill for generic drugs $15 per prescription unit or refill for brand name drugs on the Plan's formulary(see note below) $30 per prescription unit or refill for brand name drugs not listed on the Plan's formulary, unless you meet certain criteria for the prescription drug (see note below) Prescriptions filled at non-participating pharmacies will be covered at 80% of BlueCHiP, Coordinated Health Partners' Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
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.	See Above
Not covered: • *Drugs and supplies for cosmetic purposes* • *All other vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Drugs available without a prescription or for which there is a non-prescription equivalent avaiable* • *Drugs to enhance athletic performance* • *Injectible fertility drugs* • *Medical supplies such as dressings and antiseptics* • *Drugs and supplies for the purposes of weight reduction*	*All Charges*

Section 5 (g). Special Features

Feature	Description
Reciprocity benefit	BlueCHiP, Coordinated Health Partners offers the HMO USA Away From Home Urgent Care program. When you or a covered member are travelling throughout the United States, and need medical care before you return home, call the Away From Home Coordinator at 1-800-4-HMO-USA (1-800-446-6872). The Away From Home Coordinator will assist you with scheduling an appointment with a qualified doctor during normal business hours and give you directions to a doctor's office.
High risk pregnancies	If you are pregnant, you will be part of our Little Steps prenatal program. Little Steps is designed to work with you and your physician to help you have the healthiest baby possible. Little Steps includes free classes on parenting, newborn care, and breast-feeding. The classes are held at participating hospitals throughout Rhode Island. For more information, please contact Customer Service at 1-800-564-0888.

Section 5 (h). Dental benefits

IMPORTANT

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

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

IMPORTANT

Accidental injury benefit	You Pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. You pay nothing.	Nothing
Dental benefits	
We have no other dental benefits.	

Section 5 (i). Point of service benefits

Facts about this Plan's POS option

At your option, you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals whenever you need care, except for the benefits listed below under "What is not covered." Benefits not covered under Point-of-Service must either be received from or arranged by Plan doctors to be covered. When you obtain covered non-emergency medical treatment from a non-Plan doctor without a referral from a Plan doctor, you are subject to the deductibles, coinsurance and maximum benefit stated below.

What is covered

Under the Point-of-Service benefit, you are covered for medically necessary, covered health services when you self-refer to a non-participating provider or to a BlueCHiP provider without a referral. You may receive medically necessary covered health services listed in this brochure, except for the services listed under what is not covered. Once you use the Point-of-Service benefit, all services associated with the episode of care (i.e., lab, X-ray, hospitalization) will be paid according to your Point-of-Service benefit. If you choose to use the Point-of-Service benefit, you will receive a lower allowance than when the standard HMO benefit is utilized.

You are able to self-refer to a non-participating provider either inside or outside of our service area. You must call BlueCHiP for authorization for hospitalizations.

Plan Authorization

Services requiring Plan authorization under the Plan's standard HMO benefits continue to require authorization under the POS benefit. When you utilize a non-participating provider, you are responsible for assuring that Plan authorization is obtained in advance for such services. If you do not obtain Plan authorization for services that require Plan authorization, we will not cover the service.

Deductible

When the Point-of-Service benefit is utilized, **you pay** a $250 deductible per member per calendar year or a $500 deductible per family per calendar year for doctor's visits, other outpatient services, and hospital services. The deductible is not reimbursable by the Plan. If you decide to use non-participating providers or self-refer to a participating provider, this deductible applies to all covered benefits. Copays under the BlueCHiP, Coordinated Health Partners' Point-of-Service benefit cannot be used to meet your calendar year deductible.

Coinsurance

When you self-refer to Plan participating providers, the Plan pays 80% of its fee allowance after the deductible is met; **you pay** 20% of the fee allowance.

When you self-refer to non-Plan participating providers, the Plan pays 80% of its fee allowance after the deductible is met; **you pay** 20% of the fee allowance and all charges over and above the fee allowance.

Maximum Benefit

You are protected by an out-of-pocket maximum of $3,000 per person, per calendar year and $6,000 per family per calendar year. This includes deductibles and copayments. Charges over the fee allowance cannot be applied to the out-of-pocket maximum.

Emergency Benefits

True, medically necessary emergency care (even if received from a non-participating provider) is always covered as a standard HMO benefit.

Prescription Drugs

You may have prescriptions filled when utilizing the Point-of-Service benefit. You will be covered at 80% of the BlueCHiP, Coordinated Health Partners after a $30 copay. The benefits and requirements are the same as those for the standard HMO Prescription Drug Benefit.

What is not covered

- Anesthesia consultations
- Chiropractic care
- Diagnostic procedures, such as laboratory tests and X-rays
- Durable Medical Equipment (DME) and medical supplies
- Emergency room visits
- Home health services
- Infertility services
- Mental conditions/substance abuse benefits
- Outpatient physical, speech and occupational therapies, cardiac rehabilitation
- Rehabilitation hospitalizations
- Skilled nursing facility care
- Transplant coverage
- Vision care benefits

How to obtain benefits

If you receive services from a non-participating provider, you may be required to pay up front and submit to us for reimbursement. Please call Customer Service at 401-274-3500 or toll free at 1-800-564-0888 for a claim form. We will provide you with a form within 15 days of your request. Submit the claim to BlueCHiP, Coordinated Health Partners, 15 LaSalle Square, Providence, RI 02903 as soon as possible. You must submit a complete claim form 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.

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

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

Medicare prepaid plan Enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 41, annuitants and former spouses with FEHBP coverage and Medicare Part B may elect to drop their FEHBP coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later re-enroll in the FEHBP Program. Most federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for informaton on dropping your FEHBP enrollment and changing to a Medicare prepaid plan. Contact us at 1-800-505-2583 for information on the Medicare prepaid plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 1-800-505-2583 for information on the benefits available under the Medicare HMO.

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition and we agree, as discussed under *What Services Require Our Prior Approval* on page 10.**

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 that is 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 and Drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 401-274-3500 or toll-free at 1-800-564-0888. 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: **15 LaSalle Square**
Providence, RI 02903

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: 15 LaSalle Square, Providence, RI 02903; 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 medical provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. 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 3, 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 401-274-3500 or toll-free at 1-800-564-0888 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:
- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment, too, or
- You can call OPM's Health Benefits Contracts Division 3 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 medical expenses without regard to fault. This is called "double coverage."

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

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

The Original Medicare Plan

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

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care.

We will not waive any of our copayments, coinsurance, and deductibles.

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

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, but we will not waive any of our copayments, coinsurance, or deductibles.

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare managed care plan. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care plan's service area.

• Enrollment in Medicare Part B

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

TRICARE

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Copayment

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

Coinsurance

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

Covered services

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

Custodial care

Custodial care means non-medical care, including room and board, provided to you if you have a mental or physical condition and require assistance in your daily living or personal needs. Custodial care can be provided by persons without professional skills or training who can assist you with dressing, bathing, eating, taking medication and preparation of special diets.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 32.

Experimental or Investigational services

Experimental or investigational services include any treatment, procedure, facility, equipment, drug, device, supply or service (herinafter referred to collectively as "service") when the service has progressed to limited human application, but has not been recognized as proven effective in clinical medicine. A service is considered experimental or investigational if the Plan determines that one or more of the following circumstances are true: 1) the service is the subject of an ongoing clinical trial or is under study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis; or 2) the prevailing opinion among experts regarding the service is that further studies or clinical trials are necessary; or 3) the current belief in the pertinent specialty of the medical profession in the United States is that the service or supply should not be used for the diagnosis or indications being requested outside of clinical trials or other research settings because it requires further evaluation for that diagnosis or indications.

Group health coverage

A Plan maintained by an employer to provide medical care, directly or indirectly, to employees, ex-employees and their families.

Medical necessity

Medical necessity means the health care service provided to treat your illness or injury. The services must: 1) be essential or diagnosis, treatment, or care of your condition; 2) be commonly and customarily recognized in your provider's profession as appropriate for your diagnosis; 3) be performed in the most cost-effective manner or at a location providing a less intensive level of care; and 4) not be determined by us to be experimental or investigational.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. We determine our allowance as follows: for Plan participating providers, our allowance is the amount the physician charges for the covered service or the amount that Plan has negotiated to pay for the covered service; for no-Plan participating providers, our allowance is the the amount the physician charges for the covered service, the amount the Plan determines to be appropriate based on our list of allowances for the covered service or procedure or the maximum amount the Plan pays any doctor for the covered service or procedure.

Us/We

Us and we refer to BlueCHiP, Coordinated Health Partners.

You

You refers to the enrollee and each covered family member.

• No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that you had limitation 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 FEHB Program 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 and your family, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

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

Your employing or retirement office will not notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

When benefits and premiums start

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

• Your medical and claims records are confidential

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

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

• When you retire

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

When you lose benefits

• When FEHB coverage ends

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

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

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

• Spouse equity coverage

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

• TCC

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

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

Get the RI 79-27, which describes TCC, and the RI 70-5, the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees, from your employing or retirement office or from www.opm.gov/insure.

• Converting to individual coverage

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

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

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

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

• Getting a certificate of group health plan coverage

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

Inspector General advisory

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 401-274-3500 ot toll-free at 1-800-564-0888 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.

Summary of benefits for BlueCHiP, Coordinated Health Partners, Inc. - 2001

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office..	Office visit copay: $10	13
Services provided by a hospital: • Inpatient..... • Outpatient	 Nothing Nothing	 22 23
Emergency benefits: • In-area ..... • Out-of-area	$10 for an office visit; $20 for an urgent care visit; $25 for an emergency room visit. $10 for an office visit; $20 for an urgent care visit; $25 for an emergency room visit.	25 25
Mental health and substance abuse treatment	Regular cost sharing	26
Prescription drugs	$5 for generic drugs; $15 for brand name drugs; $30 for non-formulary drugs.	29
Dental Care	No benefit.	31
Vision Care: • Eye Exams..... • Eye Glasses	 $10 Nothing for one pair of eye glasses to correct an impairment directly caused by intraocular surgery; No other benefit for eye glasses.	 17 17
Special features: Reciprocity benefit; high risk pregnancy.		30
Point-of-Service benefits --	Yes	32
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $2,294/Self Only or $5,874/Family enrollment per year. Some costs do not count toward this protection.	11

Notes

Notes

2001 Rate Information for BlueCHiP, Coordinated Health Partners, Inc.

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

Postal rates apply to 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
Self Only	DA1	$86.59	$32.18	$187.61	$69.73	$102.22	$16.55
Self and Family	DA2	$195.82	$108.30	$424.28	$234.65	$231.17	$72.95