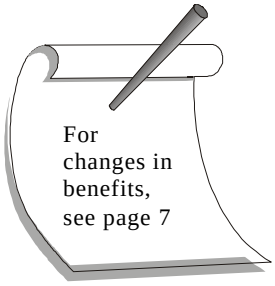
Blue Cross-HMO 2001

http:// www.bluecrossca.com

A Health Maintenance Organization



Enrollment in this Plan is limited; see page 6 for requirements.

Enrollment Code:
M51 Self Only
M52 Self and Family

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

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 73-517

Table of Contents

Introduction

Blue Cross of California, P.O. Box 4089, Woodland Hills, Ca. 91365

This brochure describes the benefits of the Blue Cross – HMO under our contract (CS 2514) 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 Blue Cross.

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 and coinsurance 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.

Who provides my health care

When you enroll you should choose a primary care physician. Your primary care physician will be the first doctor you see for all your health care needs. If you need special kinds of care, this physician will refer you to other kinds of health care providers.

Your primary care physician will be part of a Blue Cross HMO contracting medical group. There are two types of Blue Cross HMO medical groups.

- A primary medical group (PMG) is a group practice staffed by a team of doctors, nurses, and other health care providers.
- An independent practice association (IPA) is a group of doctors in private offices who usually have ties to the same hospital.

You and your family members can enroll in whatever medical group is best for you.

- You must live or work within 30 miles of the medical group.

You and your family members do not have to enroll in the same medical group.

How we pay providers

Your medical group is paid a set amount for each member per month. Your medical group may also get added money for some types of special care or for overall efficiency, and for managing services and referrals. Hospitals and other health care facilities are paid a set amount for the kind of service they provide to you or an amount based on a negotiated discount from their standard rates. If you want more information, please call us at 800-235-8631, or you may call your medical group.

You do not have to pay any Blue Cross HMO provider for what we owe them, even if we don't pay them. But you may have to pay a non-Plan provider any amounts not paid to them by us.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Committee on Consumer Protection and Quality in the Health Care Industry. You may get information about your health plan, its networks, providers, and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you.

If you want specific information about us, call 800-235-8631, or write to P.O. Box 4089, Woodland Hills, CA 91365. You may also contact us by fax at 818-234-6401, or visit our website at www.bluecrossca.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. Our service area is:

Northern California

--Amador	--Fresno	--Marin	--Placer	--San Joaquin	--Stanislaus
--Alameda	--Humboldt	--Mendocino	--Plumas	--San Mateo	--Tehama
--Butte	--Kings	--Merced	--Sacramento	--Santa Cruz	--Tulare
--Contra Costa	--Lake	--Modoc	--San Benito	--Shasta	--Tuolumne
--Del Norte	--Lassen	--Napa	--Santa Clara	--Solano	--Yolo
--El Dorado	--Madera	--Nevada	--San Francisco	--Sonoma	

Southern California

--Imperial	--Los Angeles	--Orange	--San Diego	--San Louis Obispo
--Santa Barbara	--Ventura			

You may also enroll with us if you live in or work in the Zip Codes of the following counties:

KERN: 93203, 93205-06, 93215-17, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93249-52, 93255, 93263, 93276, 93280, 93283, 93285, 93287, 93300-09, 93311-13, 93380-89, 93399, 93504-05, 93516, 93518-19, 93523-24, 93528, 93531, 93554, 93555, 93556, 93560-61, 93570, 93581-82, 93596

RIVERSIDE: 91718-20, 91752, 91753, 91760, 92201-03, 92210, 92211, 92220, 92223, 92230, 92234-36, 92240, 92241, 92253-55, 92258, 92260-64, 92270, 92276, 92282, 92292, 92303, 92320, 92330-31, 92343-44, 92348, 92353, 92355, 92360-62, 92367, 92370, 92379-81, 92383, 92387-88, 92390, 92395-96, 92500-09, 92513-19, 92521-23, 92530-32, 92542-46, 92548, 92550, 92552-57, 92562-64, 92567, 92570-72, 92581-87, 92589-93, 92595-96, 92599

SAN BERNARDINO: 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758, 91761-64, 91784-86, 91798, 92337, 92252, 92256, 92268, 92277-78, 92284-86, 92301, 92305, 92307-08, 92311-13, 92314-18, 92321-22, 92324-27, 92329, 92333-37, 92339-42, 92345-47, 92350, 92352, 92354, 92356-59, 92365, 92368-69, 92371-78, 92382, 92385-86, 92391-94, 92397, 92398, 92399, 92400-18, 92420, 92423-24, 92427

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 or urgent care services.

If you or a covered family member move outside of our service area, you can enroll in another plan. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our Blue Cross HMO network will be the same with regard to coinsurance, copayments, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed higher patient cost sharing and shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find 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 4.2 percent for Self Only and 4.2 percent for Self and Family.
- Diabetes education programs are now covered as described on page 21. Also covered are therapeutic shoes and inserts designed to prevent foot complications due to diabetes.
- Coverage will be provided for formulas and food products (approved by the FDA) for the treatment of phenylketonuria when prescribed by a Plan physician.

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 a prescription at a participating 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 800/235-8631.

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. For treatment of a mental health or substance abuse condition you may request an authorized referral to a non-Plan provider. See Mental Health and Substance Abuse Benefits (Section 5e) for details.

• Plan providers

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

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

•Plan facilities

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

What you must do to get care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. Your primary care physician will be the first doctor you see for all your health care needs. If you need special kinds of care, this doctor will refer you to other kinds of health care providers. This decision is important since your primary care physician provides or arranges for most of your health care. Your primary care physician will be part of a Blue Cross HMO contracting medical group. There are two types of Blue Cross HMO medical groups:

- A primary medical group (PMG) is a group practice staffed by a team of doctors, nurses, and other health care providers.
- An independent practice association (IPA) is a group of doctors in private offices who usually have ties to the same hospital.

You and your family members can enroll in whatever medical group is best for you.

- You must live or work within 30 miles of the medical group.
- You and your family members do not have to enroll in the same medical group.

•Primary care

Your primary care physician can be a general or family practitioner, internist or pediatrician. Certain specialists as we may approve may also be designated primary care physician. 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 doctor may refer you to another physician if you need special care. Your primary care physician must approve all the care you get except when you have an emergency or need urgent care.

Your doctor's medical group has to agree that the service or care you will be getting from the other health care provider is medically necessary**.** Otherwise it won't be covered.

- You will need to make the appointment at the other doctor's office.
- Your primary care physician will give you a referral form to take with you to your appointment. This form gives you the approval to get this care. If you don't get this form, ask for it or talk to your Blue Cross HMO coordinator.
- You may have to pay a copayment. You shouldn't get a bill, unless it is for a copayment, for this service. If you do, send it to your Blue Cross HMO coordinator at your primary medical group right away. The medical group will see that the bill is paid. If you need additional help you can call our customer service department.

Standing Referrals. If you have a condition or disease that:

- Requires continuing care from a specialist; or is
- Life-threatening;
- Degenerative; or
- Disabling;

your primary care physician may give you a standing referral to a specialist or specialty care center. The referral will be made if your primary care physician, in consultation with you, and a specialist or specialty care center, if any, determine that continuing specialized care is medically necessary for your condition or disease.

If it is determined that you need a standing referral for your condition or disease, a treatment plan will be set up for you. The treatment plan:

- Will describe the specialized care you will receive;
- May limit the number of visits to the specialist; or
- May limit the period of time that visits may be made to the specialist.

If a standing referral is authorized, your primary care physician will determine which specialist or specialty care center to send you to in the following order:

- First, a Blue Cross HMO contracting specialist or specialty care center which is associated with your medical group;
- Second, any Blue Cross HMO contracting specialist or specialty care center; and
- Last, any specialist or specialty care center;

that has the expertise to provide the care you need for your condition or disease.

After the referral is made, the specialist or specialty care center will be authorized to provide you health care services that are within the specialist's area of expertise and training in the same manner as your primary care physician, subject to the terms of the treatment plan.

Remember: We only pay for the number of visits and the type of special care that your primary care physician approves. Call your physician if you need more care. **If your care isn't approved ahead of time, you will have to pay for it (except for emergencies or urgent care.)**

Ready Access. There are two ways you may get special care without getting an approval from you medical group. These two ways are the "Direct Access" and "Speedy Referral" programs. Not all medical groups take part in the Ready Access program. See your Blue Cross HMO Directory for those that do.

Direct Access. You may be able to get some special care without an approval from your primary care physician. We have a program called "Direct Access", which lets you get special care, without an approval from your primary care physician for:

- Allergy
- Dermatology
- Ear/Nose/Throat
- OB-GYN

Ask your Blue Cross HMO coordinator if your medical group takes part in the "Direct Access" program. If your medical group participates in the Direct Access program, you must still get your care from a physician who works with your medical group. The Blue Cross HMO coordinator will give you a list of those doctors.

Speedy Referral. If you need special care, your primary care physician may be able to refer you for it without getting an approval from your medical group first. The types of special care you can get through Speedy Referral depend on your medical group.

If You Are A Woman
You can get OB-GYN services from a doctor who specializes in caring for women (OB-GYN) or family practice doctor who does OB-GYN and works with your medical group.

- You can get these services without an approval from your primary care physician.
- Ask your Blue Cross HMO coordinator for the list of OB-GYN health care providers you must choose from.

When You Want a Second Opinion
There may be times when you want a second opinion. Perhaps you have a question about your condition or your primary care physician or a specialist you have been referred to thinks you should have a treatment or surgery you are not sure about. You can ask that another primary care physician or specialist advise you about what you should do. If care is being provided by a specialist, the second opinion will be provided by a doctor in the same specialty.

- If you want a second opinion, ask the Blue Cross HMO coordinator at your medical group. For additional assistance, call us at 800/235-8631.
- The second opinion will consist of a consultation only. No other services, such as x-rays and laboratory tests or other procedures are included.
- In most cases, the doctor or specialist providing the second opinion will be part of your medical group or will be another doctor who has an agreement with us.
- A decision will be made promptly. If you have a serious condition, a decision will be made within 72 hours when possible.
- If your request is denied, and you are unsatisfied, see Section 8: The disputed claims process. You can request that we review the denial.

Here are other things you should know about specialty care:

- 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.

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**

There may be a time when your primary care physician says you need to go to the hospital. If it is not an emergency, the medical group will look into whether or not it is medically necessary. If the medical group approves your hospital stay, you will need to go to a hospital that works with your medical group. The same is true for admissions 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 800/235-8631. 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.

Section 4. Your costs for covered services

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

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

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

- **Deductible** — This Plan does not have a deductible.

- **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.

Your out-of-pocket maximum for coinsurance and copayments

After your copayments total $1,000 for one family member or $3,000 for three or more family members in any calendar year, you do not have to pay any more for covered services. However, copayments or coinsurance for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments or coinsurance for these services:

- *Prescription drug benefits*
- *Infertility services*

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 7 for how our benefits changed this year and page 60 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 800/235-8631 or at our website at www.bluecrossca.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……... • Office medical consultations…… • Second surgical opinion……... • Initial examination of a newborn child covered under a family enrollment ……...	Nothing Nothing Nothing $10 per office visit $10 per office visit Nothing in hospital ($10 per office visit if exam is done in the doctors office)
Professional services of physicians • At home	$10 per 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
• Full physical exams and periodic check-ups ordered by your primary care physician……	$10 per office visit
• Eye exams to determine the need for vision correction. Vision exams include a vision check by your primary care physician to see if it is medically necessary for you to have a complete vision exam by a vision specialist. If approved by your primary care physician, this may include an exam with diagnosis, a treatment program and refractions……	Nothing
• Ear exams to determine the need for hearing correction. Hearing exams include tests to diagnose and correct hearing……	Nothing
• Health screenings as prescribed by your primary care physician, such as mammograms, Pap tests, prostate cancer screenings, sigmoidoscopies, etc……	Nothing
• Immunizations prescribed by your primary care physician……....	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*

Preventive care, (all enrolled children regardless of age)	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care for routine examinations and care, such as: •• Full physical exams and periodic check-ups ordered by your primary care physician …… ••Eye exams to determine the need for vision correction. Vision exams include a vision check by your primary care physician to see if it is medically necessary for you to have a complete vision exam by a vision specialist. If approved by your primary care physician, this may include an exam with diagnosis, a treatment program and refractions…… ••Ear exams to determine the need for hearing correction. Hearing exams include tests to diagnose and correct hearing……	 Nothing Nothing Nothing
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. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	 $10 per office visit Nothing $10 per office visit

Family planning	You pay
• Voluntary sterilization for females (tubal ligation)……..	$150
• Voluntary sterilization for males (vasectomy)…….	$50
• Family planning visits …….	$10 per office visit
• Shots and implants for birth control…….	Nothing
• Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a doctor……...	Nothing
• Doctor's services to prescribe, fit and insert an IUD or diaphragm……..……	$10 per office visit
• Genetic testing, when medically necessary……..	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)* Note: We cover fertility drugs under the prescription drug benefit.	50% for all care
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 serum……	Nothing

Treatment therapies	You pay
• Chemotherapy and radiation therapy……	Nothing
• Respiratory and inhalation therapy……	Nothing
• Dialysis – Hemodialysis and peritoneal dialysis……	Nothing
• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy…….	Nothing
• Growth hormone therapy when approved by your primary care physician……..	Nothing

Rehabilitative therapies	You pay
• Visits for rehabilitation, such as physical therapy, occupational therapy or speech therapy when prescribed by your physician for the services of each of the following: ••qualified licensed physical therapists; •• licensed speech therapists; and •• licensed occupational therapists.	Nothing
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 60 days.	Nothing
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges*

Hearing services (testing, treatment, and supplies)	You pay
• Hearing testing which includes screenings to diagnose and correct hearing	Nothing
Not covered: • Hearing aids or services for fitting or making a hearing aid	*All charges*

Vision services (testing, treatment, and supplies)	You pay
• Vision screening includes a vision check by your primary care physician to see if it is medically necessary for you to have a complete vision exam by a vision specialist. If approved by your primary care physician, this may include an exam with diagnosis, a treatment program and refractions.	Nothing
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*

Foot care	You pay
We cover medically necessary care for the diagnosis and treatment of conditions of the foot, when prescribed by your physician. See durable medical equipment for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Routine foot care*	*All charges*

Orthopedic and prosthetic devices	You pay
• Surgical implants	Nothing
• Artificial limbs or eyes	Nothing
• The first pair of contact lenses or eye glasses when needed after a covered and medically necessary eye surgery	Nothing
• Breast prostheses following a mastectomy	Nothing
• Prosthetic devices to restore a method of speaking when required as a result of a laryngectomy	Nothing
• Colostomy supplies	Nothing
• Supplies needed to take care of these devices	Nothing
Not covered: • *Orthopedic shoes (except when joined to braces) or shoe inserts (except custom molded orthotics). This does not apply to shoes and inserts designed to prevent or treat foot complications due to diabetes.*	*All charges*

Durable medical equipment (DME)	You pay
• You can rent or buy up to **$2,000 (a calendar year)** of long-lasting medical equipment (called durable medical equipment) and supplies if they are: --Ordered by your Plan physician. --Used only for the health problem. --Used only by the person who needs the equipment or supplies. --Made only for medical use. We cover items such as: • Hospital beds • Wheelchairs • Insulin pumps • Surgical bras **Note:** Covered medical supplies include therapeutic shoes and inserts designed to prevent foot complications due to diabetes.	Nothing
Durable Medical Equipment is Not covered if: --It is needed only for your comfort or hygiene. --It is for exercise. --It is needed for making the room or home comfortable, such as air conditioning or air filters.	*All charges*

Home health services	You pay
You can get up to three 2-hour visits a day for the following home health care, furnished by a home health agency (HHA) or visiting nurse association (VNA): • Care from a registered nurse • Physical therapy, occupational therapy, speech therapy, or respiratory therapy • Visits with a medical social service worker • Care from of a health aide who works under a registered nurse with the HHA or VNA • 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 charge*
Alternative treatments	**You pay**
Acupuncture – Medically necessary acupuncture if referred by your primary care physician and approved by the medical group, for the treatment of chronic pain.	$10 per office visit
Not covered: • Acupressure, or massage to help pain, treat illness or promote health by putting pressure to one or more areas of the body	*All charge*
Chiropractic Care – Covered up to 20 visits in a year when you see a chiropractor in the American Specialty Health Plans (ASHP) network. Also up to $50 per calendar year in rental or purchase charges are covered for medical equipment and supplies ordered by an ASHP chiropractor, and approved as medically necessary by ASHP. Such medical equipment includes: (1) elbow, back, thoracic, lumbar, rib or wrist supports; (2) cervical collars or pillows; (3) ankle, knee, lumbar, or wrist braces; (4) heel lifts; (5) hot or cold packs; (6) lumbar cushions; (7) orthotics; and (8) home traction units for treatment of the cervical or lumbar regions. **Note:** The *ASHP* chiropractor is responsible for obtaining the necessary approval from the Plan.	$10 per office visit
Not covered: • *Any services provided by ASHP that are not approved by us, except for the first visit;* • *The services of a non-ASHP chiropractor.*	*All charges*

Educational classes and programs	You pay
Coverage is limited to: • Diabetes self-management programs supervised by a doctor to teach you and your family members about the disease and how to take care of it. This includes training, education and nutrition therapy to enable you to use the equipment, supplies and medicines needed to manage the disease. • Other health education programs given by your primary care physician or the medical group. Ask about our many programs to: --Educate you about living a healthy life --Get a health screening --Learn about your health problem	Usually Nothing- Separate copayments may apply to some programs. Call us for more information.

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. Any costs associated with the facility charge (i.e. hospital, surgical center, etc.) are covered in Section 5 (c).

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Any medically necessary eye surgery • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Treatment of burns • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity as determined by your medical group, when the treatment is approved in advance • Insertion of internal prostethic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information. **Note:** Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits or a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing
• Voluntary sterilization for female (tubal ligation)……. • Voluntary sterilization for male (vasectomy)…… • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a)……	$150 $50 $10 per office visit
Not covered: • *Reversal of voluntary sterilization;* • *Radial keratotomy and other refractive surgeries.*	*All charges*

Reconstructive surgery	You pay
• Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function, reducing symptoms or creating a normal appearance.	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 this 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. This does not apply to surgery you might need to:* -- *give you back the use of a body part* -- *have a breast reconstruction after a mastectomy* -- *Correct or repair a deformity caused by birth defects, abnormal development, injury or illness in order to improve function, symptomatology or create a normal appearance.* *Cosmetic surgery does not become reconstructive because of psychological or psychiatric reasons.* • *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; • Splint therapy or surgical treatment for disorders of the joints linking the jawbones and the skull (the temporomandibular joints); including the complex of muscles, nerves and other tissues related to those joints; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Kidney • Liver • Lung: Single –Double • Pancreas • Allogenic (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, when approved by the Plan medical director Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Transplants not listed as covered*	*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
Dental Care– General anesthesia and facility services when dental care must be provided in a hospital or ambulatory surgery center when you are: • Less than seven years old; • Developmentally disabled; or • Your health is compromised and general anesthesia is medically necessary. **Note**: No benefits are provided for the dental procedure itself or for the professional services of a dentist to do the dental procedure.	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

Inpatient hospital continued on next page.

Inpatient hospital *(Continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood transfusions. This includes the cost of blood, blood products or blood processing • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services **Note**: Inpatient hospital services are covered for dental care only when the Stay is: --Needed for dental care because of other medical problems you may have; --Ordered by a doctor (M.D.) or a dentist (D.D.S.); and --Approved by the medical group.	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	Nothing
Dental Care– Facility services when dental care must be provided in a hospital or ambulatory surgery center when you are: • Less than seven years old; • Developmentally disabled; or • Your health is compromised and general anesthesia is medically necessary. **Note**: No benefits are provided for the dental procedure itself or for the professional services of a dentist to do the dental procedure.	Nothing

Skilled nursing care facility benefits	You pay
We cover the following care in a skilled nursing facility for up to **100 days in a calendar year**. • A room with two or more beds • Special treatment rooms • Regular nursing services • Laboratory tests • Physical therapy, occupational therapy, speech therapy, or respiratory therapy • *Drugs* and medicines given during your *stay*. This includes oxygen. • Blood transfusions • Needed medical supplies and appliances	Nothing
Not covered: custodial care	*All charges*

Hospice care	You pay
We cover hospice care if you have an illness that may lead to death within 6 months. Your primary care physician will work with the hospice and help develop your care plan. The hospice must send a written care plan to your medical group every 30 days. You can get **180 days during your lifetime** for the following hospice care. • Room and board charges in a hospice unit • Care from a registered nurse, licensed practical nurse and licensed vocational nurse • Physical therapy, occupational therapy, speech therapy and respiratory therapy • Medical social services • Care from a home health aide • Diet and nutrition advice; nutrition help such as intravenous feeding or hyperalimentation • Drugs and medicines prescribed by a doctor • Medical supplies, oxygen and respiratory therapy supplies respiratory therapy supplies • Care which controls pain and relieves symptoms	Nothing
Not covered: Independent nursing, homemaker services	*All charges*

Ambulance	You pay
You can get these services from a licensed ambulance in an emergency or when ordered by your primary care physician. (We will provide benefits for these services if you receive them as a result of a 9-1-1 emergency response system call for help if you think you have an emergency.) Air ambulance is also covered, but, only if ground ambulance service can't provide the service needed. Air ambulance service, if medically necessary, is provided only to the nearest hospital that can give you the care you need. • Base charge and mileage • Disposable supplies • Monitoring, EKG's or ECG's, cardiac defibrillation, CPR, oxygen, and IV Solutions IN SOME AREAS, THERE IS A 9-1-1 EMERGENCY RESPONSE SYSTEM. THIS SYSTEM IS TO BE USED ONLY WHEN THERE IS AN EMERGENCY.	Nothing

Section 5 (d). Emergency services

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 is urgent care?

We provide coverage for medically necessary care by non-Plan providers to prevent serious deterioration of your health resulting from an unforeseen illness or injury when you are more than 20 miles from your medical group (or your medical group's enrollment area hospital if you are enrolled in an independent practice association), and seeking health services cannot wait until you return.

If you need urgent care you should seek medical attention immediately. If you are admitted to a hospital for urgently needed care, you should contact your primary care physician or Medical Group within 48 hours, unless extraordinary circumstances prevent such notification. Follow-up care will be covered when the care required continues to meet our definition of "Urgent Care". Urgent care is defined as services received for a sudden, serious, or unexpected illness, injury or condition, which is not an emergency, but which requires immediate care for the relief of pain or diagnosis and treatment of such condition.

What to do in case of emergency:

If you need emergency services, get the medical care you need right away. In some areas, there is a 9-1-1 emergency response system that you may call for emergency services (this system is to be used only when there is an emergency that requires an emergency response).

Once you are stabilized, your primary care physician must approve any care you need after that.

- Ask the hospital or emergency room doctor to call your primary care physician.
- Your primary care physician will approve any other medically necessary care or will take over your care.

You may need to pay a copayment for emergency room services. We cover the rest.

If You Are In-Area. You are in-area if you are 20 miles or less from your medical group (or 20 miles or less from your medical group's hospital, if your medical group is an independent practice association).

If you need emergency services, get the medical care you need right away. If you want, you may also call your primary care physician and follow his or her instructions.

Your primary care physician or medical group may:

- Ask you to come into their office;
- Give you the name of a hospital or emergency room and tell you to go there;
- Order an ambulance for you;
- Give you the name of another doctor or medical group and tell you to go there; or
- Tell you to call the 9-1-1 emergency response system.

If You're Out of Area. You can still get emergency services if you are more than 20 miles away from your medical group.

If you need emergency services, get the medical care you need right away (follow the instructions above for What to do in case of emergency). In some areas, there is a 9-1-1 emergency response system that you may call for emergency services (this system is to be used only when there is an emergency that requires an emergency response). You must call us within 48 hours if you are admitted to a hospital.

Remember:

- We won't cover services that do not fit the description of medical emergency on page 29.
- Your primary care physician must approve care you get once you are stabilized, unless Blue Cross HMO approves it.
- Once your medical group or Blue Cross HMO gives an approval for emergency services, they cannot withdraw it.

Benefit Description	You pay
Emergency inside or outside of our service area	
• Emergency care at a doctor's office ……	$10 per office visit
• Emergency care at an urgent care center……	$25 per visit
• Emergency care on an outpatient basis at a hospital (if care results in admission to a hospital, the copayment will not apply)……	$25 per visit
• Emergency care at a hospital on an inpatient basis……	Nothing
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*

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.

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:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **You can get care for outpatient professional treatment of mental health and substance abuse conditions by a Plan provider without getting prior approval from your medical group. In order for care to be covered, you must go to a Plan provider. You can get a directory of Plan providers from us by calling 800/235-8631. You must get prior approval for all inpatient facility based care and any visits to a non-Plan provider. Please see Medical Management Programs on page 32 for more information.**

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
We will cover services for the treatment of mental health and substance abuse conditions provided by a Plan provider. We will also cover services of a non-Plan provider if an authorized referral is obtained.	Cost sharing and limitations for benefits that we cover (for example, visit/day limits, coinsurance, copayments, and out-of-pocket maximums) for mental health and substance abuse are based on the cost sharing and limits for similar benefits under our network medical, hospital, prescription drug, diagnostic testing, and surgical benefits.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers……...	$10 per office visit
• Medication management…..……..	$10 per office visit
• Diagnostic laboratory or x-ray tests…….……	Nothing
• Facility-based care (care provided in a hospital, psychiatric health facility, or residential treatment center)……. *Note: If facility based care is not approved by us before you get care, we **will not provide benefits.** Please see Medical Management Programs on page 32 for more information.*	Nothing
Not covered: • Services we have not approved. ***Note:** OPM's review of disputes about network treatment plans will be based on the treatment plan's clinical appropriateness. OPM will generally not order one clinically appropriate treatment plan in favor of another.*	*All charges*

Medical Management Programs for Mental Health and Substance Abuse Conditions

Medical Management Programs apply only to the treatment of mental health and substance abuse conditions for the following services:

- facility based care (facility based care is care provided in a hospital, psychiatric health facility, or residential treatment center) and
- authorized referrals to non-Plan providers.

The medical management programs are set up to work together with you and your physician to be sure that you get appropriate medical care and avoid costs you weren't expecting.

You don't have to get a referral from your primary care physician when you go to a Plan provider for professional services, such as counseling, for the treatment of mental health and substance abuse conditions. You can get a directory of Plan providers who specialize in the treatment of mental health and substance abuse conditions from us by calling 800/235-8631.

Your primary care physician must provide or coordinate all other care and your medical group must approve it.

We have two medical management programs for treatment of mental health and substance abuse conditions:

- The Utilization Review Program applies to facility-based care for the treatment of mental health and substance abuse conditions.
- The Authorization Program applies to referrals to non-Plan providers.

We will pay benefits only if you are covered at the time you get services, and our payment will follow the terms and requirements of this Plan.

Utilization Review Program

The utilization review program looks at whether care is medically necessary and appropriate, and the setting in which care is provided. We will let you and your physician know if we have determined that services can be safely provided in an outpatient setting, or if we recommend an inpatient stay. We certify and monitor services so that you know when it is no longer medically necessary and appropriate to continue those services.

You need to make sure that your physician contacts us before scheduling you for any service that requires utilization review. If you get any such service without following the directions under "How to Get Utilization Reviews," no benefits will be provided for that service.

Utilization review has three parts:

- **Pre-service review.** We look at non-emergency facility-based care for the treatment of mental health and substance abuse conditions and decide if the proposed facility-based care is medically necessary and appropriate.
- **Concurrent review.** We look at and decide whether services are medically necessary and appropriate when pre-service review is not required or we are notified while service is being provided, such as with an emergency admission to a hospital.
- **Retrospective review.** We look at services that have already been provided:
  - When a pre-authorization, pre-service or concurrent review was not completed; or
  - To examine and audit medical information after services were provided.

Retrospective review may also be done for services that continued longer than originally certified.

Effect on Benefits

- When you don't get the required pre-service review before you get facility-based care for the treatment of mental health and substance abuse conditions, we **will not provide benefits** for those services.
- Facility-based care for the treatment of mental health and substance abuse conditions will be provided only when the type and level of care requested is medically necessary and appropriate for your condition. If you go ahead with any services that have been determined to be not medically necessary and appropriate at any stage of the utilization review process, we **will not provide benefits** for those services.
- When services are not reviewed before or during the time you receive the services, we will review those services when we receive the bill for benefit payment. If that review determines that part or all of the services were not medically necessary and appropriate, we **will not provide benefits** for those services.

How to Get Utilization Reviews

Remember, you must make sure that the review has been done.

Pre-Service Reviews

No benefits will be provided if you do not get pre-service review before receiving scheduled (non-emergency) services, as follows:

- You must tell your physician that this Plan requires pre-service review. Physicians who are Plan providers will ask for the review for you. The toll-free number to call for pre-service review is 800/274-7767.
- For all scheduled services that require utilization review, you or your physician must ask for the pre-service review at least three working days before you are to get services.
- We will certify services that are medically necessary and appropriate. For facility-based care for the treatment of mental health and substance abuse conditions we will, if appropriate, certify the type and level of services, as well as a specific length of stay. You, your physician and the provider of the service will get a written notice showing this information.
- If you do not get the certified service within 60 days of the certification, or if the type of the service changes, you must get a new pre-service review.

Concurrent Reviews

- If pre-service review was not done, you, your physician or the provider of the service must contact us for concurrent review. If you have an emergency admission or procedure, you need to let us know within one working day of the admission or procedure, unless your condition prevented you from telling us or a member of your family was not available to tell us for you within that time period.
- When you tell Plan providers that you must have utilization review, they will call us for you. You may ask a non-Plan provider to call the toll free number on your Member ID card or you may call directly.
- When we decide that the service is medically necessary and appropriate, we will, depending upon the type of treatment or procedure, certify the service for a period of time that is medically appropriate. We will also decide on the medically appropriate setting.
- If we decide that the service is not medically necessary and appropriate, we will tell your physician by telephone no later than 24 hours after the decision. You and your physician will receive written notice no later than one business day after the decision.

Retrospective Reviews

- We will do a retrospective review:
  - If we were not told of the service you received, and were not able to do the appropriate review before your discharge from the hospital or residential treatment center.
  - If pre-service or concurrent review was done, but services continued longer than originally certified.
  - For the evaluation and audit of medical documentation after you got the services, whether or not pre-service or concurrent review was performed.
- If such services are determined to not have been medically necessary and appropriate, we will deny certification.

Authorization Program

The authorization program provides prior approval for medical care or service by a non-Plan provider. The service you receive must be a covered benefit of this Plan.

You must get approval before you get any non-emergency or non-urgent service from a non-Plan provider for the treatment of mental health and substance abuse conditions. The toll-free number to call for prior approval is on your member ID card.

If you get any such service, and do not follow the procedures set forth in this section, no benefits will be provided for that service.

Authorized Referrals. In order for the benefits of this Plan to be provided, you must get approval **before** you get services from non-Plan providers. When you get proper approvals, these services are called authorized referral services.

Effect on Benefits. If you receive authorized referral services from a non-Plan provider, the Plan provider copayment will apply. When you do not get a referral, **no benefits are provided** for services received from a non-Plan provider.

How to Get an Authorized Referral. You or your physician must call the toll-free telephone number on your member ID card **before** scheduling an admission to, or before you get the services of, a non-Plan provider.

When an Authorized Referral Will be Provided. Referrals to non-Plan providers will be approved only when all of the following conditions are met:

- There is no Plan provider who practices the specialty you need, provides the required services or has the necessary facilities within 50-miles of your home; AND
- You are referred to the non-Plan provider by a physician who is a Plan provider; AND
- The services are authorized as medically necessary before you get the services.

Disagreements with Medical Management Program Decisions

- If you or your physician don't agree with a Medical Management Program decision, or question how it was reached, either of you may ask for a review of the decision. To request a review, call the number or write to the address included on your written notice of determination. If you send a written request it must include medical information to support that services are medically necessary.
- If you, your representative, or your physician acting for you, are still not satisfied with the reviewed decision, a written appeal may be sent to us.
- If you are not satisfied with the appeal decision, you may follow the procedures under Section 8: The disputed claims process.

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 page 37.
- 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.** Drugs must be prescribed by a health care provider licensed to prescribe such medication, and must be given to you within one year of being prescribed.
- **Where you can obtain them.** You may fill the prescription at any licensed retail pharmacy or by our mail service program.
- **Using Participating Pharmacies.** To get medicine your physician has prescribed:
  --Go to a participating pharmacy.
  --For help finding a participating pharmacy, call us at 1-800-700-2541.
  --Show your Member ID card.
  --Pay your copayment when you get the medicine. You must also pay for any medicine or supplies that are not covered under the Plan.
  --When your prescription is for a brand name drug, the pharmacist will substitute it with a generic drug unless your physician writes "dispense as written".
- **Using Non-Participating Pharmacies. It will cost you more if you go to a non-participating pharmacy**:
  --Take a claim form with you to the non-participating pharmacy. If you need a claim form or if you have questions, call 1-800-700-2541.
  --Have the pharmacist fill out the form and sign it.
  --Then send the claim form (within 90 days) to:

  Prescription Drug Program
  P.O. Box 4165
  Woodland Hills, CA 91365-4165

  When we first get your claim, we take out:
  --Costs for medicine or supplies not covered under the Plan,
  --Then any cost more than the limited fee schedule we use for non-participating pharmacies, and
  --Then your copayment.
  The rest of the cost is covered.
- **If you are out of state,** and you need medicine,
  --Call **1-800-700-2541** to find out where there is a participating pharmacy.
  --If there is no participating pharmacy, pay for the drug and send us a claim form.

Prescription drug benefits – CONTINUED

- **Getting your medicine through the mail.** When you order medicines through the mail, here's what to do:
  --Get your prescription from your health care provider. He or she should be sure to sign it. It must have the drug name, how much and how often to take it, how to use it, the provider's name and address and telephone number along with your name and address.
  --Fill out the order form. The first time you use the mail service program, you must also send a filled out Patient Profile questionnaire about yourself**.** Call 1-888-888-DRUG (3784) for order forms and the Patient Profile questionnaire.
  --Be sure to send the copayment along with the prescription and the order form and the Patient Profile. You can pay by check, money order, or credit card.
  --Send your order to:

  Prescription Drug Program – Mail Service
  P.O. Box 550
  Pittsburgh, PA 15230-9424
  1-888-888-DRUG

  --There may be some medicines you cannot order through this program. Call 1-888-888-DRUG to find out if you can order your medicine through the mail service program.

- **We use a formulary.** A preferred drug list, sometimes called a formulary, is used to help your physician make prescribing decisions. This list of drugs is updated quarterly by a committee of doctors and pharmacists so that the list includes drugs that are safe and effective in the treatment of disease. Under the terms of your Plan, only preferred drugs are covered at participating pharmacies and through the mail order program unless the prescriber has specified dispense as written. If you are prescribed a non-preferred drug without "dispense as written", you will pay the participating pharmacy's, or mail order program's full cost of the drug.

  You can get drugs not listed as preferred drugs if the physician writes "do not substitute" or "dispense as written" on the prescription. Some drugs need to be approved - the physician or pharmacy will know which drugs they are.

  You cannot order non-preferred drugs through the mail service program.

  If you have questions about whether a drug is on the preferred drug list or needs to be approved, please call us at 1-800-700-2541.

  If we don't approve a request for a drug that is not part of our preferred drug list, you or your physician can appeal the decision by calling us at 1-800-700-2541. If you are not satisfied with the result, please see Section 8: The disputed claims process.

- **These are the dispensing limitations.** You can get a 30-day or 100 unit supply, whichever is less, if you get the drug at a retail pharmacy. You can get a 60-day supply of drugs at a retail pharmacy for treating attention deficit disorder if they:
  --Are FDA approved for treating attention deficit disorder;
  --Are federally classified as Schedule II drugs; and
  --Require a triplicate prescription form.

  You can get a 90-day supply if you get the drug from our mail service program.

  Drugs for the treatment of impotence and/or sexual dysfunction are:
  --Limited to six tablets (or treatments) for a 30-day period; and
  --Available at retail pharmacies only. You must give us proof that a medical condition has caused the problem.

Prescription drugs 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 retail pharmacy or through our mail order program: • Outpatient Drugs and medicines which require a prescription by law. Formulas prescribed by a physician for the treatment of phenylketonuria. These formulas are subject to the brand name copayment. • Oral and injectable contraceptive drugs-up to a three-cycle supply may be obtained for a single copayment charge • Prescribed contraceptive drugs and devices which are approved by the Food and Drug Administration. • Insulin, with a copayment charge applied to each vial • Diabetic supplies including insulin syringes, needles, glucose test tablets and test tape. Benedict's solution or equivalent and acetone test tablets. • Disposable needles and syringes needed for injecting covered prescribed medication • Drugs used primarily for the purpose of treating infertility • Smoking cessation drugs and medications, only if a prescription is required by law • Drugs that have FDA labeling to be injected under the skin by you or a family member • Drugs for sexual dysfunction (see limits on page 36) Here are some things to keep in mind about our prescription drug program: • At participating pharmacies, a generic equivalent will be dispensed if it is available, unless your physician specifically requires a brand name drug. • If you receive brand name drugs when there is no generic equivalent, you will still have to pay the brand name drug copayment. • We have an open formulary. If your physician believes a brand name product is necessary or there is no generic available, your physician may prescribe a name brand drug from the preferred drug list.	**For Blue Cross Participating Pharmacies:** Preferred generic drugs: **$5 copay** per prescription or refill Brand name drugs and generic, non-preferred drugs if the physician writes "dispense as written": **$10 copay** per prescription or refill **For Non-participating Pharmacies:** Generic drugs: **$5 plus 50%** of the drug limited fee schedule Brand name drugs: **$10 plus 50%** of the drug limited fee schedule **For drugs through the Mail Service Program:** Preferred generic drugs: **$5 copay** per prescription or refill Brand name drugs and generic, non-preferred drugs if the physician writes "dispense as written": **$20 copay** per prescription or refill

Covered medications and supplies *(continued)*	**You pay**
Not covered: • *Immunizing agents, biological sera, blood, blood products or blood plasma.* • *Drugs and medicines you can get without a physician's prescription, except insulin or niacin for cholesterol lowering.* • *Drugs labeled "Caution, Limited by Federal Law to Investigational Use," experimental drugs. Drugs and medicines prescribed for experimental indications.* • *Any cost for a drug or medicine that is higher than what we cover.* • *Cosmetics, health and beauty aids.* • *Drugs used mainly for cosmetic purposes.* • *Drugs for losing weight, except when needed to treat morbid obesity (for example, diet pills and appetite suppressants).* • *Drugs you get outside the United States.* • *Infusion drugs, except drugs you inject under the skin yourself.* • *Some kinds of drugs which have not been shown to work better or have fewer side effects than those listed on our list of preferred drugs. We will still cover the drug if the physician writes "dispense as written" or "do not substitute."* • *Herbal, nutritional and diet supplements.* • *Drugs to enhance athletic performance.*	*All charges*

Section 5 (g). Special Features

Feature	Description
MedCall (24-hour nurse assessment service)	Your Plan includes MedCall, a 24-hour nurse assessment service to help you make decisions about your medical care. When you call MedCall toll free at **800-977-0037**, be prepared to provide your name, the patient's name (if you're not calling for yourself), the employee's social security number, and the patient's phone number. The nurse will ask you some questions to help determine your health care needs. Based on the information you provide, the advice may be: • Home self-care. A follow-up phone call may be made to determine how well home self-care is working. • Schedule a routine appointment within the next two weeks, or an appointment at the earliest time available (within 64 hours), with your primary care physician. • Call your primary care physician for further discussion and assessment. • To go to an urgent care center used by your primary care physician. • To go to an emergency room used by your primary care physician. • Instructions to immediately call 911. In addition to providing a nurse to help you make decisions about your health care, MedCall gives you free unlimited access to its Audio Health Library featuring recorded information on more than 100 health care topics. To access the Audio Health Library, call toll free 800-977-0037 and follow the instructions given. We have made arrangements with an independent company to make MedCall available to you as a special service. It may be discontinued without notice. **Note: MedCall is an optional service. Remember, the best place to go for medical care is your primary care physician.**

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.
- Your medical group must provide or arrange for your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below. See Hospital benefits (Section 5c).
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit

We cover restorative services and supplies necessary for the initial repair (but not replacement) of sound natural teeth. The need for these services must result from an accidental injury. **You pay nothing.** Care is not covered if you damage or injure your teeth while chewing or biting.

Dental benefits

We have no other dental benefits.

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

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

Optional Dental Benefits – These are separate benefit packages that require additional premiums.

HERE'S AN OPPORTUNITY TO ENHANCE YOUR TOTAL HEALTH CARE PACKAGE BY ADDING COMPREHENSIVE DENTAL BENEFITS

Dental SelectHMO & Dental Net - Dental Maintenance Organization Options: These are plans that offer members broad ranges of dental coverage at a lower cost. Under either plan, members choose their own dentist from a network of providers, and may change their dentist at any time. Once you have enrolled in Dental SelectHMO or Dental Net, your provider will perform preventive and diagnostic services and other dental services free of charge or at a greatly reduced rate.

Key Dental SelectHMO & Dental Net Advantages

- Diagnostic and Preventive Services are FREE
- No Deductibles and No Claim Forms
- Benefits include Orthodontic Coverage

Eyewear Savings Program for Blue Cross-HMO Members at no extra premium

- Instant savings on eyewear
  As a Federal Employee and a member of the Blue Cross-HMO you are now entitled to special savings on frames, lenses (including contact lenses), as well as other important eye care accessories. These savings are available through optical departments located in selected Sears, Montgomery Ward and J.C. Penney stores.
- No Claim Forms
  There are currently more than 135 participating optical departments located throughout California. To receive your eyewear discount, just present your Blue Cross-HMO ID card to the optical department of the stores listed above.

Blue Cross Senior Secure - Medicare prepaid plan (HMO) provides complete coverage for medically necessary hospital and doctor services with no monthly premium, no deductibles and a prescription drug benefit.
Coverage includes:

•Prescription Drug	•Chiropractic Care
•Vision	•Hearing
•Dental	•Podiatry

Blue Cross Senior Secure features all of the health coverage services offered by Medicare plus some extra services Medicare does not offer. Contact Customer Service, toll free 1-888-230-7338 to obtain detailed benefits and a list of providers in your area. As indicated on page 50, you may remain enrolled in FEHBP when you enroll in a Medicare Prepaid Plan.

Benefits on this page are not part of the FEHB contract

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 we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition.**

We do not cover the following:

- 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;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program; or
- Services provided by non-Plan providers unless you receive a referral or the services are for emergency or urgent care.

Section 7. Filing a claim for covered services

How to claim benefits

You normally won't have to submit claims to us unless you receive emergency or urgent case 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. To obtain claim forms or other claims filing advice or answers about our benefits, contact us at 800-235-8631, or at our website at www.bluecrossca.com.

Deadline for filing your claim

Most claims will be submitted for you. However, there is a deadline for filing claims yourself. You must submit claims by December 31 of the year after the year you received the service. OPM can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claims 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 prior approval:

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: Blue Cross of California, P.O. Box 4089, Woodland Hills, Ca. 91365; 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. For additional review information regarding denials of experimental or investigative treatment- go to page 46.
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 II, 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 prior approval, then call us at 800/235-8671 and we will expedite our review; or

(b) We denied your initial request for care or 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 at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

Review of Denials of Experimental or Investigative Treatment. If coverage for a proposed treatment is denied because we or your medical group determine that the treatment is experimental or investigative, you may ask that the denial be reviewed by an external independent medical review organization which has a contract with the California Department of Managed Health Care. To request this review, please call us at the telephone number listed on your identification card or write to us at Blue Cross of California, 21555 Oxnard Street, Woodland Hills, CA 91367. To qualify for this review, all of the following conditions must be met:

- You have a life threatening or seriously debilitating condition. The condition meets either or both of the following descriptions:
  - A life threatening condition or a disease is one where the likelihood of death is high unless the course of the disease is interrupted. A life threatening condition or disease can also be one with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
  - A seriously debilitating condition or disease is one that causes major irreversible morbidity.
- The proposed treatment must be recommended by either (a) a Plan provider or (b) a board certified or board eligible physician qualified to treat you who certifies in writing that the proposed treatment is more likely to be beneficial than standard treatment. This certification must include a statement of the evidence relied upon.
- If this review is requested either by you or by a qualified provider, other than a Blue Cross HMO provider, as described above, the requester must supply two items of acceptable medical and scientific evidence. This evidence consists of the following sources:
  - Peer-reviewed scientific studies published in medical journals with nationally recognized standards;
  - Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, and MEDLARS database Health Services Technology Assessment Research;
  - Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
  - The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
  - Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and
  - Peer reviewed abstracts accepted for presentation at major medical association meetings.

Within five days of receiving your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your physician. Information we receive subsequently will be sent to the review panel within five business days. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days in the case of an expedited review). This timeframe may be extended by up to three days for any delay in receiving necessary records.

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 what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

•What is Medicare

Medicare is a health insurance program for:

- People 65 years of age or 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.

Section 9. Coordinating benefits with other coverage - CONTINUED

Tell us if you or a family member is enrolled in Original Medicare. 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.

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 800/235-8531.
- We will not waive any of the co-payments when you have both our Plan and Medicare.

Section 9. Coordinating benefits with other coverage - CONTINUED

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).

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 or coinsurance 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 or 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, eliminating you 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 plan service area.

•Private Contract

A physician may ask you to sign a private contract agreeing that you can be billed directly for service ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment.

•Enrollment in Medicare Part B

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

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 Plan 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 or party, you must reimburse us for any services we paid for. 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

Blue Cross HMO Coordinator

Blue Cross HMO coordinator is the person at your medical group who can help you with understanding your benefits and getting the care you need.

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 Section 4 – page 12.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See Section 4 - page 12.

Covered services

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

Custodial care

Custodial care is care for your personal needs. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, giving medicine which you usually do yourself or any other care for which the services of a professional health care provider are not needed.

Experimental or investigational services

Experimental procedures are those that are mainly limited to laboratory and/or animal research. Investigative procedures or medications are those that have progressed to limited use on humans, but which are not generally accepted as proven and effective within the organized medical community. Any experimental or investigative procedures or medications are not covered under this Plan. Your medical group or we will determine whether a service is considered experimental or investigative. Please see page 46 for more information.

Medical necessity

Medically necessary procedures, services, supplies or equipment are those that Blue Cross decides are:

- Appropriate and necessary for the diagnosis or treatment of the medical condition;
- Provided for the diagnosis or direct care and treatment of the medical condition;
- Within standards of good medical practice within the organized medical community;
- Not primarily for your convenience, or for the convenience of your physician or another provider; and

- The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

  There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, equipment, service or supply are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and

  Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

  For hospital stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. In most cases, our Plan allowance is equal to a rate we negotiate with providers. This rate is normally lower than what they usually charge and any savings are passed on to you.

Us/We

Us and we refer to Blue Cross of California.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

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

Your medical and claims records are confidential

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

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

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation (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 800/235-8631 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 they try to obtain services for a person who is not an eligible family member, or are no longer enrolled in the Plan and try to obtain benefits. Your agency may also take administrative action against you.

Department of Defense/FEHB Demonstration Project

What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 open season for the year 2000. Open season enrollments will be effective January 1, 2001. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible

DoD determines who is eligible to enroll in the FEHB Program. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

The demonstration areas

- Dover AFB, DE
- Fort Knox, KY
- Dallas, TX
- New Orleans, LA
- Adair County, IA area
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA area

When you can join

You may enroll under the FEHB/DoD Demonstration Project during the 2000 open season, November 13, 2000, through December 11, 2000. Your coverage will begin January 1, 2001. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877/DOD-FEHB (1-877/363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during the 2000 and 2001 open seasons. Your coverage will begin January 1 of the year following the open season during which you enrolled.

If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2001 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at www.opm.gov.

TCC eligibility

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

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

Other features

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

Index

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

Summary of benefits for the Blue Cross- HMO - 2001

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

Benefits	**You Pay**	**Page**
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office.....	$10 office visit copay	14
Services provided by a hospital:		
• Inpatient.....	Nothing	25
• Outpatient (other than emergency room care).....	Nothing	26
Emergency visits to a hospital emergency room or urgent care center:		
• In-area.....	$25 per visit	30
• Out-of-area.....	$25 per visit	30
Mental health and substance abuse treatment.....	Regular cost sharing	31
Prescription drugs	*Network pharmacy: $5 per preferred generic; $10 per brand name drug.* *Non-Network pharmacy: $5 plus 50% of drug limited fee per generic; $10 plus 50% of drug limited fee per brand name drug.* *Mail Order Program: $5 per preferred generic; $20 per brand name drug.*	37
Dental Care.....	Restorative services for accidental injury: you pay nothing. No other dental benefits.	40
Vision Care.....	Annual eye refraction; you pay nothing.	18
Special features: MedCall, a 24-hour nurse assessment service.		39
Protection against catastrophic costs (your out-of-pocket maximum).....	Nothing after $1,000/Self Only or $3,000/Family enrollment per year Some costs do not count toward this protection	12

2001 Rate Information for
Blue Cross- HMO

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

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

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Most of California							
High Option Self Only	M51	$70.56	$23.52	$152.88	$50.96	$83.50	$10.58
High Option Self and Family	M52	$180.02	$60.00	$390.03	$130.01	$213.02	$27.00