BluegrassFamily Health

http://www.bgfh.com

2001

A Health Maintenance Organization with a point of service product

Serving: Kentucky

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

Enrollment codes for this Plan:

Central and Eastern Kentucky
- **2B1 Self only**
- **2B2 Self and Family**

South Central Kentucky
- **BD1 Self only**
- **BD2 Self and Family**

Western Kentucky
- **BH1 Self only**
- **BH2 Self and Family**

Retirement and Insurance Service

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OPM United States Office of Personnel Management
Retirement and Insurance Service

FEHB
Federal Employees Health Benefits Program

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Introduction

Bluegrass Family Health, Inc.
651 Perimeter Drive, Suite 300
Lexington, KY 40517

This brochure describes the benefits of Bluegrass Family Health, Inc. under our contract (CS 2728) 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 Bluegrass Family Health, Inc.

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

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

Section 1. Facts about this HMO plan

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

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

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

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

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. The Plan providers that we contract with, may have financial incentives or risk sharing relationships. These are for controlling the cost of health care and are not to limit or reduce any medically necessary services.

Who provides my health care?

We are an Individual Practice Prepayment (IPP) HMO located in Lexington, Kentucky. Our provider network includes 65 participating hospitals and approximately 1,010 primary care doctors and over 2,073 specialists who practice out of their own offices.

Patients' Bill of Rights

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

- Bluegrass Family Health, Inc. is licensed as a health maintenance organization to provide comprehensive health care services.
- We are a not-for-profit organization and have been in business since 1993.

If you want more information about us, call 859/269-4475 or 800/787-2680, or write to Bluegrass Family Health, Inc., 651 Perimeter Drive, Suite 300, Lexington, KY 40517. You may also contact us by fax at 859/335-3700 or visit our website at www.bgfh.com.

Service Area

To enroll with us, you must live or work in our Service Area. This is where our providers practice. Our service area is the following counties in Kentucky:

Central & Eastern Region Code 2B			**South Central Region Code BD**	**Western Region Code BH**
Adair	Harrison	Mercer	Allen	Ballard
Anderson	Henry	Montgomery	Barren	Caldwell
Bath	Jackson	Morgan	Butler	Calloway
Bell	Jefferson	Nicholas	Cumberland	Carlisle
Bourbon	Jessamine	Oldham	Edmonson	Crittenden
Boyle	Johnson	Owen	Hart	Fulton
Bracken	Knott	Owsley	Logan	Graves
Breathitt	Knox	Pendleton	Metcalfe	Hickman
Casey	Laurel	Perry	Monroe	Livingston
Clark	Lee	Pike	Simpson	Lyon
Clay	Leslie	Powell	Warren	Marshall
Estill	Letcher	Pulaski		McCracken
Fayette	Lincoln	Robertson		
Fleming	Madison	Rockcastle		
Floyd	Magoffin	Rowan		
Franklin	Marion	Scott		
Garrard	Martin	Shelby		
Grant	Mason	Spencer		
Green	McCreary	Taylor		
Harlan	Menifee	Washington		
		Whitley		
		Wolfe		
		Woodford		

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care or point-of-service benefits. We will not pay for any other health care services. If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare quality and patient safety. OPM asked all FEHB plans to join them in this effort. You can find specific information on our patient safety activities by calling Customer Service at 859/269-4475 or 800/787-2680, **or** checking our website *at www.bgfh.com*. 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 23.9% for Self Only or 119.9% for Self and Family.
- This Plan will not offer the In-Plan Self-Referral Point of Service (POS) benefit level for the 2001 plan year. We now offer two levels of benefits. If you go to an in-network provider, you will receive HMO benefits. If you go to a non-plan provider, you will receive non-plan benefits. You no longer need to select a primary care physician. You no longer need a referral from your primary care physician to see a specialist.
- We changed the urgent care center copayment to a $20 copayment at all benefit levels.
- We increased the non-plan deductible to $700 for self only and $1,400 for self and family at the Non-Plan (POS) benefit level.
- We added an out-of-pocket limit to the HMO benefit level up to $2,500 per individual.
- We increased the out-of-pocket limit to $5,000 per individual at the Non-Plan (POS) benefit level.
- We increased the outpatient surgery copayment to $75 per procedure at the HMO benefit level.
- We changed the ambulance copayment to $50 (waived if admitted) at all benefit levels.
- We changed the prescription drug benefit to a 3-tier copayment level of $5 for generic, $10 for formulary brand name and $25 for non-formulary at the HMO benefit level for a 30-day supply.
- We reduced the allergy injection copayment to $5 per visit at the HMO benefit level and 30% per visit after the deductible at the Non-Plan (POS) benefit level.
- We increased the physical/occupational/speech rehabilitative therapy copayment to $20 per session at the HMO benefit level.
- We reduced the chiropractic services and cardiac rehabilitation therapy benefit to 20 visits per calendar year at $20 per visit at the HMO benefit level and to 20 visits per calendar year at the Non-Plan (POS) benefit level. The POS coinsurance has not changed
- We reduced the extended care/skilled nursing facility benefit to 30 days per calendar year with a $150 copayment per admission at the HMO benefit level.

- We reduced the extended care/skilled nursing facility benefit to 30 days per calendar year at the Non-Plan (POS) benefit level. The POS coinsurance has not changed.
- We increased the copayment for durable medical equipment, prosthetic and orthotic devices to 20% coinsurance at the HMO benefit level.
- We added a Hospice Non-Plan (POS) benefit with 30% coinsurance after deductible.
- We added a vision Non-Plan (POS) benefit with 30% coinsurance after the deductible for one eye exam every 12 month period for members up to age 17 and one eye exam every 24 month period for members 18 years of age and older.
- We will cover blood glucose monitors, insulin pumps and appurtenances under durable medical equipment with 20% coinsurance at the HMO benefit level. We will cover insulin syringes, testing strips, injection aids, insulin infusion devices, and oral agents for controlling sugar under our Prescription Drug benefit.
- We have expanded our service area to include the Kentucky counties of Allen, Barren, Butler, Caldwell, Crittenden, Cumberland, Edmonson, Fulton, Graves, Hart, Henry, Jefferson, Logan, Martin, Metcalfe, Monroe, Oldham, Shelby, Simpson, Spencer, and Warren.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 859/269-4475 or 800/787-2680.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance, and you will not have to file claims. If you use our point-of-service program, you can also get care from non-Plan providers, or from participating providers.

- **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, while you are not required to notify us, you and each family member should choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. You and each family member should select a PCP. Every family member does not have to select the same PCP.

- **Primary care**

Your primary care physician can be a family practitioner, internist or pediatrician or general practitioner. Your primary care physician will provide most of your health care.

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**

A referral is no longer needed to see a specialist.

Here are other things you should know about specialty care:

- If you are seeing a specialist and your specialist leaves the plan, call us and we will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:

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

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

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

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 859/269-4475 or 800/787-2680. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

Circumstances beyond our control

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

Services requiring our prior approval

For certain services, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process Prior Authorization of Health Care Services. Your physician must obtain prior authorization for the following services but not limited to:

- Cataract surgery
- Chiropractic services (through American Chiropractic Network)
- Cochlear implant
- Colonoscopy
- Dental procedures (accidental injury benefit only)
- Dialysis
- Durable Medical Equipment (purchases over $500 and ALL rentals, see below)

- Home health, including infusion therapy (see below)
- Hospice
- Inpatient admissions
- Medications
  - Growth Hormone
  - Hyalgan®
  - Synvisc®
  - Synagis®
  - Injectable drug prescriptions
- Mental Health/Substance Abuse
- Nutritional counseling/education
- Orthotics (see below)
- Pain Management
- Podiatric (foot) procedures/surgery
- Prosthetics (see below)
- Radiology procedures (MRI, OB Ultrasound, except first ultrasound, bone density)
- Reconstructive procedures (requires written request with documentation of medical necessity)
- Blepharoplasty
- Breast reconstruction (excludes reconstruction following mastectomy for treatment of cancer)
- Mammoplasty, reduction
- Rhinoplasty
- Sclerotherapy/stripping and ligation of veins
- Septoplasty
- Skilled nursing/acute rehab facilities
- Therapy services (cardiac rehabilitation, physical therapy, occupational therapy and speech therapy)
- Transplants (through Case Management, see below)

1. **In-hospital Services**
   Except for emergencies, your Plan physician must obtain Plan pre-authorization for all hospital admissions. Emergency admissions require notification as soon as reasonably possible.

2. **Organ Transplants**
   The Plan contracts with a national network of organ transplant facilities based on quality and outcomes. Candidates for an organ transplant are assigned a case manager who assists with pre- and post-transplant care and ongoing treatment. **All organ transplants require prior Plan approval.**

3. **Mental Health and Substance Abuse**
   If you and your Plan physician determine these services are needed, your Plan physician will refer you to the Plan's mental health provider. You or your Plan physician may contact the Plan's mental health provider's toll-free line directly to obtain pre-authorization for your care. Your treatment needs will be assessed and the necessary services will be arranged to be provided by the most appropriate mental health professionals.

4. **Home Health Care**
   Any recommendation of home health care services by your Plan physician as a means to avoid or reduce hospitalization must first be pre-authorized by the Plan for medical necessity.

5. **Durable Medical Equipment**
   If you have a condition requiring durable medical equipment, the Plan will work with you and your Plan physician to determine the equipment covered under your benefit plan and to make the appropriate arrangements. Purchases in excess of $500 and **all** rentals of durable medical equipment must receive prior Plan approval to ensure that it is (a) designed and able to withstand repeated use; (b) used primarily for medical purposes; (c) mainly and customarily used to service a medical purpose; and (d) suitable for use in the home.

6. **Orthotics and Prosthetics**
   Your Plan physician must obtain pre-authorization of any appliance, device, or supply that is used to (a) replace all or part of an absent body part or (b) replace all or part of the function of a permanently inoperative or malfunctioning body part.

7. **Prescription Drugs**
   Certain prescription drugs must also be preauthorized by the Plan.

8. **Medical Technology**
   Bluegrass Family Health continually evaluates new medical technology for benefit inclusion. The member can request a technology review through their Plan physician or specialist who then directs the question to the Plan. Decisions to include new medical technology are made following an extensive review of the medical and scientific literature, communication with medical experts as appropriate, and review by participating Plan physicians.

   FOR PRE-AUTHORIZATION, PLEASE CALL MEDICAL MANAGEMENT COORDINATORS AT 800/787-2680 OR 859/269-4475.

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 Plan physician you pay a copayment of $10 per office visit.

•Deductible

There is no deductible for HMO benefits.

•Coinsurance

For HMO benefits coinsurance is the percentage of our negotiated fee that you must pay for your care. For Point of Service benefits coinsurance is the percentage of our allowance that you must pay plus any remaining balance after our payment.

Example: In our Plan, you pay 50% coinsurance of our negotiated fee for infertility services and 20% coinsurance for durable medical equipment.

Your out-of-pocket maximum, coinsurance, and copayments

After your copayments and/or coinsurance, total $2,500 per person using the HMO benefits level in any calendar year, you do not have to pay any more for covered services. However, coinsurance and copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments and coinsurance for these services:

- Prescription drugs

Be sure to keep accurate records of your copayments and coinsurances 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 58 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 more information about our benefits, contact us at 859/269-4475 or 800/787-2680 or at our website at www.bgfh.com.

Section 5 (a) Medical services and supplies provided by physicians and other health care professionals

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for the HMO benefit level.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion	$10 per office visit
• During a hospital stay • Initial examination of a newborn child covered under a family enrollment • In a skilled nursing facility	Nothing
• In an urgent care center	$20 per visit
At home	$10 per visit

Diagnostic and treatment services -- *continued on next page*

Diagnostic and treatment services *(continued)*	You pay
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing if you receive these services during your office visit; otherwise, $10 per office visit
Preventive care, adult	

Routine screenings, such as:
• Blood lead level – One annually
• Total Blood Cholesterol – once every three years, ages 19 through 64
• Colorectal Cancer Screening, including
  ••Fecal occult blood test
  ••Sigmoidoscopy, screening – every five years starting at age 50
• Prostate Specific Antigen (PSA test) – one annually for men age 40 and older
• Routine pap test
Note: The office visit is covered if pap test is received on the same day; see *Diagnostic and Treatment Services*, above.
	$10 per office visit

Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years Note: In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.	$10 per office visit

Preventive care, adult -- *continued on next page*

Preventive care, adult (*continued*)	**You pay**
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.*	*All charges*
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	$10 per office visit
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit
• Examinations, such as: ••Eye exams through age 17 to determine the need for vision correction. ••Ear exams through age 17 to determine the need for hearing correction. ••Examinations done on the day of immunizations (through age 22) • Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per office visit
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You need to notify us once you know you are pregnant so that we can enroll you in our Special Delivery Maternity Care Program. • You need to precertify your normal delivery, see page 10 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment.	$10 per office visit; $100 maximum per pregnancy

Maternity care -- *continued on next page*

Maternity care *(continued)*	**You pay**
• 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; $100 maximum per pregnancy
Not covered: • *Routine sonograms to determine fetal age, size or sex*	*All charges*
Family planning	
• Voluntary sterilization—tubal ligation or vasectomy	$50 per procedure
• Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per office visit. There is no charge when the device is implanted during a covered hospitalization. There will be no refund of any portion of these copays if the implanted time-release medication is removed before the end of its expected life.
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling,*	*All charges*
Infertility services	
Diagnosis and treatment of infertility	$10 per office visit
Artificial insemination, limited to: •• *intravaginal insemination (IVI)* •• *intracervical insemination (ICI)*	50% Coinsurance
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* •• *in vitro fertilization* •• *embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Fertility Drugs*	*All charges*

Allergy care	You Pay
Testing and treatment given in the physician's office Allergy injection given in the physician's office	$5 per office visit
Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*
Treatment therapies	
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 26. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) – Drugs covered under Prescription drug benefit. See page 36. Note: – We will only cover GHT when we preauthorize the treatment. Call 859/269-4475or 800/787-2680 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$10 per office visit.
Rehabilitative therapies	
Physical therapy, occupational therapy and speech therapy -- • 2 consecutive months per condition for the services of each of the following: •• qualified physical therapists;	$20 per office visit

Rehabilitative therapies -- *continued on next page*

Rehabilitative therapies (*continued*)	You pay
•• speech therapists (limited to treatment of certain speech impairments of organic origin); and •• occupational therapists (limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living). Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 20 visits per calendar year. • Chiropractic therapy—the treatment by manual and physical means, including therapy and spinal manipulations is provided for up to 20 visits per calendar year.	$20 per office visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges*
Hearing services (testing)	
• Hearing testing if performed because of an illness or injury • Hearing testing for children if performed because of an illness or injury	$10 per office visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges*
Vision services (testing)	
In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, this Plan covers eye refractions, including written lens prescriptions, from Plan providers every 12 month period for members up to age 17 and every 24 month period for members ages 18 and over.	$10 per office visit
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*

Foot care	You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)* • *Foot orthotics*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose. • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy. • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	20% Coinsurance
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *prosthetic replacements provided less than 3 years after the last one we covered*	*All charges*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds; • standard wheelchairs; • apnea monitors • crutches; • walkers; • blood glucose monitors; and • insulin pumps. Note: Call us at 859/269-4475 or 800/787-2680 as soon as your Plan physician prescribes this equipment. Purchases in excess of $500 and **all** rentals of durable medical equipment must receive prior Plan approval.	20% Coinsurance
Not covered: • *Motorized wheel chairs* • *Vehicles* • *Air purifiers* • *Ramps* • *Stairs glides* • *Whirlpool baths*	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications when prescribed by your plan doctor, who will periodically review the program for continuing appropriateness and need.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Care by nurses primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.* • *Custodial care or rest cures* • *Domiciliary or convalescent care*	*All charges*

Alternative treatments	You pay
No Benefit	No Benefit
Not covered: • *Acupuncture* • *Anesthesia by hypnosis* • *Naturopathic services* • *Hypnotherapy* • *Biofeedback*	*All charges*
Educational classes and programs	
Coverage is limited to: • Smoking Cessation--Up to $100 for one smoking cessation program per member per lifetime, excluding all related expenses such as drugs (see page 36) • Diabetes self-management training and education, including nutrition therapy	$10 per office visit
Not covered: • *Services, supplies or other care for educational or training procedures used in connection with speech, hearing or vision.*	*All charges*

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for the HMO benefit level.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
Such as: • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over and the condition has developed to be of life-threatening nature. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information. • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a). • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$10 per office visit; nothing for hospital visits.
• Voluntary sterilization—tubal ligation or vasectomy	$50 per procedure

Surgical procedures -- *continued on next page*

Surgical procedures *(continued)*	**You pay**
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes.	$10 per office visit if performed in a physician's office; otherwise you pay nothing.
• All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury.* • *Surgeries related to sex transformation.*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Other surgical procedures that do not involve the teeth or their supporting structures; and	$10 per office visit if performed in a physician's office; otherwise you pay nothing.

Oral and maxillofacial surgery -- *continued on next page*

Oral and maxillofacial surgery (*continued*)	**You pay**
• Surgical treatment for Temporomandibular Joint Disorder (TMJ) services included in a treatment plan authorized by the Plan prior to surgery.	$10 per office visit if performed in a physician's office; otherwise you pay 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	
Limited to: • Cornea • Heart • Heart/lung • Lung • Pancreas/kidney • Kidney • Liver • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • United Resource Network (URN) is the transplant program. Please call the Plan at 800/787-2680 or 859/269-4475 for prior authorization and the list of Participating facilities. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

Anesthesia	You pay
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center	Nothing
Professional services provided in – • Office	$10 per office visit

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).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

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.	$100 per admission
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment and any covered items billed by a hospital for use at home	See above
Not covered: • *Custodial care, rest cures* • *Non-covered facilities, such as nursing homes, extended care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Take-home items* • *Blood and blood derivatives not replaced by the member*	*All charges*

Outpatient hospital or ambulatory surgical center	You pay
• Operating, recovery, and other treatment rooms	$75 per admission
• Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: • *Blood and blood derivatives not replaced by the member*	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Limited to 30 days per calendar year	$150 copay per admission
Not covered: • *Custodial care, rest cures* • *Domiciliary or convalescent care*	*All charges*
Hospice care	
We cover supportive and palliative care for a terminally ill member in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less	Nothing
Not covered: • *Independent nursing* • *Homemaker services*	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	$50 per trip (waived if admitted)

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure.
- We have no calendar year deductible for the HMO benefit level.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

If you are in an emergency situation, you should go to the nearest medical facility, for, at least, emergency screening and stabilization services. In extreme emergencies, contact the local emergency system (e.g. the 911 telephone system) or go to the nearest hospital emergency room.

Emergencies within our service area:

Be sure to tell emergency room personnel that you are a member of this Plan so they can notify us. Or a family member should notify us within 48 hours unless it is not reasonably possible to do so. It is your responsibility to ensure that we have been timely notified.

We cover any medically necessary health service that is immediately required because of injury or unforeseen illness.

Emergencies outside our service area:

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

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

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by us or provided by Plan providers except as covered under Point of Service benefits.

We pay reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

Emergency services/accidents -- *continued on next page*.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$10 per office visit
• Emergency care as an outpatient at a hospital, including doctors' services	$50 per visit (waived if admitted)
• Emergency care at an urgent care center	$20 per visit
Not covered: • *Elective care or non-emergency care*	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office	$10 per visit
• Emergency care at an urgent care center	$20 per visit
• Emergency care as an outpatient at a hospital including doctors' services	$50 per visit (waived if admitted)
Not covered: • *Elective care or non-emergency care except as covered under Point of Service benefits.* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area except as covered under Point of Service benefits.* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area except as covered under Point of Service benefits.*	*All charges*
Ambulance	
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	$50 per trip (waived if admitted)
Not covered: • *Air ambulance*	*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.

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

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

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

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per visit
• Diagnostic tests	Nothing if you receive these services during your office visit; otherwise, $10 per visit
• Services provided by an inpatient hospital or other inpatient facility	$100 per admission

Mental health and substance abuse benefits - continued on next page

Mental health and substance abuse benefits *(continued)*	**You pay**
• We cover therapeutic, respite and rehabilitative care for a member age 2 through 21 for the treatment of Autism for up to $500 per month. The maximum dollar limit for this benefit shall not apply to other health or mental health conditions of the member, which are not related to the treatment of Autism.	Copay amount applicable to the service provided.
Not covered: • *Services we have not approved* • *Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment.* • *Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate.* • *Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition.* *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Preauthorization

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

- If you and your physician determine these services are needed, your physician will refer you to this Plan's mental health provider. You or your physician may contact this Plan's mental health provider's toll-free line directly to obtain pre-authorization for your care. Your treatment needs will be assessed and the necessary services will be arranged to be provided by the most appropriate mental health professionals. Saint Joseph Behavioral Medicine Network, Inc., mental health provider, must be contacted to initiate a referral to one of the participating providers. Saint Joseph Behavioral Medicine Network's phone numbers are 859/224-2022 and 800/455-5579. A list of these providers is included in the provider directory.

Network Benefit -- *continued*

Special transitional benefit

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

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

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

Network limitation

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

How to submit network claims

You normally won't have to submit claims to us unless you receive services from a provider who doesn't contract with us, or you use point-of-service (POS) benefits from a non-Plan provider. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

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

IMPORTANT

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

- **Who can write your prescription.** A licensed physician or appropriately licensed physician extender with prescriptive authority (nurse practitioner, physician's assistant, etc.), a licensed dentist if as a result of accidental injury.
- **Where you can obtain them.** You may fill the prescription at a participating pharmacy, a non-plan pharmacy, or by mail. We pay a higher level of benefits when you use a network pharmacy.
  - If you use a non-plan pharmacy, you will receive non-plan benefits unless it is for urgent or emergent care.
  - You may receive maintenance medications through the mail-order program through FamilyMeds. You may order mail-order medications via fax, US mail or the Internet. The Internet address is www.FamilyMeds.com, the phone number is 888/787-2800 and the fax number is 888/787-2822 for FamilyMeds.
- **We use a formulary.** A formulary is a list of preferred medications.
  - You will pay a different copayment depending on whether or not the prescribed drug is on the formulary; generic, formulary brand or non-formulary.
- **These are the dispensing limitations.** Benefits for covered prescription drugs are limited to quantities that can be used in a month. Some covered medications may have additional quantity limits.
  - You can receive a 30-day supply for one copayment amount.
  - Mail order is only available for maintenance medications. You can order a 3-month supply for 3 copayments when using FamilyMeds, mail-order maintenance medication service. A minimum mail-order requirement is a 3-month supply.
  - The pharmacy benefit is a 3-tier benefit depending on the 3 levels: generic, formulary brand and non-formulary. The copayment amounts are listed in the next section "Covered medications and supplies".
- **When you have to file a claim.**
  - If you use a participating pharmacy, you will not have to file a claim.
  - If you use a non-participating pharmacy, you will have to file a claim with Bluegrass Family Health, Inc.
  - You must present your ID card at the participating pharmacies for prescription benefits.

Prescription drug benefits – *continued on the next page*

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Cancer drugs if the drug prescribed is recognized as safe and effective in the official compendium or in medical literature. • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. • Oral and injectable contraceptive drugs; contraceptive devices, diaphragms and IUDs • Insulin; a copay charge applies to each vial. • Oral agents for controlling sugar. • Disposable needles and syringes, testing strips, injection aids and other diabetic supplies necessary for the treatment of diabetes.	$5 per Generic $10 per Formulary Brand $25 per Non-formulary 3-month supply of maintenance medications for 3 copayments through mail-order service Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
• Drugs for sexual dysfunction are limited.	50% of charges up to a 8-dose monthly limit
Here are some things to keep in mind about our prescription drug program: • When a generic version of a drug exists, the generic is the preferred product and the brand name is the non-formulary product and is on the non-formulary list. If you request a name brand drug when your physician has ordered or approved a generic, you will pay the non-formulary copayment plus the cost difference between the non-formulary drug and the generic drug. • We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost.	
Not covered: • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Medical supplies such as dressing and antiseptics* • *Drugs and supplies for cosmetic purposes and to enhance athletic performance* • *Smoking cessation drugs and medication, including nicotine patches* • *Non FDA approved drugs* • *Fertility drugs*	*All charges*

Section 5 (g). Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
High risk pregnancies	Bluegrass Family Health has a Special Delivery Maternity Program that evaluates all pregnant members to promote healthy outcomes for mother and baby.

Section 5 (h). Dental benefits

IMPORTANT

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

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

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury and services must be initiated within 30 days of the injury. Injury as a result of chewing or biting is not considered an accidental injury.	$10 per office visit $50 per emergency room visit $100 per hospital admission $75 per outpatient surgery procedure

Dental benefits

We have no other dental benefits.

Section 5 (i). Point of service benefits

Point of Service (POS) Benefits--Facts about this Plan's POS option

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

What is covered

All services listed in Section 5 are covered under the POS benefits except for preventive care, infertility and transplant benefits. Benefits are payable according to the following chart.

Service	Non-Plan Providers Member Pays
Deductible	$700 Self Only/$1,400 Self and Family
Out-of-Pocket maximum	$5,000
Inpatient Hospital	30% Coinsurance after Deductible
Outpatient Hospital	30% Coinsurance after Deductible
Outpatient Surgery	30% Coinsurance after Deductible
Office Visit	30% Coinsurance after Deductible
Diagnostic Tests (unless provided during an office visit)	30% Coinsurance after Deductible
Allergy Injections	30% Coinsurance after Deductible
Maternity Visits	30% Coinsurance after Deductible
Hospital Emergency Room	$50 Copay per visit (waived if admitted)
Ambulance (ground only)	$50 Copay per trip (waived if admitted)
Urgent Care Center	$20 Copay per visit
Inpatient Mental Health	30% Coinsurance after Deductible
Outpatient Mental Health	30% Coinsurance after Deductible
Inpatient Substance Abuse	30% Coinsurance after Deductible
Outpatient Substance Abuse	30% Coinsurance after Deductible
Physical/Occupational/ Speech Therapy	30% Coinsurance after Deductible (up to 2 consecutive months)
Cardiac Rehab Therapy	30% after Deductible (20 visits per calendar year)
Chiropractic Therapy	30% Coinsurance after Deductible (20 visits per calendar year)
Home Health Care	30% Coinsurance after Deductible
Extended Care/Skilled Nursing Facility	30% Coinsurance after Deductible (30 days per calendar year)
DME, Prosthetic and Orthotic Devices	30% Coinsurance after Deductible
Hospice	30% Coinsurance after Deductible
Infertility	Not covered
Vision	30% Coinsurance after Deductible 1 Exam every year up to age 17; 1 exam every other year 18 and older
Prescriptions (30-day supply)	30% Coinsurance after Deductible
Tubal Ligation	30% Coinsurance after Deductible
Vasectomy	30% Coinsurance after Deductible
Autism	30% Coinsurance after Deductible, $500 monthly benefit, Copay applicable to service provided

Point of Service benefits -- *continued on the next page*

Section 5 (i). Point of service benefits (*continued*)

Precertification

Your Plan doctor is responsible for obtaining approval for determination of medical necessity before you may be hospitalized. **You** are responsible for verifying pre-certification requirements when using your POS benefits or seeing non-Plan providers and receiving services that require authorization. To verify Precertification you may call 800/787-2680 or 859/269-4475. **You pay** a Precertification penalty of $500 when you receive covered services that require authorization but have not been authorized. **SERVICES THAT ARE NOT MEDICALLY NECESSARY ARE NOT COVERED.**

Deductible

The Deductible applies to all covered services received from non-Plan providers except for hospital emergency room treatment. The Deductible must be satisfied each calendar year before benefits are paid. The Deductible does not apply to the out-of-pocket maximum. The Family Deductible is satisfied when one covered person satisfies an Individual Deductible in a calendar year, and the remaining covered persons together satisfy an amount equal to one Individual Deductible in a calendar year. **You pay** no Deductible for services received from a Plan doctor. **You pay** $700 for Self only enrollment and **you pay** $1,400 for Self and Family Enrollment for services received from non-Plan doctors.

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

And, if you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to any deductible of your new option. If you change plans during the year, you must begin a new deductible under your new plan.

Coinsurance

Coinsurance is calculated based on eligible expenses for the services provided. **You pay** 30% Coinsurance for most services received from non-Plan doctors. Coinsurance is subject to Plan allowances. You are responsible for all charges that exceed the Plan allowance.

Maximum Lifetime Benefit

There is no maximum lifetime benefit.

Annual Out-of-Pocket Limit

The annual out-of-pocket is the maximum amount that may be incurred by an individual or a family in a calendar year. After the out-of-pocket limit is satisfied, the Plan pays 100% of the Plan allowance for covered services. Expenses that apply to the out-of-pocket limit are copayments and coinsurance for covered services. Expenses that do not apply to the out-of-pocket limit include the Deductible, charges exceeding Plan allowances, all expenses for non-covered services, non-FEHB benefits and penalties for failure to obtain required pre-certification and compliance with Plan delivery system rules. **You pay** a maximum of $2,500 out-of-pocket per individual for HMO benefits and **you pay** $5,000 out-of-pocket per individual for non-Plan benefits.

Hospital/Extended Care

The Plan provides a wide range of benefits with no dollar limit when you are hospitalized by your Plan doctor. **You pay** 30% Coinsurance after any applicable deductible per admission for non-Plan hospitalizations or extended care not arranged by your Plan doctor. This does not include any copayment or coinsurance that applies to doctor's services.

Point of Service benefits -- *continued on the next page*

Section 5 (i). Point of service benefits (*continued*)

Emergency Benefits

Emergencies are always paid as an In-Plan benefit.

Mental Conditions/Substance Abuse Benefits

Inpatient mental conditions and inpatient substance abuse benefits are covered. **You pay** a $100 copay per admission for each benefit for plan doctors/facilities and **you pay** 30% Coinsurance after any applicable deductible for non-Plan doctors/facilities. Outpatient mental conditions and outpatient substance abuse benefits are covered. **You pay** a $10 copay per visit for Plan doctors/facilities and **you pay** 30% Coinsurance after any applicable Deductible for non-Plan doctors/facilities.

What is not Covered

Preventive care, fertility and transplant benefits are not covered when received from non-Plan providers.

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

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

ConcordiaPLUS Dental Plan

At Bluegrass Family Health we know that dental health is an important part of your family's wellness. Therefore, Bluegrass Family Health is pleased to offer its members the opportunity to receive dental benefits through United Concordia. It is a comprehensive plan that emphasizes preventive and diagnostic care, generally by covering such services in full or with only a nominal copayment.

To enroll in this dental plan, you must be enrolled in Bluegrass Family Health, complete and sign the ConcordiaPLUS enrollment form. ConcordiaPLUS premiums are payable to United Concordia on an annual basis by check, Visa or MasterCard.

ConcordiaPLUS covered services include preventive and diagnostic services such as but not limited to, oral exams and bitewing x-rays. Restorative services include, but are not limited to, routine filings, simple extraction and crowns.

This optional plan is available to Federal employees during the scheduled Federal open enrollment period for coverage effective January 1, 2001. Federal employees who do not enroll at this time will not be eligible for these dental benefits until the next open enrollment period. For more information regarding the ConcordiaPLUS dental health plan, please contact United Concordia at 800/822-3368.

This is not a contract. For a complete schedule of benefits, please see your ConcordiaPLUS Certificate of Coverage.

Bluegrass Family Health, Inc. "Health Helpers"

As a Bluegrass Family Health member, you are eligible for Health Helper discounts of 10% to 25% on Optical, Wellness and Dental needs from the providers listed on the Health Helper page of the Plan's Provider Directory.

Optical Discounts

Optical services are not a covered benefit under the FEHB benefits program. To accommodate those members who need optical services, Plan members may obtain services such as vision exams, glasses and contacts lenses at a discounted fee from the providers listed on the Health Helper page of the Plan's Provider Directory.

Wellness Discounts

Bluegrass Family Health has made arrangements with businesses to give HMO Members a substantial discount on their fitness services. Wellness is a big part of our plan and Bluegrass Family Health has decided to do all we can to assist our Members in that area. All you need to do is show your ID Card and these discounts can be yours at the establishments listed on the Health Helper page of the Plan's Provider Directory.

Dental Discounts

Bluegrass Family Health members can enjoy discounts on Dental services from certain dentist. Many dentists have agreed to supply preventive dental services at a discounted rate for orthodontic, restorative, surgical and other dental needs. We, at Bluegrass Family Health, Inc., wish to assist our members in any way we can to have the best possible treatment in all areas of your health and Health Helpers is how we are able to do this. Please refer to the list of dentists on the Health Helper page of the Plan's Provider Directory.

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

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

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical, hospital and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 859/269-4475 or 800/787-2680.

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

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

Submit your claims to:
Bluegrass Family Health, Inc.
651 Perimeter Drive, Suite 300
Lexington, KY 40517
Phone numbers: 859/269-4475
800/787-2680
Fax number: 859/335-3700

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Bluegrass Family Health, Inc., 651 Perimeter Drive, Suite 300, Lexington, KY 40517*;* and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436.

Disputed Claims Process -- *continued on the next page*

The Disputed Claims process (*Continued)*

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

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

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must provide a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

6 If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs or supplies. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 859/269-4475 or 800/787-2680 and we will expedite our review; or

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division III at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

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

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

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

•What is Medicare?

Medicare is a Health Insurance Program for:

•• People 65 years of age and older.

•• Some people with disabilities, under 65 years of age.

•• People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

•• Part A (Hospital Insurance). Most people do not have to pay for Part A.

•• Part B (Medical Insurance). Most people pay monthly for Part B.

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

•The Original Medicare Plan

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

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. We will not waive any of our copayments, coinsurance and deductibles.

The following chart illustrates whether Original Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…		
a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB		✓
Ask your employing office which of these applies to you.		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or	✓	
b) Are an active employee		✓

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

- 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 Customer Service at 859-269-4475, 800-787-2680 or visit us at on the Internet at www.bgfh.com.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

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

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan eliminating your FEHB premium (OPM does not contribute to your Medicare managed care plan premium). For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare+Choice service area.

- **Enrollment in Medicare Part B**

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

TRICARE

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 13.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 13.

Covered services

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

Custodial care

Custodial care is care that is mainly maintenance care or care to assist the patient in meeting activities of daily living which does not treat an illness, disease, accidental injury or condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications not requiring constant attention of trained medical personnel.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 13.

Experimental or investigational services

Experimental or investigational services will be determined by the Plan's Chief Medical Officer and the Director of Quality Outcomes. These determinations will be based on using FDA Guidelines and Hayes Technology, an outside consultant.

Medical necessity

Medical necessity means that care or treatment is required to identify or treat an illness or injury. Treatment needed must be appropriate with regard to standards of good medical practice. Medical necessity is determined by us.

Plan allowance

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

- Usual, Customary & Reasonable (UCR) amount
- UCR is the amount that we determine to be the Plan allowance for a particular service. We use our standard payment schedule to determine UCR. You will only be responsible for copays and coinsurance when you use Plan providers. You will not have to pay for any amount charged that is above the plan allowance. However, if you use non-Plan providers, you will be responsible for any deductible, copay or coinsurance plus any amount above the Plan allowance.

Us/We

Us and we refer to Bluegrass Family Health, Inc.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

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

Your medical and claims records are confidential

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

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

When you retire

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

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

- **TCC**

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

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

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

•Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Inspector General Advisory

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 859/269-4475 or 800/787-2680 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Index

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

NOTES:

Summary of benefits for the Bluegrass Family Health, Inc. HMO Plan - 2001

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

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $10 per visit for primary care and specialist	15
Services provided by a hospital:		
• Inpatient.....	$100 Copay per admission	28
• Outpatient	$75 Copay per admission	29
Emergency benefits:		
• In-area	$50 copay per visit (waived if admitted)	31
• Out-of-area	$50 copay per visit (waived if admitted)	31
Mental health and substance abuse treatment	Regular cost sharing	32
Prescription drugs	Generic $5 Copay; $10 Formulary Brand; $25 Non-formulary, Drugs for sexual dysfunction-50% of charges up to the dosage limits	36
Dental Care.....	Accidental injury benefit; you pay nothing	38
Vision Care.....	One refraction every 12 month period for members up through age 17 and every 24 month period for members ages 18 and over. You pay a $10 copay per visit	20
Special features: Flexible benefits option, High risk pregnancies, ……		37
Point of Service benefits – Yes ……..		39
Protection against catastrophic costs (your out-of-pocket maximum).....	Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $2,500 per individual in any calendar year. You don't have to pay any more for covered services except for the listed exceptions.	13

2001 Rate Information for
Bluegrass Family Health

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

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

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Central/Eastern Kentucky							
Self Only	2B1	$86.59	$34.84	$187.61	$75.49	$102.22	$19.21
Self and Family	2B2	$195.82	$119.89	$424.28	$259.76	$231.17	$84.54
South Central Kentucky							
Self Only	BD1	$86.59	$39.62	$187.61	$85.85	$102.22	$23.99
Self and Family	BD2	$195.82	$132.33	$424.28	$286.71	$231.17	$96.98
Western Kentucky							
Self Only	BH1	$86.59	$42.02	$187.61	$91.05	$102.22	$26.39
Self and Family	BH2	$195.82	$138.55	$424.28	$300.19	$231.17	$103.20

Addendum

to the

Bluegrass **Family Health**

Federal Brochure # RI 73-689

Effective January 1, 2001

Section 1. <u>Facts about this HMO plan</u> will have the following added to <u>Who provides my health care?</u>

Members who have chosen either the Community Health Plan (CHP) or Direct Panel of Providers must access providers within their chosen panel in order to receive HMO benefits. If you access providers outside of your chosen panel, you will be subject to your POS benefits. In certain circumstances, you will have access to the panel of providers you did not select, at HMO benefits. Please refer to the <u>2001 Bluegrass Family Health Information Guide and Provider Network</u> book additional more information.

Section 5 (e) <u>Mental health and Substance Abuse Benefits</u> will have the following added to the Benefit Description:

• Services in approved alternative care settings such as partial hospitalization, residential treatment, and full-day hospitalization.	$100 per admission
• Intensive outpatient treatment	$75 per outpatient program

2001 Bluegrass Family Health, Inc.