Health Maintenance Plan

http://www.anthem.com

Anthem

2002

A Health Maintenance Organization

Serving: Most Of Ohio

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 6 for requirements.

Enrollment codes for this Plan:

R51 Self Only
R52 Self and Family

Authorized for distribution by the:

United States
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FEHB
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Health Benefits Program

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Introduction

Health Maintenance Plan
1351 William Howard Taft Road
Cincinnati, Ohio 45206-1775

This brochure describes the benefits of Community Insurance Company, dba Anthem Blue Cross and Blue Shield*, under our contract (CS 1659) 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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes summarized on page 7. Rates are shown at the end of this brochure.

*An independent licensee of the Blue Cross and Blue Shield Association. Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company. ®Registered marks Blue Cross and Blue Shield Association.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; "we" means Health Maintenance Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW, Washington, DC 20415-3650.

Inspector General Advisory

Stop health care fraud!

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

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800/848-9276 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
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.

Section 1. Facts about this HMO plan

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

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

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

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. 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:

- Disenrollment rates for 2000
- Compliance with State and Federal licensing or certification requirements and the dates met. If noncompliant, the reason for noncompliance.
- Accreditations by recognized accrediting agencies and the dates received
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentially and transfer of medical record
- Years in existence
- Profit status
- Medical Records
- Transitional Care

If you want more information about us, call 800/228-4375, or write to Mail No. CC1-014, 1351 William Howard Taft Road, Cincinnati, Ohio 45206-1775. You may also contact us by fax at 513/872-3929 or visit our website at www.anthem.com.

Service Area

To enroll in this Plan, you must live in or work in our service area. This is where our providers practice. Our service area is:

Cincinnati Area: In ***Ohio*** -- Brown, Butler, Clermont, Clinton, Hamilton, and Warren counties, and ZIP codes 45110 and 45142 in Highland County

Cleveland Area: In ***Ohio*** **--** Cuyahoga, Geauga, Lake, Lorain, Medina, and Summit counties, and ZIP codes 44032, 44033, 44066, 44076, 44084, 44085, 44093 and 44099 in Ashtabula County

Dayton Area: In ***Ohio*** **--** Butler, Champaign, Clark, Clinton, Greene, Miami, Montgomery, Preble, Shelby, and Warren counties, ZIP codes 45304, 45313, 45328, 45329, 45331, 45332, 45336, 45352, 45358 and 45380 in Darke County, 43128 and 43142 in Fayette County, and 43310, 43311, 43318, 43319, 43324, 43331, 43333, 43343 and 43357 in Logan County

Akron-Canton Area: In ***Ohio*** **--** Ashland, Carroll, Harrison, Holmes, Medina, Portage, Stark, Summit, Tuscarawas, and Wayne counties

Warren-Youngstown Area: In ***Ohio*** **--** Columbiana, Jefferson, Mahoning, and Trumbull counties

Columbus Area: In ***Ohio*** -- Coshocton, Delaware, Fairfield, Franklin, Licking, Pickaway, and Union counties, and ZIP codes 43029, 43064, 43140, 43143, 43151, 43153 and 43162 in Madison County

Toledo-Defiance Area: In ***Ohio*** -- Allen, Defiance, Erie, Fulton, Hancock, Henry, Huron, Lucas, Ottawa, Paulding, Putnam, Seneca, Williams, and Wood counties, ZIP codes 43407, 43410, 43420, 43431, 43435, 43442, 43448, 43469 and 44841 in Sandusky County, and 45832, 45863, 45886 and 45891 in Van Wert County

Ordinarily, you must receive care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency or urgent care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

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. Refer to Section 5(g). *Special Features* on page 37 for details regarding our reciprocity benefits. 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 2002

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5, *Benefits*. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- We changed the address for sending disputed claims to OPM. (Section 8)

Changes to this Plan

- Your share of the non-Postal premium will increase by 27% for Self Only or 44% for Self and Family.
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a))
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- We clarified the Preventive care, adult benefits by removing the entry for blood lead level testing for adults because it is a test more typically done for children. (Section 5(a))
- We clarified the Family planning and Infertility benefits by providing more examples of covered and not covered benefits. (Section 5(a))
- We clarified Surgical procedures to show that we cover a comprehensive range of services, such as operative procedures. (Section 5(b))
- The urgent care copay will increase from $5 to $25 per visit.
- The emergency room copay will increase from $25 to $50 per visit.
- The $1,500 calendar year maximum for durable medical equipment/orthopedic and prosthetic devices and reconstructive surgery (breast prostheses) will be removed.
- The prescription drug copays for a 30-day supply will increase from: $5 copay for generic, $12 for formulary name brand and $24 for non-formulary name brand to $8 for generic, $15 for formulary name brand and $25 for non-formulary name brand.
- The prescription drug copays for a 90-day supply will increase from: $10 copay for generic, $24 for formulary name brand and $36 for non-formulary name brand to $16 for generic, $30 for formulary name brand and $40 for non-formulary name brand.
- The two consecutive month time limit on rehabilitative therapy is being eliminated. Physical and occupational therapy will now be provided for up to 60 visits per year, speech therapy will now be provided for up to 20 visits per year and cardiac rehabilitation will now be provided based upon the Plan's medical policy.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800/228-4375.

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.

- **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 primary/specialty/etc, providers in the provider directory, which we update periodically. The list is also on our website at www.anthem.com.

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician (PCP). This decision is important since your primary care physician provides or arranges for most of your health care.

How you choose a PCP

1. Ask family and friends about their doctors. While you're at it, ask health care practitioners you respect, too. Personal recommendations can mean a lot.

2. Consider a get-acquainted visit if the doctor is accepting new patients. (Many doctors do not charge for such an appointment, but make sure.) Use this time to ask questions, not to get advice about specific medical complaints.

   Here are some questions you might ask:

   What are your office hours?

   Who will handle my care when you aren't available?

3. Pay attention. Does the physician explain things so you can understand? Are you comfortable talking with him or her? Is the tone of the conversation friendly and respectful? Is the physician listening carefully to you?

- **Primary care**

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

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

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see optometrists and OB/GYNS without a referral.

How do I get specialty care?

Except in a medical emergency or when a primary care doctor has designated another doctor to see patients when he or she is unavailable, you must contact your primary care doctor for a referral before seeing any other doctor or before you obtain special services. Referral to a participating specialist is given at the primary care doctor's discretion; if specialists or consultants are required beyond those participating with us, your primary care doctor will make arrangements for appropriate referrals.

Before going to the specialist, for the initial consultation or for follow-up care, make sure your primary care doctor has written a referral for you to take with you to the specialist's office and has indicated the referral information in your medical records. Your primary care doctor will also notify us of the referral by telephone, fax or mail. On referrals, the primary care doctor will give specific instructions to the specialist as to what services are to be performed. If additional services or visits are suggested by the specialist, you must first check with your primary care doctor. If you are receiving services from a doctor who leaves the Plan, we will pay for covered services until we can arrange with you for you to be seen by another participating doctor.

Here are other things you should know about specialty care:

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

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

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

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

  – Terminate our contract with your specialist for other than cause

  – Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan

  – Reduce our service area and you enroll in another FEHB Plan

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800/228-4375. If you are new to the FEHB Program, we will arrange for you to receive care.

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

- You are discharged, not merely moved to an alternative care center; or

- The day your benefits from your former plan run out; or

- The 92nd day after you become a member of this Plan, whichever happens first.

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

Circumstances beyond our control

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

Services requiring our prior approval

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

Your physician must obtain precertification for services such as, but not limited to:

- All inpatient admissions (except maternity)
- Outpatient surgeries such as but not limited to: hysterectomy, EGD, colonoscopy, tonsillectomy & adenoidectomy
- Cardiac rehabilitation
- OB ultrasounds (second and subsequent)
- Newborn admissions that extend beyond the mother's discharge
- MRI or MRA

Precertification is a procedure that requires an approval to be obtained from us before incurring expenses for certain covered services. When care is evaluated, the medical necessity will be determined. For admissions, the appropriate length of stay will also be determined. For certain services you will be required to use the provider designated by our Health Care Management staff.

Medical necessity includes a review of both the service and the setting. When approved, a copy of the approval will be provided to you, the physician, and the hospital or facility. The care will be covered according to your benefits for the number of days approved unless our concurrent review determines that the number of days should be revised. As a result of concurrent review, additional days of inpatient care may be approved which exceed the number of days originally authorized by our Health Care Management staff. With prior notice by us, the number of days originally authorized by precertification may be reduced when it is determined that continued inpatient care is no longer medically necessary.

Your PCP and other network providers know which services require precertification and will obtain any required precertification. If a request is denied, the provider may request a reconsideration to be completed within 3 days of the request. An expedited reconsideration may be requested when the member’s health requires an earlier decision.

For emergency admissions, precertification is not required; however, you must notify your Primary Care Physician of your admission within 24 hours or as soon as possible within a reasonable period or services after 24 hours could be denied.

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Section 4. Your costs for covered services

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

- **Copayment** — A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

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

- **Deductible** — We do not have a deductible.

- **Coinsurance** — Coinsurance is the percentage of our negotiated fee that you must pay for your care.

  Example: You pay 20% of our allowance for ambulance services.

Your catastrophic protection out-of-pocket maximum

After your copayments and/or coinsurance total $1,500 per person or $3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments and/or coinsurance for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments and/or coinsurance for these services:

- Dental services
- Prescription drugs

Be sure to keep accurate records of your copayments and/or coinsurance 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 57 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 claim forms, claims filing advice, or more information about our benefits, contact us at 800/228-4375.

(a) Medical services and supplies provided by physicians and other health care professionals……14-21

- Diagnostic and treatment services
- Lab, X-ray, and other diagnostic tests
- Preventive care, adult
- Preventive care, children
- Maternity care
- Family planning
- Infertility services
- Allergy care
- Treatment therapies
- Physical and occupational therapies
- Speech therapy
- Hearing services (testing, treatment, and
- Vision services (testing, treatment, and supplies)
- Foot care
- Orthopedic and prosthetic devices
- Durable medical equipment (DME)
- Home health services
- Chiropractic
- Alternative treatments
- Educational classes and programs

(b) Surgical and anesthesia services provided by physicians and other health care professionals 22-25

- Surgical procedures
- Reconstructive surgery
- Oral and maxillofacial surgery
- Organ/tissue transplants
- Anesthesia

(c) Services provided by a hospital or other facility, and ambulance services 26-28

- Inpatient hospital
- Outpatient hospital or ambulatory surgical center
- Extended care benefits/skilled nursing care facility benefits
- Hospice care
- Ambulance

(d) Emergency services 29-30

- Medical emergency
- Ambulance

(e) Mental health and substance abuse benefits..... 31-32

(f) Prescription drug benefits 33-35

(g) Special features 36-37

- Flexible benefits option
- 24 hour nurse line
- Reciprocity benefit
- Centers of Excellence for transplants/heart surgery
- Discount programs

(h) Dental benefits 38-40

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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.
- 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, physicians assistants or nurses • In a primary care physician's office • In a specialty physician's office • Office medical consultations • Second surgical opinion	$10 per office visit
Professional services of physicians • In an urgent care center	$25 per office visit
Professional services of physicians • During a hospital stay • In a skilled nursing facility • At home	Nothing
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine mammograms • Pathology • X-rays • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing
Not covered: Sleep disorders unless we authorize them	*All charges*

Preventive care, adults	You pay
Routine screenings, such as: • Total Blood Cholesterol • Colorectal Cancer Screening, including – Fecal occult blood test – Sigmoidoscopy, screening - every five years starting at age 50 • Prostate Specific Antigen (PSA test) - one annually for men age 40 and older • Routine pap test • Routine mammogram –covered for women age 35 and older, as follows: – From age 35 through 39, one during this five year period – From age 40 through 64, one every calendar year – At age 65 and older, one every two consecutive calendar years	Nothing
Not covered: Physical exams 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, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines annually, age 65 and over	$10 per office visit; Nothing for immunizations
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit; Nothing for immunizations
• Well-child care charges for routine examinations, immunizations and care (through age 22) • 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)	Nothing if you receive these services during your office visit, otherwise, $10 per office visit

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care • One routine sonogram Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 11 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. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b)	Nothing
Not covered: Subsequent routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	
Voluntary family planning services, limited to: • Voluntary sterilization	20% of our allowance
• Surgically implanted contraceptives (such as Norplant) Note: We cover oral and injectable contraceptives (such as Depo provera) under the prescription drug benefit	Nothing
• Intrauterine devices (IUDs) • Diaphragms (when provided in a physician's office) Note: See Section 5(f), *Prescription drug benefit*, for coverage when purchased through a retail pharmacy	50% of our allowance
Not covered: • *Reversal of voluntary surgical sterilization* • *Voluntary abortion except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest*	*All charges*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: – Intravaginal insemination (IVI) – Intracervical insemination (ICI) – Intrauterine insemination (IUI)	$10 per office visit; 20% of our allowance for treatment
Diagnosis and treatment of infertility, such as: • Fertility drugs Note: We cover injectable fertility drugs under medical benefits and oral fertility drugs under the prescription drug benefit	50% of our allowance
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* – *In vitro fertilization* – *Embryo transfer, gamete GIFT and zygote ZIFT* – *Zygote transfer* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Allergy care	
Testing and treatment	$10 per office visit; 20% of our allowance for testing and treatment
Allergy injections	20% of our allowance when performed in an allergy Specialist's office; otherwise, $10 per office visit at a Primary Care physician's office
Allergy serum	20% of our allowance
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 25 • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	Nothing
• Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit Note: We will only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that GHT is medically necessary. We will ask you or your physician to submit the following: – A letter of medical necessity – Laboratory results, and – A growth chart We **will not** cover GHT or related services and supplies if you do not request preauthorization from us.	50% of our allowance
Physical and occupational therapies	
• 60 visits per condition for the services of each of the following: – Qualified physical therapists and – Occupational therapists Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction. Approval is based upon our medical policy.	Nothing
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs* • *Inpatient hospital stays for physical therapy purposes only*	*All charges*
Speech therapy	
• 20 visits per condition	Nothing

Hearing services (testing, treatment, and supplies)	You pay
• Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit; Nothing if you receive these services during your office visit
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
• One eye refraction per year Note: See Preventive care, children for eye exams for children	$10 per office visit
• First pair of lenses following cataract surgery	50% of our allowance
Not covered: • *Eyeglasses or contact lenses and examinations for them* • *Eye exercises and vision training* • *Radial keratotomy* .	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• 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 and the surgical implant following mastectomy Note: See Section 5(b) for coverage of the surgery to insert the device	50% of our allowance

Orthopedic and prosthetic devices - Continued on next page

Orthopedic and prosthetic devices - *Continued*	**You pay**
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome Note: See Section 5(b) for coverage of the medical treatment of TMJ pain dysfunction syndrome	50% of our allowance up to a $200 maximum
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups*	*All charges*
Durable medical equipment (DME)	
Rental or purchase, at our option, including repair and adjustment of durable medical equipment prescribed by your Plan physician, such as oxygen and oxygen equipment. Under this benefit, we also cover items such as: • Hospital beds • Wheelchairs • Crutches • Walkers • Blood glucose monitors; (when purchased at a participating medical supply provider) • Insulin pumps • First pair of lenses following cataract removal • Medical supplies, such as surgical dressings and colostomy bags	50% of our allowance
Not covered: • *Devices and equipment used for environmental control or to enhance the environmental setting, such as air conditioners, humidifiers or air filters* • *Supplies that can be used by other family members such as: adhesive tape, band-aids, alcohol and cotton balls*	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (RN), licensed practical nurse (LPN), or home health aide • Services include oxygen therapy, intravenous therapy and medications	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication*	*All charges*

Chiropractic	You pay
No benefit	*All charges*
Alternative treatments	
No benefit	*All charges*
Educational classes and programs	
Coverage is limited to: • Diabetes self-management	$10 per office visit
• Smoking cessation (one smoking cessation program per member, per lifetime) Note: See Section 5(e) for individual or group counseling coverage	Nothing up to $100; *All charges thereafter*
Not covered: Second and subsequent smoking cessation programs	*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.
- 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).
- YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR 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	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Treatment of burns • Normal pre- and post-operative care by the surgeon • Endoscopy procedures • Biopsy procedures • 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 over, or 100% over his or her normal weight according to current underwriting standards – That has persisted for a duration of at least five years – For which physician monitored and sanctioned non-surgical treatment has been unsuccessful for at least twelve to eighteen consecutive months Eligible members must be age 18 or over • Insertion of internal prosthetic devices, such as pacemakers and artificial joints. See Section 5(a), *Orthopedic and prosthetic devices,* for device coverage information. Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing

Surgical procedures - Continued on next page

Surgical procedures *(Continued)*	**You pay**
• Voluntary sterilization	20% of our allowance
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care in Section 5(a)*	*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: cleft lip; cleft palate; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: – Surgery to produce a symmetrical appearance on the other breast – Treatment of any physical complications, such as lymphedemas	Nothing
– 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	50% of our allowance
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*

Oral and maxillofacial surgery	You pay
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	Nothing
• Medical treatment related to temporomandibular joint disease Note: See Section 5(a), *Orthopedic and prosthetic devices*, for appliance cost	Nothing up to $200; *All charges thereafter*
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Dental care involved in the treatment of temporomandibular joint (TMJ) pain dysfunction or syndrome*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Blue Quality Centers for Transplant (BQCT) Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient	Nothing in a Plan designated organ transplant facility; 20% of our allowance in a participating, non-designated organ transplant facility
Not covered: • *Implants of artificial organs* • *Transplants not listed as covered* • *Travel expenses related to transplant benefits*	*All charges*
Anesthesia	
Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing
Not covered: Professional services provided in a dentist's office. See Section 5(h) for dental benefits.	*All charges*

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.
- We have no calendar year deductible.
- 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 Sections 5(a) or (b).
- **YOUR PHYSICIAN 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 • Meals and special diets • Nursery charges Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate	Nothing
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services	Nothing

Inpatient hospital - Continued on next page

Inpatient hospital *(Continued)*	**You pay**
Not covered: • *Custodial care* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Inpatient hospital stays for physical therapy purposes only* • *Inpatient hospital stays when the patient checks out Against Medical Advice (A.M.A.)* • *Take home drugs* • *Non-covered facilities; such as schools*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing
Not covered: • *Services for sleep disorders, unless authorized by the Plan* • *Take home drugs*	*All charges*
Extended care benefits/skilled nursing care facility benefits	
Extended care/skilled nursing facility benefits: Up to 180 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically necessary as determined by a Plan doctor and approved by the Plan. • Days 0 - 30	Nothing
• Days 31 – 180	50% of our allowance
Not covered: Custodial care	*All charges*

Hospice care	You pay
Home Health Care provided by Hospice nurses	Nothing
Not covered: Independent nursing, homemaker services and hospice services provided in a hospice facility	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	20% of our allowance

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.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area: If you are in an emergency situation, you must contact your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are our member so they can notify us. You or a family member must notify your primary care doctor within 24 hours, unless it was not reasonably possible to do so. It is your responsibility to ensure that your primary care doctor has been timely notified.

If you need to be hospitalized, we must be notified within 24 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 a non-Plan facility and our 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 you believe delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

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

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

If you need to be hospitalized, 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 a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

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

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$10 per office visit
• Emergency care at an urgent care center or in the outpatient department of a hospital, including doctors' services	$25 per office visit
• Emergency care as an outpatient at a hospital, including doctors' services	$50 per visit; if visit results in an admission, you pay nothing
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
• Emergency care at a doctor's office	$10 per office visit
• Emergency care at an urgent care center or in the outpatient department of a hospital, including doctors' services	$25 per office visit
• Emergency care as an outpatient at a hospital, including doctors' services	$50 per visit; if visit results in an admission, you pay nothing
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
Professional land and air ambulance service when medically appropriate See Section 5(c) for non-emergency service	20% of our allowance

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

IMPORTANT

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.
- We have no deductible.
- 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.
- YOUR PHYSICIAN 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 illnesses or conditions
Professional services, including medication management, individual therapy or group therapy by providers such as psychiatrists, psychologists, or clinical social workers provided in: • Office	$10 per office visit
Professional services by providers such as psychiatrists, psychologists, or clinical social workers provided in the office for treatment of tobacco cessation	Nothing
Professional services, including medication management, individual therapy or group therapy by providers such as psychiatrists, psychologists, or clinical social workers provided in: • Hospital (inpatient) • Hospital outpatient department	Nothing

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits *(Continued)*	**You pay**
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, full-day hospitalization or facility based intensive outpatient treatment	Nothing
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* • *Psychological testing when not medically necessary to determine the appropriate treatment of a short-term psychiatric condition* *The same exclusions contained in this brochure that apply to other benefits apply to these mental health and substance abuse benefits, unless the services are included in a treatment plan that we approve.* *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Preauthorization

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

- If you feel you need mental health or substance abuse services, you may call:
  - Group Health Associates at 513/326-9999 in the Cincinnati area
  - Magellan Behavioral Health at 800/788-4003 outside the Cincinnati area

Group Health Associates or Magellan will work with you to determine your needs and begin the treatment planning process. Referrals for any necessary services will also be handled by Group Health Associates or Magellan.

Your mental health and substance abuse services must be provided by Plan providers. You may obtain a provider directory by calling us at 800/228-4375.

Limitation

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

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on page 35.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible**.**
- Prior authorization is the process required to dispense certain drugs when the use of a drug is defined or limited by your medical condition.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription?** A Plan physician or licensed dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at an Anthem Rx Network Plan pharmacy or by mail for maintenance medication.
- **We use a formulary.** Prescription drugs are prescribed by Plan doctors and dispensed in accordance with our prescription drug formulary. All prescription drugs on the formulary have been approved by the Food and Drug Administration (FDA). The formulary consists of medications that have been rigorously reviewed and selected by a committee of practicing doctors and clinical pharmacists for their safety, quality and effectiveness. Coverage will be provided for both formulary and non-formulary medications when prescribed by a Plan doctor. However, when non-formulary drugs are dispensed a higher copay will apply.

  We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug listing, call 800/228-4375 or visit our website at www.anthemprescription.com.

- **These are the dispensing limitations.** Prescriptions filled by a retail pharmacy or through a mail order pharmacy have a limitation on days supply and different levels of copayments based on the days supply. You may obtain a 30-day supply or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin) at a Plan pharmacy or up to a 90-day supply through our mail order program. Remind your doctor to write for the maximum days supply. Any continuous therapy medication presently covered by us within the limits of applicable State and Federal laws, can be dispensed through the mail order program. Your prescriptions will be filled using FDA dispensing guidelines.

  Your prescription claims' history and patient profile information will be used by us to administer your pharmacy program and to identify possible drug interactions, duplications or other adverse events that may occur. This profile allows us to determine if you are trying to refill your prescription too soon, which could cause your claim to be rejected and could require you to file again at a later date.

  If you receive a name brand drug, whether by mail order or from a Plan pharmacy, the copayment for the name brand applies regardless of whether:
  - A generic equivalent is unavailable
  - The prescription order specifies "Dispense as Written"
  - You choose the name brand drug instead of a generic drug

A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified "Dispense as Written" for the name brand drug, you will still have to pay the name brand copay.

- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive name brand drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original name brand product. Generics cost less than the equivalent name brand product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as name brand drugs.

  You can save money by using generic drugs. However, you and your physician have the option to request a name brand if a generic option is available. Using the most cost-effective medication saves money.

- **When you have to file a claim.** Typically you will not have to file a claim for prescription drugs; however, if you have had to pay for a prescription due to some unforeseen circumstance, you will have to submit the original prescription receipt to : Health Maintenance Plan, Mail No. CC1-014, 1351 William Howard Taft Road, Cincinnati, OH 45206-1775.

Prescription drug benefits begin on the next page

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States requires a physician's prescription for their purchase • FDA-approved prescription drugs, injectable drugs (such as depo provera) and devices for birth control • Insulin • Disposable needles and syringes needed to inject covered prescribed medications are covered at the name brand copayment. • Diabetic supplies including insulin syringes, needles, glucose test tablets and test tape, Benedict's solution or equivalent, glucose monitors and acetone test tablets are covered at the name brand copayment. • Drugs for the treatment of impotence, such as Viagra: HMP requires proof of medical necessity prior to approving benefits. Then, this Plan will cover a maximum of six tablets per month, subject to the following guidelines. The patient: – Must be a male over age 18 – Is being treated for erectile dysfunction (ED) regardless of the cause, and – Is not on medication containing nitrates • Smoking cessation prescription drugs and medications	**Up to a 30-day supply at a Plan pharmacy** $ 8 copay for generic drugs $15 copay for formulary name brand drugs $25 copay for non-formulary name brand drugs **Up to a 90-day supply through the mail order program** $16 copay for generic drugs $30 copay for formulary name brand drugs $40 copay for non-formulary name brand drugs Note: If there is no generic equivalent available, you will still have to pay the name brand copay
• Immuno-Suppressive Agent • Fertility drugs • Human growth hormones	50% of our allowance
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Drugs available without a prescription or for which there is a nonprescription equivalent available* • *Drugs obtained at a Non-network pharmacy except for out-of-area emergencies* • *Drugs to enhance athletic performance* • *Drugs for weight loss purposes (except when authorized by the Plan doctor for treatment of morbid obesity)* • *Replacement prescriptions such as lost, stolen or spilled*	*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.
24 hour nurse line	You have access to Personal Health Advisor (PHA), a health information service, 24 hours a day, seven days a week. All calls are completely confidential. You can: • Speak with a registered nurse for help with everyday health decisions and for health counseling on chronic conditions. • Listen to pre-recorded health care topics in the Audio Health Library. • Locate doctors and hospitals in your area. You can access Personal Health Advisor by calling 888/474-2258 or through the internet website: www.pha-online.com/anthem.
Centers of excellence for transplants/heart surgery	We use the Blue Quality Centers for Transplant Network (BQCT) as our transplant network. The network consists of leading medical facilities throughout the nation. For a list of transplant hospitals near you, call 800/824-0581. We utilize a network of institutions that have met stringent clinical standards for the following heart services: • Coronary artery bypass graft (CABG) • Percutaneous transluminal coronary angioplasty (PTCA) • Heart valve procedures • Other major cardiovascular procedures You can refer to our provider directory for further information concerning our transplant and heart surgery centers of excellence.

Special features – Continued on next page

Section 5 (g). Special features *(Continued)*

Feature	Description
Reciprocity benefit	**Away from Home Care Program** HMP offers guest memberships at affiliated HMO plans through an Away from Home Care Program. Whenever you or a family member is away from the HMP service area for more than 90 days, you may become a guest member at an affiliated HMO near your destination. Reasons to consider a guest membership include extended out-of-town business, children away at school, dependent children in another state, or a winter "snowbird" residency in the South. To determine if a guest membership is available at your destination, call 800/355-6414. If you or a family member are away from the HMP for less than 90 days you will only have coverage for emergency or urgent care services. You will have to contact your primary care physician to obtain the appropriate referrals for these services.
Discount programs	**Anthem Advantage** You can receive negotiated savings on selected health and wellness services and programs simply by being an eligible Anthem Blue Cross and Blue Shield Health Maintenance Plan member. To obtain information about these programs please call us at 800/228-4375 or visit our website at www.anthem.com. Companies participating in the Anthem Advantage program include: • **Beltone®"** – free hearing exams and discounts on hearing aids • **Complementary Blue**SM – discounts on vitamins, herbs, sports nutrition products, books and videotapes • **GlobalFit** – discounts at participating fitness clubs • **Vision One** – discounts on frames, contacts, bifocals • **House of Healing** – soothe your body, mind and soul with discounts on products to help you rev up or chill out • **fatbrain™** – beef up your gray matter with discounts on recommended titles in the Anthem Bookstore at fatbrain • **SafeTech** – (a div. Of Troxel) – preferred pricing on bicycle and inline skating helmets • **Safe Beginnings®"** – discounts on child-proofing and family safety products • **FTD.com** – discounts on some internet orders

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a 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 within three days of an accident (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing

Dental benefits

See benefit chart on the following page.

We cover the following dental services when you use a participating Plan dentist and we have indicated when copayments apply. This benefit description does not list exclusions. Contact us for specific exclusions at 800/228-4375 or 513/872-8242 (in the local dialing area).

Dental Benefits	
Service	**You pay**
DIAGNOSTIC X-rays including bite wings and panoramic; oral examinations and treatment plan; vitality test; and oral cancer exam	Nothing
PREVENTIVE Prophylaxis; annual topical application of fluoride to children age 12, preventive dental instructions	Nothing
RESTORATIVE (Fillings) Amalgam – one surface Amalgam – two surfaces Amalgam – three surfaces (Build up per tooth) Plastic or composite – single surface Plastic or composite – two surfaces	80% of our allowance
ORAL SURGERY (Including preoperative and postoperative treatments under local anesthetics) Extraction (simple) Alveolectomy per quadrant Impaction (soft tissue) Impaction (complete bony)	80% of our allowance
PROSTHODONTICS Complete upper or lower denture Cast chrome partial – upper or lower Acrylic partial – upper or lower (with clasps) Repair broken denture Denture adjustment Reline upper or lower complete denture or partial (office) Reline upper or lower complete denture or partial (laboratory) Space maintainers (for primary teeth)	80% of our allowance

Dental Benefits - Continued on next page

Dental Benefits *(Continued)*	
Service	**You pay**
PROSTHODONTICS - *Continued* Stainless steel crown (for primary teeth) Bridge abutments or pontics	80% of our allowance
PERIODONTICS (Under local anesthetics) Examination, treatment plan Periodontal, root planing and curettage Hemisection Gingivectomy or gingivoplasty Osseous surgery (per quadrant) Equilibration (entire mouth)	80% of our allowance
ENDODONTICS (Under local anesthetics) Pulpotomy (including restoration) Root canal filling – one canal Each additional canal Apicoectomy, performed as separate surgical procedure	80% of our allowance
ORTHODONTICS (Braces) Initial Consultation Diagnosis and treatment plan *(Limited to one, two-year course of phase II treatment per eligible child up to age 19)*	80% of our allowance
Missed appointments without 24 hours prior notification	$10.00
ACCIDENTAL INJURY BENEFIT Restorative services and supplies necessary to promptly repair within three days of accident (but not replace) sound natural teeth. *(The need for these services **must** result from an accidental injury)*	Nothing
Not covered: *All other dental services not shown as covered*	*All charges*

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.**

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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 and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 800/228-4375.

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

Submit your claims to: **Health Maintenance Plan**
PO Box 37180
Louisville, KY 40233-7180

Prescription drugs

When you must file a claim, such as prescription drugs that you had to pay for, submit the original itemized Pharmacy receipt that comes with the prescription.

Submit your claims to: **Health Maintenance Plan**
Mail No. CC1-014
1351 William Howard Taft Road
Cincinnati, OH 45206-1775

Other supplies or services

When you must file a dental claim, such as out-of-network care, submit a completed Standard ADA (American Dental Association) Claim Form.

Submit your claims to: **Dental Network of America**
Ohio Claims
Two Transam Plaza Drive
Oakbrook Terrace, IL 60181

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: Health Maintenance Plan, Mail No. CC1-014, 1351 William Howard Taft Road, Cincinnati, OH 45206-1775; 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 II, 1900 E Street, NW, Washington, D.C. 20415-3630.

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 include 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 or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800/228-4375 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 II at 202/606-3818 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. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 800/MEDICARE (800/633-4227) for more information.

- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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

- **The Original Medicare Plan (Part A or Part B)**

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

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PCP, or precertified as required.

We will not waive any of our copayments and/or coinsurance.

(Primary payer chart begins on next page.)

The following chart illustrates whether **the Original Medicare Plan** 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.)		
1) 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),	✓	
2) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
3) 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, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

Please note, if your Plan physician does not participate in Medicare, you may have to file a claim with Medicare on occasion.

Claims process when you have the Original Medicare Plan: You probably will never have to file a claim when you have both our Plan and the Original Medicare Plan.

- 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. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 800/228-4375.

We do not waive any costs when you have the Original Medicare Plan: When Original Medicare is the primary payer, we do not waive any out-of-pocket costs.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan - - 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 provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 800/MEDICARE (800/633-4227) or at www.medicare.gov.

If you enroll in a Medicare managed care plan, the following options are available to you:

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

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments and/or coinsurance. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Meicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in 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 managed care plan's service area.

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

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 illness 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 care. 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.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

Covered services

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

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include, but are not limited to:

- Personal care such as help in walking, getting in and out of bed, bathing, eating by spoon, tube or gastrostomy, exercising or dressing
- Homemaking such as preparing meals or special diets
- Moving the patient
- Acting as a companion or sitter
- Supervising medication that can usually be self administered
- Treatment services that any person may be able to perform with minimal instruction, including, but not limited to, recording temperature, pulse and respirations or administration and monitoring of feeding systems

We determine which services are custodial.

Experimental or investigational services

A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time it is furnished. Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or biological product is experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or the written informed consent used by the

treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Group health coverage

Health care coverage that a member is eligible for because of employment, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies, or that pays a specific amount for each day or period of hospitalization.

Medical necessity

Services, drugs, supplies or equipment provided by a hospital or covered provider of the health care services that the Carrier determines:

- Are appropriate to diagnose or treat the patient's condition, illness or injury
- Are consistent with standards of good medical practice in the United States
- Are not primarily for the personal comfort of the patient, the family or the provider
- Are not a part of or associated with the scholastic education or vocational training of the patient and
- In the case of inpatient care, cannot be provided safely on an outpatient basis

The fact that a covered provider has prescribed, recommended or approved a service, supply, drug or equipment does not, in itself, make it medically necessary.

Our allowance

Our allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:

- Amounts charged by other providers for the same or similar service
- Any unusual medical circumstances requiring additional time, skill or experience and
- Other factors we determine are relevant, including, but not limited to, a resource based relative value scale

Us/We

Us and we refer to Health Maintenance Plan.

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 joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

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

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

- **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.

- **Temporary Continuation of Coverage (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, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

Enrolling in TCC. 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. It explains what you have to do to enroll.

- **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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group 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.

For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover long-term care needs. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. *LTC insurance can supplement care provided by family members, reducing the burden you place on them.*

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. *Many People now consider long term care insurance to be vital to their financial and retirement planning.*

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8- hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the *"Not covered"* blocks in Sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100-day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retiress will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

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Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

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Summary of benefits for Health Maintenance Plan - 2002

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

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office.....	Office visit copay: $10 primary care; $10 specialist	14
Services provided by a hospital:		
• Inpatient.....	Nothing	26
• Outpatient.....	Nothing	27
Emergency benefits:		
• In-area.....	$50 per visit	30
• Out-of-area	$50 per visit	30
Mental health and substance abuse treatment	Office visit copay: $10 Inpatient hospital: Nothing Outpatient hospital: Nothing	31
Prescription drugs:		35
• Network pharmacy……..	$8 generic copay; $15 formulary name brand copay; $25 non-formulary name brand copay	
• Mail order…….	$16 generic copay; $30 formulary name brand copay; $40 non-formulary name brand copay	
Dental Care		
• Preventive care……	Nothing	39
• Other services……	80% of our allowance	
Vision Care		
• One annual refraction…….……	$10 per visit	19

Summary of benefits for Health Maintenance Plan - 2002 - continued on next page

Summary of benefits for Health Maintenance Plan – 2002 *(Continued)*

Benefits	You Pay	Page
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Protection against catastrophic costs (your out-of-pocket maximum).....	Nothing after $1,500/Self Only or $3,000/Family enrollment per year Some costs do not count toward this protection.	12

2002 Rate Information for
Health Maintenance Plan (HMP)

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, 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 who are not career postal employees. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Most of Ohio							
Self Only	R51	$97.86	$36.47	$212.03	$79.02	$115.52	$18.81
Self and Family	R52	$223.41	$93.11	$484.06	$201.73	$263.75	$52.77