BlueCross BlueShield of Missouri

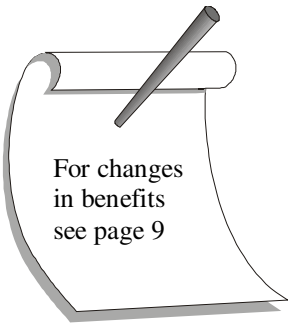
An independent licensee of the Blue Cross and Blue Shield Association

BlueCHOICE®

http://www.bcbsmo.com

2002

A Health Maintenance Organization



Serving: **St. Louis, Central, Southeast and Southwest Missouri areas and St. Clair and Madison counties in Illinois**

Enrollment in this plan is limited. You must live in our Geographic service area to enroll. See page 8 for requirements.

This plan has commendable accreditation from the NCQA. See the *2002 Guide* for more information on accreditation.

Enrollment code:

9G1	**Self Only**
9G2	**Self and Family**

Authorized for distribution by the:

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

FEHB
Federal Employees Health Benefits Program

RI-73-516

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Introduction

BlueCHOICE
1831 Chestnut Street
St. Louis, Missouri 63103-2275

This brochure describes the benefits of BlueCHOICE HMO under our contract (CS 2838) 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 are summarized on page 9. Rates are shown at the end of this brochure.

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 BlueCHOICE.
- 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 800/932-4480 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 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, hospitals and other types of providers 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. We reimburse primary care physicians through capitation, which includes the majority of services the primary care physician renders. We compensate certain services, such as immunizations or cardiac diagnostic testing in the office as fee for service.

Who provides my health care?

This plan is an individual-practice Plan. All participating doctors practice in their own offices in the community. Unless it is an emergency, benefits are available only from doctors, hospitals and other health care providers that are in the BlueCHOICE network. The Plan arranges with doctors and hospitals to provide medical care for both the prevention of disease and the treatment of serious illness.

You must select a primary care doctor for each covered family member. Approximately 1,300 primary care physicians participate in BlueCHOICE. For most care, you must contact your primary care doctor for a referral or authorization before seeing any other doctor for specialty care or nonemergency hospital services. A wide variety of specialists are participating Plan doctors. Many are Board certified as indicated in the BlueCHOICE directory. If you need hospital care, your Plan primary doctor will admit you to a participating hospital where he/she has admitting privileges.

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 Web site (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.

About the plan and care management: Blue Cross and Blue Shield of Missouri has over 60 years of experience in the health insurance industry. We began as St. Louis Blue Cross in 1936. In 1945, Missouri Medical Service, commonly known as Blue Shield, began business in the St. Louis area. The two companies merged in 1986, forming Blue Cross and Blue Shield of Missouri, a not-for-profit health service corporation. In 1994, Blue Cross and Blue Shield of Missouri formed a new managed care company, Alliance Blue Cross Blue Shield.

Effective November 30, 2000, Blue Cross and Blue Shield of Missouri and its for-profit managed care subsidiary, Alliance Blue Cross Blue Shield, merged into a single, for-profit, publicly traded Delaware corporation. The insurance-related business that was part of the old Blue Cross and Blue Shield of Missouri has been transferred to and assumed by Healthy Alliance Life Insurance Co., a wholly owned subsidiary of Blue Cross and Blue Shield of Missouri, as part of the reorganization.

BlueCHOICE, the for-profit HMO subsidiary of Blue Cross and Blue Shield of Missouri, began operations in 1988. Blue Cross and Blue Shield of Missouri, BlueCHOICE and Healthy Alliance Life Insurance Co. are independent licensees of the Blue Cross and Blue Shield Association.

Utilization management services include:

- Precertifications of medical/surgical, mental health, rehabilitation, skilled nursing, outpatient and home health care
- Concurrent review of medical/surgical, mental health, rehabilitation, skilled nursing, outpatient and home health care
- Retrospective review
- Discharge planning
- Alternative care planning
- Individual case management
- Appeal for denial of payment due to lack of medical necessity
- Medical review

Our contracts with network providers require them to handle all certifications for BlueCHOICE members. You will not have to be concerned about managed care procedures as long as your receive care from network providers.

We offer special programs to help members with health conditions such as asthma, diabetes and high-risk pregnancy. These are voluntary programs to help members manage their particular health condition. These programs are explained in Section 5(g).

Accreditation status: BlueCHOICE is accredited by the National Committee for Quality Assurance (NCQA). The comprehensive review process evaluates how well a plan manages its benefits. The accreditation process evaluates more than 60 standards in the following six categories:

- quality management and improvement
- physician qualifications and evaluation
- members' rights and responsibilities
- preventive health services
- utilization management and
- medical records

Networks, providers and facilities: The BlueCHOICE network includes approximately 1,300 primary physicians, 3,600 specialists and 68 hospitals. Approximately 77 percent of network physicians are Board Certified and 90 percent are accepting new patients. The physician's Board status and whether or not he/she is accepting new patients are included in the BlueCHOICE provider directory.

We have established credentialing polices that require us to select and recredential physicians every two years, based on an evaluation of their experience and training, board certification and staff privileges at network hospitals. Our program goals are to support the development and maintenance of credentialing and recredentialing standards for our participating providers, review the qualifications of potential participating providers against established standards, and to reassess the qualifications and performance of our network providers.

Our credentialing criteria for network hospitals include accreditation by the Joint Committee on Accreditation of Health Care Organizations (JCAHO), Medicare certification, effective utilization management pricing, geographic location, scope of services and utilization experience.

If you want more information about us, call 1-800-932-4480. For the hearing impaired (TDD), call 1-800-822-1215.

Service Area

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

The *St. Louis Area*, including the *Missouri* counties of Crawford, Franklin, Gasconade, Jefferson, Lincoln, Montgomery, Pike, St. Charles, St. Francois, St. Louis (City and County), Ste. Genevieve, Warren and Washington; *the Central Missouri Area* counties of Adair, Audrain, Boone, Callaway, Camden, Chariton, Cole, Cooper, Howard, Linn, Macon, Maries, Miller, Moniteau, Monroe, Morgan, Osage, Phelps, Pulaski, Putnam, Randolph, Schuyler and Sullivan; *the Southwest Missouri Area* counties of Barry, Barton, Cedar, Christian, Dade, Dallas, Douglas, Greene, Hickory, Jasper, Laclede, Lawrence, McDonald, Newton, Ozark, Polk, Stone, Taney, Texas, Webster and Wright; and *the Southeast Missouri Area* counties of Butler, Carter, Ripley and Wayne.

You may also enroll with us if you live in the Illinois counties of Madison or St. Clair and work in Missouri.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care 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 moves outside our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office. As a BlueCHOICE member, you may have access to physician care through the BlueCard® Traditional network. This nationwide network is made up of 9,500 hospitals and 744,000 physicians that participate with Blue Cross and Blue Shield Plans across the country. Benefits are easy to use – a "suitcase" logo on members' ID cards will identify them as BlueCard members. To locate a BlueCard provider outside the BlueCHOICE service area, members simply call the toll-free BlueCard Access number on their ID card (1-800-810-blue) or visit the **BlueCard Hospital and Doctor Finder** at **www.BCBS.com**. Members should contact their primary care physician just as they would if they were at home. The primary care physician will provide a non-network referral and coordinate care with the out-of-area provider as appropriate.

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

- 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))
- Your share of the non-Postal premium will increase by 10% for Self Only or 10% for Self and Family.
- 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))
- Coverage has been added for cochlear implants. (Section 5(a))
- We are adding up to 20 visits per calendar year for chiropractic care, which will be covered as a combined physical therapy/chiropractic benefit. (Section 5(a))
- Treatment limitations for speech therapy have been removed, which will be covered when medically necessary, up to 20 visits per calendar year.
- We added treatment for smoking cessation to our mental health and substance abuse benefits, with no copayment for individual and group counseling. And, we will cover prescribed FDA-approved medication for the treatment of tobacco use at the regular prescription drug copayments.
- The University of Missouri Hospital and Clinic, the Ellis Fischel Cancer Center and 400 affiliated physicians joined the network in July, 2000.
- Capital Region Medical Center and its physician group in Jefferson City joined the network in October, 2000.
- Missouri Baptist Medical Center in St. Louis is no longer a participating network provider.

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 1-800-932-4480**.**

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and you will not have to file claims.

- **Plan providers**

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

We list Plan providers in the provider directory, which we update annually. The BlueCHOICE directory is also on our Web site**,** www.bcbsmo.com. The online directory is updated daily.

- **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 annually. The list is also on our Web site.

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. This decision is important since your primary care physician provides or arranges for most of your health care.

Use the directory or Web site to select a physician convenient to you. Write the physician's office code number in the space provided on your Provider Selection Card. You'll find the office number listed before each primary care physician's name. See the Selection Card for instructions.

- **Primary care**

Your primary care physician can be a family or general practitioner, internist, pediatrician or geriatrician. 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. You can change your primary care physician at any time. We will send you a new ID card with your new doctor's name and phone number on the front.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. However, you may see a network OB/GYN for any medically necessary OB/GYN care without a referral. And you may go to a network eye care provider for one routine vision exam each calendar year without a referral.

Here are other things you should know about specialty care:

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

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

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

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

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

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

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

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

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

If you think you have a mental health or substance abuse problem, we encourage you to see your primary care physician, who will coordinate your care. Your primary care physician may treat you or recommend that you call our mental health and substance abuse benefits manager.

If you do not wish to go through your primary care physician for care, you may call our mental health and substance abuse benefits manager directly at 1-800-965-2583. A trained professional will evaluate your needs and authorize your care.

- **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 1-800-932-4480. 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, is medically necessary, and follows generally accepted medical practice.

We call this review and approval process precertification and recertification. Your physician must obtain precertification before you can receive certain types of care, such as:

- Inpatient hospital care
- Outpatient hospital care
- Care in a freestanding surgery center or skilled nursing facility
- Home health care

Your physician must obtain recertification if your care needs to continue longer than originally certified.

Your BlueCHOICE primary care physician or specialist will handle all certification requirements for you. However, if you receive emergency care at a non-network facility, you will need to contact us for approval. Please see Section 5(d) for further information.

Section 4. Your costs for covered services

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

• **Copayments**	A copayment is a fixed amount of money you pay to the provider, 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**	We do not have coinsurance.

Your catastrophic protection out-of-pocket maximum for copayments

After you pay 100% of your annual premium in copayments for one family member, or 100% of your annual premium for two or more family members, you do not have to make any further payments for certain services for the rest of the year. This is called a catastrophic limit. However, copayments for your prescription drugs and dental services do not count toward these limits and you must continue to make these payments.

Be sure to keep accurate records of your copayments since you are responsible for informing us when you reach the limits.

Section 5. Benefits – OVERVIEW

(See page 9 for how our benefits changed this year and pages 66-67 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-932-4480.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • Office medical consultations • Second surgical opinion	$10 per office visit
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility	Nothing
At home	$10 per visit
Not covered: • Care that is not medically necessary • Care that is investigational • Care from a non-network provider without prior approval from us	*All charges.*

Diagnostic and treatment services -- Continued on next page

Diagnostic and treatment services *(Continued)*	**You pay**
Lab, X-ray and other diagnostic tests	
Laboratory tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	• Nothing if services are received during your office visit • $10 copay applies to services received at outpatient facilities
Preventive care, adult	
Routine screenings, such as: • Total blood cholesterol – once every three years* • Colorectal cancer screening, including – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50* • Chlamydial infection • Prostate Specific Antigen (PSA test) – one annually for men age 40 and older* • Routine Pap test – annual*	$10 per office visit

*or more frequently if recommended by your BlueCHOICE physician.

Preventive care, adult *(Continued)*	**You pay**
• Routine mammogram – once per calendar year or more frequently if recommended by a physician	$10 per visit
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – ages 19 and over is based on medical necessity • Influenza/Pneumococcal vaccines	Nothing ($10 office visit copay applies to any other covered services)
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* • *Immunizations for travel or occupational reasons.*	*All charges.*
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing ($10 office visit copay applies to any other covered services)
• Well-child care charges for routine examinations, immunizations and care (through age 22) • Examinations, such as: – Eye exams to determine the need for vision correction – Ear exams to determine the need for hearing correction – Newborn hearing screening, rescreening and initial amplification – Examinations done on the day of immunizations *Not covered:* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* • *Immunizations for travel or occupational reasons.*	$10 per office visit

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 12 for specific details. • 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. If you leave in *less than* 48 hours (or 96 hours after a cesarean delivery), we will cover two home visits by a registered nurse provided through a network home health agency.	$10 (for first office visit only)
• 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.	Nothing
• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5(c)) and Surgery benefits (Section 5(b)).	Nothing
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	
A broad range of voluntary family planning services, limited to: • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms NOTE: We cover oral contraceptives under the prescription drug benefit.	$10 per office visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling, voluntary abortions and related care.	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, limited to: – in vitro fertilization – gamete intrafallopian tube transfer (GIFT) – zygote intrafallopian tube transfer However, we will only cover these treatments if you or your spouse: (1) have not been able to become pregnant or sustain a pregnancy through reasonable, less costly and medically appropriate covered infertility treatment; (2) have not undergone four completed oocyte retrievals (except if a live birth follows a completed oocyte retrieval, then we will cover two more completed oocyte retrievals); and (3) have the procedures performed at medical facilities that conform to the American College of Obstetrics and Gynecology guidelines or to the American Fertility Society's minimum standards for in vitro fertilization.	$10 per office visit
Artificial insemination: – *intravaginal insemination (IVI)* – *intracervical insemination (ICI)* – *intrauterine insemination (IUI)*	Nothing
Oral fertility drugs and injectable fertility drugs *Note: Preauthorization is required for fertility medication.*	We cover fertility drugs under the prescription drug benefit. Please refer to Section 5(f).
Not covered • *Treatment for infertility following voluntary sterilization* • *Cost of donor sperm* • *Cost of donor egg* • *Any treatment not specified above*	*All charges.*
Allergy care	
• Testing and treatment • Allergy injection	$10 per office visit $3 per visit ($10 office visit copay applies to any other covered services)
• Allergy serum	Nothing
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges.*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High-dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 30.	Nothing
• Respiratory and inhalation therapy	$10 per visit outpatient
• Dialysis – Hemodialysis and peritoneal dialysis	$10 per visit outpatient
• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	Nothing
• Growth hormone therapy (GHT) Note: Before administering any GHT treatment, your BlueCHOICE physician needs to obtain authorization by submitting a written request to our Provider Services Unit. Please check with your BlueCHOICE physician before receiving GHT treatment. We will not cover GHT or related services and supplies unless you have received prior authorization. Growth hormone is covered as a medical benefit.	Nothing
Not covered: Therapy that is not listed as covered in this booklet. For example, massage therapy or exercise conditioning.	*All charges.*

Physical and occupational therapies	You pay
• 20 visits per calendar year for physical therapy and chiropractic care combined, and • 20 visits per calendar year for occupational therapy. For the services of each of the following: – qualified physical therapists and chiropractors, and – occupational therapists. Note: We only cover physical and occupational 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, but not limited to, a heart transplant, bypass surgery or a myocardial infarction, is provided for one consecutive 12-week program per calendar year • Pulmonary rehabilitation for up to 14 sessions within 12 months and then one session every 3 months thereafter Note: See Chiropractic care	$10 per office visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*
Speech therapy	
• 20 visits per calendar year	$10 per office visit

Hearing services (testing, treatment, and supplies)	You pay
• Routine hearing exams • Newborn hearing, screening, rescreening and initial amplification	$10 per office visit
Not covered: • *Hearing aids, testing and examinations for them, except for newborns*	*All charges.*
Vision services (testing, treatment, and supplies)	
• Routine eye exam (one per calendar year) • Eyeglasses and contact lenses are covered up to $35 per 24-month period. Reduced-cost glasses or contact lenses from selected providers**.**	$10 per office visit
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	$10 per office visit
• Eye exam to determine the need for vision correction for children (see Preventive care, children) • Annual eye refractions	$10 per office visit
Not covered: • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery, including LASIK procedures*	*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	You pay
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants; and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5 (c) for payment information. See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	Nothing
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *foot orthotics* • *heel pads and heel cups* • *lumbosacral supports* • *orthotic devices used primarily for convenience, comfort or for participation in athletics* • *corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges.*

Durable medical equipment (DME)	You pay
We cover the use of standard models of the durable medical equipment (DME) and medical supplies listed below when medically necessary to treat certain conditions. Your primary care physician or network specialist must give you a prescription for the equipment or supplies. You must obtain the equipment or supplies from a network DME provider. We only provide benefits up to our allowed amount for supplies and for basic models of equipment. If you want other than the basic model, you must pay your copay and any charges above the allowed amount for the basic equipment. We determine what is a basic model. Following is a list of covered equipment and medical supplies. The copay is shown at right.	$10 to $100
Air flotation mattress and alternating pressure pump	$ 10
Apnea monitor [1]	$ 25
Bi-directional Positive Airway Pressure (BIPAP) apparatus [1]	$ 50
Bill phototherapy system [1]	$ 25
Blood glucose monitor [1]	$ 25
Bone growth stimulator (electrical) [2]	$100
Canes	$ 10
Commode (bedside)	$ 10
Continuous Passive Motion (CPM) Devices	$ 25
Continuous Positive Airway Pressure (CPAP) apparatus [1]	$ 25
Replacement CPAP apparatus	$ 25
Continuous Positive Airway Pressure (CPAP) humidifier	$ 25
Crutches	$ 10
Enteral feeding equipment	$ 25
Enteral feeding supplies	$ 10
Formulas for treatment of phenylketonuria or any inherited disease of amino and organic acids, one month supply per copayment	$ 15
Hospital bed (electric)	$ 50
Hospital bed (nonelectric)	$ 25
Incontinence cathethers and irrigation supplies, one month supply per copayment [1]	$ 10
Insulin pump [2]	$100
Insulin pump supplies [2]	$ 25
Intermittent Positive Pressure Breathing Apparatus (IPPB) [1]	$ 25
Lymphedema pumps/lymphedema sleeves	$ 50
Mattress overlays	$ 25
Medical and post-surgical dressings, irrigation supplies, and dressing tape, one month supply per copayment	$ 10
Nebulizer compressor [1]	$ 25
Neuromuscular Electronic Stimulator (NMES)	$ 25
Ostomy supplies, all types, one month supply per copayment	$ 10
Oxygen, one month supply per copayment	$ 50
Patient lifts	$ 25
Peak flow meters	$ 10
Pulmoaids	$ 10
Spacers for Metered Dose Inhalers (MDI)	$ 10
Sphygmomanometer for gestational hypertension	$ 25
Suction catheters, one month supply per copayment [1]	$ 10
Suction equipment	$ 25

Transcutaneous Electrical Nerve Stimulator (TENS) Units Traction devices Walkers Wheelchairs (electric) Wheelchairs (non-electric) Wheelchair gel pads The maximum benefit for a medically necessary nonstandard wheelchair is $2,000. The regular copay for a manual or electric wheelchair applies. [2] ABI Vest, used to treat members with cystic fibrosis, is available for $200 per month. [1] Includes initial provision of nonpharmaceutical medically necessary supplies. [2] Subject to review by BlueCHOICE. To obtain more information, you may contact us at 1-800-932-4480.	$ 25 $ 25 $ 10 $ 50 $ 25 $ 10 $ 10
Not covered: • Dialysis equipment (rental or purchase) • Equipment or supplies that are not listed as covered • Nonstandard models of equipment	*All charges.* Copay plus any charges above the allowed amount for the basic equipment.
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Your physician will periodically review the program for appropriateness and need. • 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;* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges.*

Chiropractic	You pay
• 20 visits per calendar year for chiropractic care and physical therapy combined • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application Note: See Physical therapy	$10 per office visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs* • *maintenance care* • *relaxation therapy*	*All charges.*
Alternative treatments	
See Non-FEHB benefits, page 44.	
Educational classes and programs	
• Smoking Cessation	Please refer to Mental health and substance abuse benefits in Section 5(e); for prescription drug benefits, Section 5(f); and for non-FEHB benefits, Section 5(i).
• Asthma and diabetes self-management	Please refer to Special features, Section 5(g).

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • 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 or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information.	Nothing, unless services are received during an office visit, then the $10 copay applies.

Surgical procedures continued on next page.

Surgical procedures *(Continued)*	**You pay**
• Voluntary sterilization • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing, unless services are received during an office visit, then the $10 copay applies.
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: – the condition produced a major effect on the member's appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: – surgery to produce a symmetrical appearance on the other breast; – treatment of any physical complications, such as lymphedemas; – breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing, unless services are received during an office visit, then the $10 copay applies.
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*

Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Extractions of teeth that interfere with radiation therapy; • Treatment of trauma resulting in injuries to the jaw, cheeks, lips, tongue, roof and floor of the mouth; • Treatment of bony impactions; • Surgical correction of anatomical abnormalities for treatment of temporomandibular disease when approved in advance by BlueCHOICE; and • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing, unless services are received during an office visit, then the $10 copay applies.
General anesthesia for certain dental patients, limited to: • Children through age 4 • Severely disabled people; and • People with medical or behavioral conditions that require hospitalization or general anesthesia for dental care. The general anesthesia must be provided in a network hospital, network freestanding surgery center or dentist's office. A primary care physician referral is required. The dental procedures themselves are not covered.	Nothing
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/pancreas • Liver • Lung: single –double • Pancreas • Allogeneic bone marrow transplant, if the treatment is part of a National Cancer Institute (NCI) phase III or IV trial, or the treatment is available elsewhere as part of a NCI phase III or IV trial. Donor screening tests and donor search expenses are also covered for allogeneic 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. National Transplant Program (NTP): We are a member of the Blue Quality Centers for Transplants. Note: Autologous bone marrow or stem cell transplants after high-dose chemotherapy to treat breast cancer, and related care, must be received at St. Louis University Hospital/SLU Care**.** All care for transplants must be coordinated through BlueCHOICE in writing. The physician should send a letter to the BlueCHOICE Medical Director requesting precertification. If you live outside the St. Louis metropolitan area, we may cover up to $10,000 in reasonable and necessary expenses for transportation, lodging and meals while you are away from home for the transplant. *This must be approved in advance by Case Management.* Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: • *Implants of artificial organs* • *Transplants not listed as covered* • *Organ donation expenses unless this program is covering the organ transplantation.*	*All charges*

Anesthesia	You pay
Professional services provided in – • Hospital (inpatient) General anesthesia for certain dental patients, limited to: • Children through age 4 • Severely disabled people; and • People with medical or behavioral conditions that require hospitalization or general anesthesia for dental care. The general anesthesia must be provided in a network hospital, network freestanding surgery center or dentist's office. A primary care physician referral is required. The dental procedures themselves are not covered.	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing $10 per office visit

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility**,** unless it is an emergency, (see Section 5(d)).
- 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; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing

Inpatient hospital continued on next page.

Inpatient hospital *(Continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and guest beds* • *Private nursing care*	*All charges.*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Nothing

Extended care benefits/skilled nursing care facility benefits	You pay
Extended care/skilled nursing facility (SNF): We cover treatment in a network skilled nursing facility for a condition that otherwise would require hospital confinement. You may transfer directly from the hospital. If you do not, your primary care physician must obtain advance approval from BlueCHOICE. We will cover the care only as long as it is medically necessary. We will notify you if we determine SNF care is no longer necessary. Then we will not cover any SNF charges after the date in the notice. We cover the following SNF services: • Semiprivate room and board (We will cover a private room if BlueCHOICE agrees in advance that it is medically necessary. If not, you are responsible for any difference between the private room and the semiprivate room.) • General nursing care • Drugs, medications, biologicals, supplies, equipment and services ordered by the attending network physician with the primary care physician's prior authorization.	Nothing
Not covered: custodial care	*All charges*
Hospice care	
When a terminally ill member's life expectancy has reached six months or less, the member may benefit from hospice care. This care provides pain control and emotional support. Your primary care physician must obtain advance approval from BlueCHOICE. You must go to a network hospital or receive care from a network home health agency licensed to provide hospice care. The hospice provider will write a treatment plan for your signature. BlueCHOICE and your primary care physician must coordinate your care. We also cover inpatient hospice care for short-term pain control.	Nothing
Not covered: Independent nursing, homemaker services; bereavement services	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	Nothing

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

Emergencies at network hospitals within our service area:

If possible, when an unexpected condition arises, call your primary care physician– unless you believe any delay would be harmful. This applies even if it's after office hours. Your primary care physician will tell you whether to go to the emergency room. Your primary care physician's number is listed on the front of your ID card.

If you need additional care after an emergency condition is stabilized, precertification is required. Your BlueCHOICE physician will handle this for you. We will make a decision about the care within 30 minutes after we receive all the necessary information.

When you need care right away but it is not an emergency, always call your primary care physician. Your primary care physician may have you come into the office for an urgent appointment. An urgent appointment is one scheduled with a physician for the same day or during hours not normally used for appointments.

Emergencies at non-network hospitals (inside or outside our service area):

If possible, when an unexpected condition arises, call your primary care physician unless you believe any delay would be harmful. This applies even if it's after office hours. Your primary care physician will tell you whether to go to the emergency room. Your primary care physician's number is listed on the front of your ID card.

If you receive emergency care before you call your primary care physician, you or a family member should notify your primary care physician as soon as possible. We encourage you to try to call within 24 hours. Your primary care physician's number is listed on the front of your ID card.

If you need additional care after an emergency condition is stabilized, precertification is required. We will make a decision about the care within 30 minutes after we receive all the necessary information.

If you are admitted as an inpatient to a non-network hospital as a result of an emergency, you, your doctor or a family member should call BlueCHOICE as soon as possible for precertification of the case. BlueCHOICE will cover your care until you are stabilized. Then you must transfer to a BlueCHOICE network hospital. The transfer must be coordinated through BlueCHOICE in advance.

BlueCHOICE will not provide benefits for continued care at a non-network hospital after you are stable enough to transfer.

When you need care right away but it is not an emergency, always call your primary care physician. Your primary care physician may have you come into the office for an urgent appointment. An urgent appointment is one scheduled with a physician for the same day or during hours not normally used for appointments.

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	$10 per office visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 at emergency room(waived if admitted)
• Hospital observation	$50 (waived if admitted)
If you need follow-up care after emergency treatment, call your primary care physician. If your primary care physician cannot provide the care, he or she will give you a written referral to a network specialist. If you are treated in the emergency room and then held for observation, only one copay will be charged. *If you receive follow-up care without a written referral from your primary care physician, you must pay all charges.*	
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	$10 per office visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 at emergency room (waived if admitted)
• Hospital observation	$50 (waived if admitted)
If you need follow-up care after emergency treatment, call your primary care physician. If your primary care physician cannot provide the care, he or she will give you a written referral to a network specialist. If you are treated in the emergency room and then held for observation, only one copay will be charged. After your condition is stabilized, you, the hospital, a family member or a friend must call us for approval of continued care. Benefits are available only until BlueCHOICE determines that your condition has improved enough for you to travel back to the BlueCHOICE service area. *If you receive follow-up care without a written referral from your primary care physician, you must pay all charges.*	

Emergency outside our area *(continued)* *Not covered:* • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area*	*All charges.*
Ambulance	
Professional ambulance and air ambulance service when medically appropriate. Transportation by air ambulance must be approved in advance by BlueCHOICE**.** See 5(c) for non-emergency service.	Nothing

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

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Copayments are the same as for any other illness or condition.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per office visit

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits *(Continued)*	**You pay**
• Diagnostic tests	$10 per office visit or test
• Individual and group therapy for the treatment of smoking cessation	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing on inpatient basis; $10 per visit for outpatient
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM generally will 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 think you have a mental health or substance abuse problem, we encourage you to see your primary care physician. Your primary care physician may treat you or may recommend that you call our mental health and substance abuse benefits manager.

If you do not wish to go through your primary care physician for mental illness or substance abuse care, to receive benefits you must call our mental health and substance abuse benefits manager before you receive care. This number is 1-800-965-2583, and is also listed on your ID card.

Network providers will handle all authorizations for you. However, your benefits allow up to two visits each calendar year to diagnose and assess a mental health condition, in or out of network, without authorization.

Mental health providers are included in the BlueCHOICE directory**.**

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 the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Some prescription drugs are covered only if your physician obtains prior authorization from us. In addition, coverage for some drugs is provided in limited quantities.
- 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 plan dentist must write the prescription, unless it is an emergency.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy, or by mail for a maintenance medication**.** For the same copay, you can also use the Internet to place your prescription orders at www.express-scripts.com.
- **Reimbursement for prescriptions purchased out-of-area will be covered up to the allowed amount after a $25 copayment.**
- **Most maintenance drugs are available through mail order.** To find out if a certain maintenance drug is available by mail order, call 1-800-655-1936.
- **We use an incentive-based three-tier formulary.** A formulary is a list of preferred drugs chosen for use based upon their effectiveness, safety and cost. Drugs are prescribed by Plan doctors and dispensed in accordance with BlueCHOICE's drug formulary. Nonpreferred brand-name drugs will be covered when prescribed by a Plan doctor. The Plan must authorize a nonpreferred brand-name drug before it may be dispensed. It is the prescribing doctor's responsibility to obtain the Plan's authorization. You pay a $5 copay per prescription unit or refill for generic drugs; $10 for preferred brand-name drugs; and $15 for nonpreferred brand-name drugs. When a generic drug is available but you or your physician request the brand-name drug, you pay the price difference between the generic and brand-name drug as well as the $5 copay per prescription or refill *unless* your physician has obtained prior authorization for the brand-name drug. When the physician has obtained the prior authorization, you pay only the appropriate brand copay.
- **These are the dispensing limitations**. Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply for retail or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin); and are available at $5 for generic; $10 for preferred brand-name; and $15 for nonpreferred brand-name.

  Mail order prescription drugs are dispensed for up to a 90-day supply, and are available at $10 for generic; $20 for preferred brand-name; and $30 for nonpreferred brand-name.
- **Why use generic drugs?** Generic drugs normally cost considerably less than brand-name drugs. So, the copayment you pay for generic drugs is also lower. The generic name of a drug is its chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand-name drugs must meet the same standards for safety, purity, strength and effectiveness. They are dispensed in the same dosage and taken in the same way.
- **When you have to file a claim.**
  Follow the same procedures for filing a prescription drug claim found in Section 7.

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 and online program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered*. • Drugs that under state law are dispensed only with a written prescription from a physician or other lawful provider. • Insulin • Disposable needles and syringes for the administration of covered medications, including insulin • Drugs for sexual dysfunction (See Limited Drug Benefits below) • FDA-approved prescription drugs and devices for birth control • Diabetic test strips, lancets • FDA-approved medications for the treatment of tobacco use **Please note:** • Most prescriptions are limited to a 30-day supply each time the prescription is filled. • Refills your doctor authorizes are covered for up to 12 months from the original prescription date. Then a new prescription is required. • Some prescription drugs are covered only if your physician obtains prior authorization from us. In addition, coverage for some drugs is provided in limited quantities. • Intravenous fluids and medication for home use are provided under home health services at no charge; and some injectable drugs are covered under Medical and Surgical Benefits. **Limited Drug Benefits** Prescription benefits for the treatment of sexual dysfunction will only be available with prior authorization where sexual dysfunction is secondary to a medical condition and the medical history and work-up is documented. You must receive prior authorization before receiving any prescription for the treatment of sexual dysfunction. If approved, four prescribed treatments per month will be available and subject to the nonpreferred brand-name copayment.	Retail (up to a 30-day supply) $5 generic $10 preferred brand $15 nonpreferred brand Mail order and online (up to a 90-day supply) $10 generic $20 preferred brand $30 nonpreferred brand Note: If there is no generic equivalent available, you will still have to pay the brand-name copay.

Covered medications and supplies *(continued)*	**You pay**
Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name-brand drug when a Federally approved generic drug is available, *whether or not your physician has specified Dispense as Written* for the name-brand drug, you have to pay the difference in cost between the name-brand drug and the generic, unless your physician has obtained prior authorization for the brand-name drug. • We have an incentive-based, three-tier 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 copy of our Preferred Drug List, please call Client Services at 1-800-932-4480 or visit our Web site at www.bsbsmo.com/member_services.	
Not covered: • Drugs for which there is a nonprescription equivalent available • Drugs obtained at a non-Plan pharmacy (except out-of-area). • Vitamins and nutritional substances that can be purchased without a prescription • Medical equipment, devices and supplies such as dressings and antiseptics • Drugs for cosmetic purposes • Drugs to enhance athletic performance • Test agents and devices • Appetite suppressants and other drugs for weight loss • Nonprescription medicines	*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.
Away From Home Care	Through our BlueCard® program, BlueCHOICE offers its members medical care in emergency and urgent situations when traveling outside the service area. Also, members who are traveling for an extended time or who are on an extended work assignment in another city may be eligible to apply for a Guest Membership in a local Blue Cross and Blue Shield HMO. The Guest Membership also temporarily covers dependent children who are away at school or living in another city. For more information, see Section 1, page 8, or members can call Customer Service at the number listed on the back of their ID card.
RightSteps®	This is a voluntary program that strives to help mothers-to-be avoid potential problems during pregnancy. Pregnant women who choose to participate are asked to complete a questionnaire within 20 weeks of becoming pregnant. An obstetrical registered nurse will then contact the member periodically to provide information on pregnancy and childbirth. We encourage the member to have early, regular prenatal care and to pay attention to her lifestyle behaviors. Mothers-to-be who participate in the program will also receive a nationally recognized book on pregnancy, childbirth and infant care; up to a $40 reimbursement for the cost of a childbirth or parenting class; and a gift from us after the baby arrives.
TakeCharge® Asthma Program	Our goal is to help our members who have asthma manage their disease more successfully. Working with the patient's physician, we provide case management services to severe asthmatics through frequent phone calls, individual care plans, home health visits (as approved by the patient's doctor), durable medical equipment benefits and asthma educational material. Adults and children with mild or moderate asthma receive asthma educational materials as requested.

Section 5 (g). Special features

TakeCharge® Diabetes Program	This comprehensive care and disease management program is designed to support the health care needs of people with diabetes. The program is a complimentary, value-added service offered to members with diabetes to reinforce the diabetes treatment plan that has been designed by each member's physician. The member's doctor and other members of the diabetes management team also receive information about the program. This program provides newsletters, reminder cards and other important educational health information to members with diabetes throughout the year.
Note: Special programs such as *RightSteps®, TakeCharge® Asthma Program and TakeCharge® Diabetes Program* are special programs that are available to members who have primary health coverage through BlueCHOICE.	

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 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

Dental Benefits

Service	You pay
The following dental services are covered when provided by your participating Plan primary dentist: • Office visit for oral examination, limited to two visits per calendar year • Oral prophylaxis (cleaning) as necessary, limited to two visits per calendar year • Topical application of fluorides is limited to two courses of treatment per calendar year, limited to children under age 18 • Oral hygiene instruction • Dietary advice and counseling • Consultations with Primary Dentist *Not Covered: Any procedures or services not listed.*	$ 5 per office visit

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

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them**. Fees you pay for these services do not count toward the FEHB out-of-pocket maximum. Your medical program copay does not apply to these services. You must pay for the services or supplies when you receive them.

Wellness and Education Programs

Eat Smart: Learn to eat right and control your weight. You'll get $75 if you achieve your weight loss goal through a participating facility.

Breathe Easy: Smoking cessation classes offered in cooperation with local health care providers teach you some helpful tips for kicking the habit. Earn $50 for regular class attendance and for quitting smoking.

Physical Fitness: If you are 18 or older, we will reimburse you 25% (up to $100) for a single membership and 50% of annual dues (up to $200) for a family membership at the health club of your choice.

Self-Help Educational Information: Free literature is available on a variety of subjects, including stress, alcohol, drugs and cholesterol.

Discounted Services

Hearing Aids: Free hearing evaluations and savings on hearing aids are available through Accent Hearing Network providers and HearAmerica providers.

Vision Care: BlueCHOICE members may receive discounts on eye exams, lenses and frames by showing their ID card at a participating vision center. Members also can receive discounts off the regular retail price for all eye care accessories, including contact lens solutions and non-prescription sunglasses. Members can obtain discounted eye wear and eye care services through Access Eye Care network, Unity Health Eye Care network or Crown Optical.*

*Savings on LASIK surgery are available to members through Crown Optical. For more information, contact Crown at 1-800-232-4526.

Alternative Health Programs through American Specialty Health Networks: BlueCHOICE provides access to an alternative health care discount program through American Specialty Health Networks (ASHN). BlueCHOICE members can pay discounted fees when they see chiropractors, acupuncturists and massage therapists in ASHN's credentialed network. Members receive ASHN's toll-free telephone number to request provider directories and program brochures when they enroll.

In addition, members can access ASHN's national network of fitness clubs at the clubs' lowest membership rates. Additionally, members can try the fitness facilities at no charge for one full week.

Additional discounts are available for everything from educational videos to herbal supplements ordered through the Internet. Just go to **www.bcbsmo.com** for additional information.

For more information on any of the special programs described on this page, call Client Services at 1-800-932-4480.

Note: We may receive payments from the providers of these discount programs to cover administrative and related costs associated with offering the programs and services to members. We do not select or recommend providers for the discount programs and do not recommend or prescribe the services or treatments provided. We encourage members to consult with their physician about any of these services or products.

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 the 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.

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 1-800-932-4480.

How to file a claim:

- You can obtain claim forms by calling Client Services at 1-800-932-4480. The back of the claim form has complete filing instructions.
- You can use the same claim form to file a claim for all your health care benefits.
- You may submit claims for more than one person in the same envelope. *However, you must submit a separate claim form for each person.* Attach each person's bill to the correct form.
- Complete the claim form fully and accurately. You must check "yes" or "no" for each question. If you do not answer a question, we may have to return your claim to you. This is also true if you do not provide additional information required.
- When you write in your identification number on the claim form, be sure to include the first three digits.
- We can only accept itemized bills. Each bill must show: the name of the patient; the name and address of the provider of care; a description of each service and the date provided; a diagnosis; and the charge for each service.
- Canceled checks and nonitemized bills that show only "balance due" or "for professional services rendered" are not sufficient.
- Include all bills for covered services not previously submitted.
- If you have paid the provider, mark each bill "paid."
- In some cases, we will pay you directly for covered services. In other cases, we will pay the provider.
- Please keep copies of the completed claim form and itemized bills.
- Send your claims to the address shown on the form.

Prescription drugs

- Major chains and independent pharmacies belong to your pharmacy network. At these pharmacies, if you show your BlueCHOICE ID card, you should only be responsible for paying your share of the cost. The pharmacy should file your claim, and we will pay the pharmacy directly.

At a Non-Network Pharmacy: If you go to a non-network pharmacy in an urgent or emergency situation outside the BlueCHOICE service area, you are responsible for paying for your prescription at the time of service and then filing a claim. Your program will not provide benefits if you use a non-network pharmacy within the BlueCHOICE service area.

You can obtain a Prescription Drug Claim Form by calling Client Services at 1-800-932-4480.

You can file up to three prescriptions on each form. *Please do not use a regular health benefits claim form to file your prescription drug claim.* If you do, your claim may be denied.

- Please fill out a separate claim form for each person and pharmacy.
- Be sure to provide all the information requested for each prescription. You may need to have the pharmacy complete the form or get the information from the pharmacy.
- Then you or the pharmacist should fill out the pharmacy's name, address and National Association of Board of Pharmacy (NABP) number.
- On the completed form, *tape* your *original* itemized prescription drug receipt(s). Please do not send cash register receipts, canceled checks, bottle labels, copies of the original prescription drug receipts, or your own itemization of charges.
- The receipt(s) must show: the prescription number, the patient's name, the name of the drug, the quantity and unit dose, and the strength of the drug.
- Sign the claim form. Then mail it and your receipt(s) to the address shown on the form.

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 six months from the date of our decision; and (b) Send your request to us at: BlueCHOICE Grievance Unit P.O. Box 66828 St. Louis, MO 63166-6828 (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request -- go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 2, 1900 E Street, NW, Washington, DC 20415-3620. 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 its 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 1-800-932-4480 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 it can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 2 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. All programs together will not pay more than 100% of allowable expenses. The allowable expense is the maximum amount that a plan will pay for covered services. 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 1-800-MEDICARE 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 + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

•The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is a Medicare+Choice plan that 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 and you will still be responsible for the Plan's copayments.*

(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.)		✓
4) Are a Federal judge who retired under Title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of Title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you—or a covered family member—have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and a) Are an annuitant	✓	
b) Are an active employee, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

•Filing a claim

When this Plan is primary and you have a claim for covered services that you must file yourself, please follow the claim filing instruction in Section 7.

Once you receive an Explanation of Benefits (EOB) from us, then file a claim for your Medicare benefits. *(For information on filing a Medicare claim, contact your Social Security office.) When Original Medicare is primary* you must submit your claims to Medicare first. The federal government requires most health care providers and suppliers to file your

Medicare claims for you. So in most cases, you shouldn't need to file a claim to obtain your Medicare benefits.

Also, in most cases, *you* shouldn't need to file to receive the benefits of *this* program. If the services or supplies are covered by Medicare, the Medicare carrier will usually forward your medical claim to us. Then we will provide the benefits of this program automatically in most cases.

You should *not* submit a claim for benefits of this program if your Medicare EOB states, in part: "This information is being sent to your private insurer." This note means that the Medicare carrier is submitting your claim to us. Then we can provide the benefits of this program. If this note is on your Medicare EOB, please do *not* submit a claim to us. Also, please let your providers of care know that they should *not* submit your claim to us. When we receive duplicate claims, this increases costs.

Your Medicare EOB may not indicate that your claim has been referred to supplemental claims processing. In that case, you should file your own claim.

•To file your own claim

To file, send us a copy of your Medicare EOB. Include a completed claim form and copies of your itemized bills. Send the information to the address shown on the claim form.

You should also file a claim if you receive services or supplies that are not covered by Medicare but are covered by this program. Send a completed claim form and copies of your itemized bills to us.

•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 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

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

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but **you will still be responsible for** copayments**.** If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare 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 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.

Copayment

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

Covered services

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

Custodial care

Services that do not seek to cure, but are provided primarily for the convenience of the patient or his or her family, the maintenance of the patient, or to assist the patient in meeting his or her activities of daily living, rather than primarily for therapeutic value in the treatment of a Condition. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, eating, preparation of special diets, supervision over self-administration of medications not requiring constant attention of trained medical personnel, or acting as a companion or sitter.

Note: BlueCHOICE will have the sole discretion to determine whether Care is Custodial Care. BlueCHOICE may consult with professional peer review committees or other appropriate sources for recommendations.

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.

An FDA-approved drug, device or biological product (for use other than its intended purpose and labeled indications), or medical treatment or procedure 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, 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 authorized 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.

FDA-approved drugs, devices, or biological products used for their intended purpose and labeled indication and those that have received FDA approval subject to postmarketing approval clinical trials, and devices classified by the FDA as "Category B Non-experimental/Investigational Devices" are not considered experimental or investigational.

Group health coverage

A health benefit plan that is offered to employees through their place of employment or to the membership of a sponsoring organization such as a union or association.

Medical necessity

We only cover care that is medically necessary. But we do not cover all medically necessary care. Even if the type of care is covered in general, the care is not covered if we determine it was not medically necessary in a specific case. BlueCHOICE must agree that care was medically necessary.

However, in some cases, you will not have to pay for care that was not medically necessary. In these cases, the provider is responsible. You do not need to pay if *all* of the following are true:

- You obtained the proper referral for the care.
- BlueCHOICE did not notify you in advance that the care was not medically necessary.
- The services would have been covered if they were medically necessary.

To be medically necessary, care must be provided to diagnose or treat a condition. Also, the type and level of care must be necessary and appropriate. We use current standards of medical practice to decide necessity and appropriateness. The type and level of care must not be more than what is necessary.

For example, surgery may not be medically necessary for your condition if your provider has not tried more conservative treatment. Also, inpatient care is not medically necessary if appropriate care is available on an outpatient basis.

Plan allowance

The maximum amount we will pay for covered services.

Us/We

Us and we refer to BlueCHOICE.

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

•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 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 their 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.
- Retirees 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.

Department of Defense/FEHB Demonstration Project

What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 open season for the year 2000. Open season enrollments will be effective January 1, 2002. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible

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

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

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

The demonstration areas

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

When you can join

You may enroll under the FEHB/DoD Demonstration Project during the 2001 open season, November 12, 2001, through December 10, 2001. Your coverage will begin January 1, 2002. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877/DOD-FEHB (1-877/363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during open season. Your coverage will begin January 1, 2002. If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a Web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2002 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM Web site at www.opm.gov.

Temporary Continuation of Coverage (TCC)

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

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

Other features

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

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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.

Summary of benefits for BlueCHOICE – 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	15
Services provided by a hospital:		
• Inpatient.....	Nothing	32
• Outpatient	Nothing	33
Emergency benefits:		
• In-area.....	$ 50 per emergency room visit	37
• Out-of-area.....	$ 50 per emergency room visit	37
Mental health and substance abuse treatment	Regular cost sharing	39
Prescription drugs.....	$5 generic $10 preferred brand name $15 nonpreferred brand name	41
Mail order	$10 generic $20 preferred brand name $30 nonpreferred brand name	
Dental Care	Preventive care only; $5 copay	46
Vision Care	Routine eye exam (one per calendar year); $10 per office visit. Eyeglasses and contact lenses are covered up to $35 per 24-month period. Reduced-cost glasses or contact lenses from selected providers.	22

Special features: • Away From Home Care • RightSteps® • TakeCharge® Asthma Program • TakeCharge® Diabetes Program		44
Protection against catastrophic costs (your out-of-pocket maximum)	After you pay 100% of your annual premium in copayments for one family member, or 100% of your annual premium for two or more family members, you do not have to make any further payments for certain services for the rest of the year. Some costs do not count toward this protection.	13

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2002 Rate Information for
BlueCHOICE

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
Self Only	9G1	$92.00	$30.67	$199.34	$66.45	$108.87	$13.80
Self and Family	9G2	$199.19	$66.39	$431.57	$143.85	$235.70	$29.88