The Health Plan of the Upper Ohio Valley

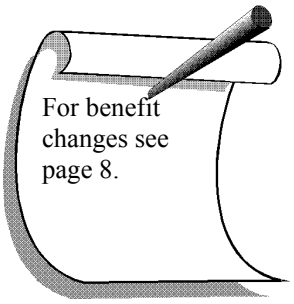
http://www.healthplan.org

2002

A Health Maintenance Organization

Serving: Eastern Ohio and Northern and Central West Virginia

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 7 for requirements.



This Plan has an excellent accreditation from the NCQA. See the 2002 Guide for more information on accreditation.

Enrollment codes for this Plan:

U41 Self Only
U42 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 73-553

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Introduction

The Health Plan of the Upper Ohio Valley Inc. (The Health Plan HMO)
52160 National Road, East
St. Clairsville, Ohio 43950

This brochure describes the benefits of The Health Plan HMO under our contract (CS 2616) 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 8. 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 The Health Plan HMO.
- 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 us know. Visit OPM's "Rate US" feedback area at www.opm.gov/insure or e-mail us at fehbwebcomments@opm.gov.

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 800/624-6961 and explain the situation.
- If we do not resolve the issue, call

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 and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. We pay our physicians under a fee-for-service basis, meaning that our physicians get paid only when they provide service to you.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

We are considered an Individual Practice Association (IPA) type of HMO, providing medical services by contracting with over 1,200 primary care and specialty care physicians and 24 hospitals. We serve the residents of Eastern Ohio and Northern and Central West Virginia.

- We are a 501(c)(4) Not-for-Profit organization
- We are federally-qualified and state-certified
- We hold Certificates of Authority in 20 West Virginia counties and 8 Ohio counties
- We have commendable accreditation from the National Committee for Quality Assurance (NCQA)
- We began operations in 1979

If you want more information about us, call 800/624-6961, or write to The Health Plan, 52160 National Road, East, St. Clairsville, Ohio 43950. You may also contact us by fax at 740/695-5297 or visit our website at www.healthplan.org

Service Area

To enroll with us, you must live in or work in our service area. This is where our providers practice. Our service area is these counties:

In Ohio: Belmont, Guernsey, Harrison, Jefferson, Monroe, Muskingum, Noble, and Washington.

In West Virginia: Barbour, Brooke, Doddridge, Gilmer, Hancock, Harrison, Lewis, Marion, Marshall, Monongalia, Ohio, Pleasants, Preston, Ritchie, Taylor, Tyler, Upshur, Wetzel, Wirt, and Wood.

Normally, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency or urgent care. We will not pay for any other health care service outside our service area.

If you or a covered family member moves outside of our service area, you can enroll in a new plan. If your dependents live out of the area (for example, if you child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 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 removed the requirement that services must be needed to restore functional speech from the speech therapy benefit (Section 5 (a))

Changes to this Plan

- Your share of the non-postal premium will increase 14.7 % for Self Only and 16.3 % for Self and Family.
- You will pay 30% of our allowance for Growth Hormone Therapy. Previously, we did not charge a copayment for Growth Hormone Therapy.
- We will limit Outpatient Rehabilitative Therapies to the greater of two months or 20 visits per condition. Previously, we limited Outpatient Rehabilitative Therapy to two months per condition.
- For covered medications and supplies available for up to a 31-day supply you will pay $10 per generic drug, $20 per formulary brand name drug and $35 per non-formulary name brand drug. See page 35. Previously, you paid $5 per generic drug, or $10 per brand name drug.
- We now cover certain intestinal transplants (Section 5 (b))

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800/624-6961.

Where you get covered care

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

- **Plan providers**

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

We list Plan providers in the provider directory, which we update periodically. The list is also on our website. We have two provider lists, one for the Ohio Valley Region and one for the Mountaineer Region. The Ohio Valley Region provider list includes providers in the northern panhandle of West Virginia and Eastern Ohio. The Mountaineer Region provider list includes providers in north and west central West Virginia.

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician from our provider lists. This decision is important since your primary care physician provides or arranges for most of your health care. If you do not select a primary care physician, it may result in non-payment of claims.

- **Primary care**

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

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one. You and each family member may change primary care physicians once per month.

- **Specialty care**

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

an OB/GYN without a referral if you select one as your secondary care physician.

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.

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800/624-6961. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

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

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this preauthorization. Your physician must obtain preauthorization for services, such as, elective and extended hospital stays, CAT Scans, MRIs, outpatient surgeries, durable medical equipment, skilled nursing care, home health services, outpatient thearapies, and scheduled ambulance transports.

We will review the requested service and our Medical Director will either approve it or deny it. In the event of denial, your physician will be notified by phone within one business day and by mail. You will receive notice by mail. If we do not authorize your services, you may request a second review. If we uphold our denial, you may file a formal appeal with us. See page 41 for the disputed claims process.

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

  Example: In our Plan, you pay 20% of charges for durable medical equipment.

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

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

- Prescription Drugs
- Dental services (accidental in nature)

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

Section 5. Benefits -- OVERVIEW

(See page 8 for how our benefits changed this year and page 55 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 800/624-6961 or 740/695-3585 or at our website at www.healthplan.org.

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

IMPORTANT

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

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

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office • In-office medical consultation • In-office surgical opinion • At home	$10 per visit
Professional services of physicians • In an urgent care center (see page 31 for urgent care benefit) • During a hospital stay • In a skilled nursing facility • Second surgical opinion while in a hospital	Nothing
Lab, X-ray and other diagnostic tests	**You pay**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing, if you receive these services during your office visit; otherwise, $10 per visit.

Preventive care, adult	
Routine screenings, such as • Total Blood Cholesterol • Colorectal Cancer Screening Prostate Specific Antigen (PSA test) Routine pap test Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years Routine immunizations, such as: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines	Nothing, if you receive these services during your office visit; otherwise, $10 per visit.
Not covered: Physical exams not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing, if you receive these services during your office visit; otherwise, $10 per visit.
• Examinations, such as: -Eye exams provided by PCP, through age 17 to determine the need for vision correction. -Ear exams through age 17 to determine the need for hearing correction • Well-child care charges for routine examinations, immunizations and care up to age 22 • Child health supervision services (review of physical and emotional status, birth to age nine)	$10 per visit
Maternity care	
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 10 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	$10 for initial visit only
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*

Family planning	You pay
A broad range of voluntary family planning services, such as : • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs, such as Depo Provera • Contraceptive devices, such as diaphragms and Intrauterine devices (IUDs) NOTE: We cover oral contraceptives under the prescription drug benefit	$10 per visit Note: Depo Provera is $15 per injection in addition to the office visit copay.
Not covered: reversal of voluntary surgical sterilization, genetic counseling, paternity testing, Estrogen & Androgen pellet implants.	*All charges.*
Infertility services	
Diagnosis and treatment of infertility, such as: • Artificial insemination: - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) • Basic health care services such as diagnostic and exploratory procedures to determine infertility including surgical procedures to correct medically diagnosed diseases or conditions of the reproductive organs	$10 per visit
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* *- in vitro fertilization* *- embryo transfer, gamete GIFT and zygote ZIFT* *- surrogate parenting* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm and sperm washing* • *Cost of donor egg* • *Fertility drugs (oral, topical or injectible)* • *Experimental services*	*All charges.*

Allergy care	
Testing and treatment Allergy injection	$10 per visit
Allergy serum	Nothing
Not covered: 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 25. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	$10 per visit
• Growth hormone therapy (GHT) Note: – We cover GHT under our medical benefits. We will only cover GHT when we preauthorize the treatment. Call 800/624-6961 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	30% of our allowance
Physical and occupational therapies	
• Outpatient (the greater of two months or 20 visits per condition) and inpatient (60 days per calendar year) for the services of each of the following: -qualified physical therapists and -occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.	$15 per outpatient visit Nothing per inpatient visit
•Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, at a plan-approved facility for up to 12 weeks or 36 visits per calendar year.	Nothing
•Pulmonary rehabilitation at a plan-approved facility for up to 12 weeks or 36 visits per calendar year.	Nothing

Rehabilitative therapies *(Continued)*	**You pay**
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*
Speech therapy	
• Outpatient (the greater of two months or 20 visits per condition) and inpatient (60 days per calendar year)	$15 per outpatient visit Nothing per inpatient visit
Hearing services (testing, treatment, and supplies)	
• Hearing exams are limited to one per calendar year to determine the need for hearing correction • Hearing testing for children through age 17 (see *Preventive care, children*) • Hearing aids are limited to one hearing aid per lifetime	$10 per visit
Not covered: • *All other hearing testing* • *Replacement or repair of hearing aids and batteries for them*	*All charges.*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) • Eye exam provided by PCP, to determine the need for vision correction for children through age 17 (see preventive care) • Ophthalmologist visits for diagnosis and treatment of diseases of the eye. (requires prior approval)	$10 per visit
Not covered: • *Eyeglasses, frames or contact lenses and examinations for them, after age 17,* • *Eye exercises, vision therapy and orthoptics,* • *Radial keratotomy and other refractive surgery.*	*All charges.*
Foot care	
Routine foot care by a licensed Podiatrist, 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.	$15 per visit

Foot care *(Continued)*	**You pay**
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 fallen arches, 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)* • *Strapping or taping of the feet* • *Hygienic and preventive maintenance care such as, cleaning and soaking the feet, the use of skin creams to maintain skin tone of either ambulatory or bedfast patients and any other service performed in the absence of localized illness, injury or symptoms involving the foot*	*All charges.*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See 5(b) for coverage of the surgery to insert the device. • Foot orthotics	20% of charges
• Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	30% of charges
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Replacement of prosthetics provided prior to the end of their expected life (except for replacement due to growth or development in children up to age 18)*	*All charges.*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds; • standard model wheelchairs; • crutches; • walkers; • ostomy and catheter supplies; and • insulin pumps. Note: DME must be medically necessary and be pre-authorized by us prior to dispensing. DME is limited to standard model only.	20% of charges
• blood glucose monitors Note: We require the use of specific blood glucose monitors.	Nothing
Not covered: • *Replacement of DME prior to the end of its expected life (except for replacement due to growth or development in children up to age 18)* • *Batteries for DME items, such as batteries required for hearing aids, tens units, wheelchairs and glucometers* • *Equipment or supplies primarily used for patient comfort or convenience* • *Home modifications* • *Supplies such as, tape, alcohol, Q-tips/swabs, gauze, bandages, thermometers, aspirin, diapers (adult or infant), heating pads, or ice bags* • *Professional medical equipment such as, blood pressure units, or stethoscopes*	*All charges.*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. Note: We must preauthorize Home health services prior to services being rendered.	Nothing

Not covered: • *nursing care requested by, or for the convenience of, the patient or the patient's family;* • *home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges.*
Chiropractic	
• Up to 20 visits per calendar year with approved referral from your PCP	$15 per visit
Not covered: • *Non-subluxation services*	*All charges*
Alternative treatments	
Biofeedback Therapy (for incontinence only)	30% of charges
Not covered**:** • *Acupuncture services* • *Naturopathic services* • *Hypnotherapy* • *Biofeedback (except for incontinence)* • *Massage therapy* • *Christian Science Treatment* • *All other alternative treatment services not listed as covered*	*All charges.*
Educational classes and programs	
Coverage is limited to: • Work site Smoking Cessation classes – This program is available when requested by your employer. Our full time nurse provides classes. If you are interested in these classes, please call us at 800/ 624-6961 or 740/695-3585 for more information. • Diabetes education – Up to 8 group and 8 individual classes in a 12-month period.	Nothing

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- 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% 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.	$10 per office visit; nothing for hospital visits
• Voluntary sterilization • Treatment of burns	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*

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

Oral and maxillofacial surgery *(Continued)*	**You pay**
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Non-medical TMJ services*	*All charges.*
Organ/tissue transplants	
Transplants must be approved by our Medical Director and are limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas Note: We cover actual acquisition costs of the donor when we cover the recipient.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center • Skilled nursing facility	Nothing
Professional services provided in – • Office	$10 per 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.
- We have no calendar year deductibles.
- 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 ELECTIVE 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)*	**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 • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing
Not covered: • *Custodial care, rest cures, domiciliary or convalescent care* • *Non-covered facilities* • *Personal comfort items, such as telephone, television, barber services, guest meals and 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 • 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	
Skilled nursing facility (SNF): Up to 120 days per calendar year when full-time nursing care and confinement to a SNF is medically appropriate. All necessary services are covered, such as: • Bed, board, and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the SNF when prescribed by your physician	$25 per day
Not covered: custodial care or domicillary care, respite care, private duty nursing, intermediate care, rest cure or other services primarily to assist in the activities of daily living and personal comfort items , such as hygienic and convenience items and telephones and televisions	*All charges*

Hospice care	You pay
• Supportive and palliative care for a terminally ill member, including home care and family counseling. Note: These services are provided when your physician certifies that the member is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing
Not covered: • *Independent nursing, homemaker services* • *See "not covered" under SNF benefits*	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	$25 per service

Section 5 (d). Emergency services/accidents

IMPORTANT

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

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

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

In extreme emergencies, contact the local emergency system (e.g., 911-telephone system). If you are in an emergency situation, you should follow these steps:

- **First:** When practical, call your PCP day or night. He or she can direct you to the appropriate care and can assure the proper follow-up to that care.

- **If your PCP cannot be reached,** call our 24-hour emergency number, 800/624-6961 or 740/695-3585. You will be put in contact with our nurse on call for directions on what to do.

- **In a situation when a telephone call is impractical or impossible**, go directly to one of our nearest participating hospital emergency rooms, if possible. Identify yourself as a Health Plan member. You or a family member must contact us within 48 hours of the visit, unless it was not reasonably possible to do so. It is your responsibility to ensure that we have been timely notified. You should also inform your physician of the situation, that way your care can be better coordinated.

Emergencies within our service area: If you are in an emergency situation within our service area, please follow the above steps under "What to do in case of emergency". If you need to be hospitalized, we must be notified within 48 hours or on the first working day following the admission, unless it was not reasonably possible to notify us within that timeframe. If you are hospitalized in non-Plan facilities and your physician believes care can be better provided in a Plan facility, you will be transferred when medically feasible with any ambulance charges covered in full. Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition. Any follow-up care recommended by non-Plan providers must be approved by us or provided by Plan providers.

Emergencies outside our service area: If you are in an emergency situation outside our service area, please follow the above steps under "What to do in case of emergency". If you need to be hospitalized, we must be notified within 48 hours or on the first working day following the admission, unless it was not reasonably possible to notify us within that timeframe. If your physician believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full. Any follow-up care recommended by non-Plan providers must be approved by us or provided by Plan providers.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$10 per visit
• Emergency or urgent care at an urgent care center	$25 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 per visit Note: Waived if admitted
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care or urgent care at an urgent care center	$25 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 per visit Note: Waived if admitted
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service*	*All charges.*
Ambulance	
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	$25 per service

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

IMPORTANT

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per visit

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits *(Continued)*	**You pay**
• Diagnostic tests • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered: Services we have not approved. Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.	*All charges.*

Preauthorization

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

Contact our Behavioral Health Administrator toll free at (877) 221-9295 for mental health and substance abuse services

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.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A licensed physician, licensed dentist or oral surgeon, nurse practitioner, optometrist, or physician's assistant must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy.
- **We use a formulary.** Drugs are prescribed and dispensed in accordance with our drug formulary. A drug formulary is a list of brand name drugs that we cover. We cover non-formulary drugs prescribed by a Plan doctor. 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 our formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure or drug formulary, call 800/624-6961. You may also choose to receive a non-formulary prescription and pay the higher third tier copay.

- **These are the dispensing limitations.** Generally, we allow dispensing of FDA-approved drugs up to a 31-day supply per copay. Limits may be applied to assure that dispensing of medication conforms to the approved Federal labeling of the formulary drug. Furthermore, if you have your prescription filled too early, it will not be allowed. You must use three-fourths of the days supplied before a refill will be allowed.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

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

When you have to file a claim. If you are in a situation outside our service area, for which you cannot go to a plan pharmacy and a physician has prescribed covered medication that is urgently needed, please go to any pharmacy and purchase the medication. Return your receipt to The Health Plan and you will be reimbursed in full, less the applicable copay amount.

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 for up to a 31-day supply: • Drugs for which a prescription is required by law • Diabetic supplies, including insulin, glucose test tablets and test tape, Benedict's solution or equivalent and acetone test tablets • Disposable needles and syringes for the administration of covered medications • Intravenous fluids and medications for home use, some injectible drugs (such as Depo Provera) are covered under medical services and supplies • Contraceptive drugs and devices (devices are covered under medical services and supplies) • Prenatal vitamins • Sexual dysfunction drugs have dispensing limitations. Contact the Plan for details.	$10 per prescription unit or refill for generic drugs. $20 per prescription unit or refill for formulary brand name drugs $35 per prescription unit or refill for non-formulary brand name drugs Note: If there is no generic equivalent available, you will still have to pay the applicable brand name copay.

Covered medications and supplies *(Continued)*	**You pay**
Not covered: • *Drugs and supplies for cosmetic purposes* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Medical supplies such as dressings and antiseptics* • *Drugs to enhance athletic performance* • *Smoking cessation drugs and medications, including nicotine patches* • *Drugs for weight control* • *Infertility drugs* • *Vitamins and nutritional substances that can be purchased without a prescription* • *Nonprescription medicines*	*All Charges*

Section 5 (g). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization days for oral surgical procedures only when certified by the PCP as being medically necessary to safeguard your life and approved by us. We do not cover dental procedures.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	Nothing.

Dental benefits

We have no other dental benefits.

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

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB Program, but are made available to all enrollees and family members who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium; any charges for these services do not count toward any FEHB deductible, out-of-pocket maximum copay charges, etc. These benefits are not subject to the FEHB disputed claims procedures.

Medicare+ Choice product- This Plan offers Medicare recipients the opportunity to enroll in its Medicare+ Choice product. The Plan's service area for Medicare+ Choice is different then its FEHB program service area. You must have Medicare part A & B to enroll in the Medicare+ Choice product. For more information about the Medicare+ Choice product, please contact us at 740/695-7656, or 800/624-6961.

Vision One eyecare program - The Plan is pleased to offer its FEHB members savings on your eyecare needs...frames, lenses, contacts, and exams. Operated in conjunction with Cole Vision, you may now obtain substantial savings on a wide range of vision services at any of the 1600 participating Sears, JC Penny, Montgomery Wards, or Pearle Vision Express Departments nationwide. To take advantage of these savings, simply show your Health Plan ID card at the above participating eyecare centers. Your savings are applied directly to your purchase. There is no paperwork to fill out or claim forms to submit.

Merck-Medco Mail Service Pharmacy – The Plan is now offering a voluntary mail order prescription drug program administered by Merck-Medco Mail Service Pharmacy. The Merck-Medco Mail Service Pharmacy is a convenient, safe and cost effective way to obtain prescription medications for chronic conditions such as diabetes, asthma or high blood pressure as well as prescriptions taken on a long-term basis such as birth control pills.

If you or a covered family member take medications on a long-term basis, the mail order prescription drug program may save you money. The mail order copay is twice the cost of the 31-day retail copay for a **90-day supply**, as follows:

$20 for a generic prescription
$40 for a preferred (formulary) prescription
$70 for a non-preferred (non-formulary) prescription

If you would like more information about this program, please contact us at 740/695-3585 or 800/624-6961. You may also contact Merck-Medco Customer Service at 800/988-2262 or visit them at www.merckmedco.com.

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 or condition and we agree, as discussed under What Services Require Our Prior Approval on page 11.**

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical, hospital and prescription drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 800/624-6961.

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

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

Submit your claims to: **The Health Plan**
Attn: Claims Department
52160 National Road, East
St. Clairsville, Ohio 43950

Other supplies or services

Same as above.

Deadline for filing your claim

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: 52160 National Road, East, St. Clairsville, Ohio 43950; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or 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 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

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

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

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

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

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

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800/624-6961 and we will expedite our review; or

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

•What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

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

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

•The Original Medicare plan

The Original Medicare Plan is available everywhere in the United States. It is the way 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 the Original Medicare Plan 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 prior authorized as required.

We will not waive any of our copayments or coinsurance.

(Primary payer chart begins on next page.)

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

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

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

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something

about filing your claims, call us at (800) 624-6961; or email us at info@healthplan.org.

•Medicare managed care plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benfits 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 our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments, or coinsurance for your FEHB coverage.

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

• If you do not enroll Medicare Part A or Part B

Note: 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 members, eligible dependents, 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 eligible 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 12.

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

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

Custodial care
Treatment or services that are designed mainly to help the patient with daily living activities.

Deductible
A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.

Experimental or investigational services
Services, devices or drugs that we determine are not nationally accepted in conjunction with accredited specialty consultants, government agencies, and other regulatory agencies.

Group Health Coverage
Health care coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies.

Medical necessity
A service, device, or drug that meets its standardized medical criteria, derived from recognized accredited national sources. It is important to know that your physician may recommend a service, device, or drug that may sometimes not qualify as being medically necessary. Medical necessity is determined by our Medical staff, in coordination with local or regional members of the medical community or academic faculties.

Plan allowance
Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance based on our contracted amounts with our providers.

Us/We
Us and we refer to The Health Plan HMO

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 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.

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins 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.

•TCC

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

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

•Converting to individual coverage

You may convert to an 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. If you become eligible for other group health coverage, you will **not** be offered an individual policy.

Getting a Certificate of Group Health Plan Coverage

You may be entitled to continued coverage through the Health Insurance Portability and Accountibility Act of 1996 (HIPPA). This Federal law 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.

Get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. It highlights 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 HIPPA, and it has 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. It 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 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 planing.

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. {RV: 7-26}*

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.

Index

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

NOTES:

NOTES:

Summary of benefits for The Health Plan HMO - 2002

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

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist	14
Services provided by a hospital:		
• Inpatient	Nothing	27, 28
• Outpatient	Nothing	28
Emergency benefits:		
• In-area	$50 per visit	31
• Out-of-area	$50 per visit	31
Mental health and substance abuse treatment	Regular cost sharing	32, 33
Prescription drugs	$10 copay generic $20 copay formulary brand $35 non-formulary brand	34, 35, 36
Dental Care	No benefit.	37
Vision Care	$10 per visit.	19
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $1,500/Self Only or $3,000/Family enrollment per year Some costs do not count toward this protection	11

2002 Rate Information for
The Health Plan of the Upper Ohio Valley

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	U41	$88.00	$29.33	$190.67	$63.55	$104.13	$13.20
Self and Family	U42	$223.41	$99.25	$484.06	$215.04	$263.75	$58.91