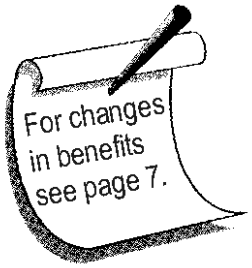
M•Plan

http://www.mplan.com

2002

A Health Maintenance Organization



Serving: *Indiana Metropolitan areas*

Enrollment in this Plan is limited; see page 5 for requirements.

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

Enrollment codes for this Plan:

IN1 Self Only
IN2 Self and Family

Authorized for distribution by the:

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

Federal Employees
Health Benefits Program

RI 73-578

Table of Contents

Introduction

This brochure describes the benefits of M•Plan under our contract (CS2643) 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 are summarized on page 7. 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 M•Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let 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 317/571-5320 and explain the situation.
- If we do not resolve the issue, call

THE HEALTH CARE FRAUD HOTLINE
202/418-3300 or write to:
The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415.

Penalties for Fraud

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

Section 1. Facts about this HMO plan

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

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

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

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

How we pay providers

We contract with hospital networks 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.

M•Plan provides health care through several different networks of physicians. Provider networks are comprised of a specific group of primary care physicians, specialists and other providers affiliated with a specific hospital or network of hospitals. Services are only available from providers within the provider network you select. If a particular service is not available from your network, you will be referred to another M•Plan health network provider. Services of a specialty care doctor can only be received by referral from the selected primary care doctor.

Who provides my healthcare?

M•Plan provides health care through several different networks of physicians. Provider networks are comprised of a specific group of primary care physicians, specialists and other providers affiliated with a specific hospital or network of hospitals. Services are only available from providers within the provider network you select. If a particular service is not available from your network, you will be referred to another M•Plan health network provider. Services of a specialty care doctor can only be received by referral from the selected primary care doctor.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about your 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.

- M•Plan is licensed by the State of Indiana as a Competitive Medical Plan.
- We have been in existence since 1989.
- M•Plan is a for-profit HMO owned by The Health Care Group.

If you want more information about us, call 317/571-5320, or write to M•Plan Member Services, 8802 N. Meridian Street, Suite 100, Indianapolis, IN 46260. You may also contact us by fax at 317/571-5337 or visit our website at www.mplan.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This means you must maintain a permanent residence within or work within our service area. You must select a participating primary care physician whose office is located within fifty (50) miles of where you live. Our service area includes the Indiana counties of: Adams, Allen, Bartholomew, Boone, Brown, Carroll, Cass, Clinton, Daviess, Decatur, DeKalb, Delaware, Dubois, Fulton, Gibson, Grant, Hamilton, Hancock, Hendricks, Henry, Howard, Huntington, Jackson, Jennings, Johnson, Knox,

Kosciusko, Lagrange, Lawrence, Madison, Marion, Marshall, Martin, Miami, Monroe, Morgan, Noble, Orange, Pike, Posey, Rush, St. Joseph, Shelby, Spencer, Steuben, Tipton, Vanderburgh, Wabash, Warrick, Wells and Whitley.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency or urgent care as described on page 27. We will not pay for any other health care services.

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

Section 2. How we change for 2002

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

Program-wide changes

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

Changes to this Plan

- Your share of the non-Postal premium will increase by 22.4% for Self Only or 31.8% for Self and Family.
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5 (a))
- We clarified the Preventive care, adult benefits by removing the entry for blood lead level testing for adults because it is a test more typically done for children. (Section 5(a))
- We increased speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5 (a))
- We now cover certain intestinal transplants. (Section 5 (b))
- We changed the address for sending disputed claims to OPM. (Section 8)

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 317/571-5320.

Where you get covered care

You get care from "Plan providers" and "Plan facilities" that work within specific networks. Our directory lists M•Plan providers and facilities according to their networks. You will only pay copayments or coinsurance for covered services 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 the National Committee for Quality Assurance standards.

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

- **Plan facilities**

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

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose one of the M●Plan provider networks. Then, you choose a primary care physician within that network. Your decision is important because your primary care physician provides or arranges for your health care services within his or her network. Services of a specialty care doctor can only be received by referral from your primary care doctor.

You may only receive services from providers within your selected network unless a particular service is unavailable from network providers. If this happens, you will be referred to another M•Plan health network provider who can provide the service you need.

- **Primary care**

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

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

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. Except in a medical emergency, or when a primary care doctor has designated another doctor to see patients when he or she is unavailable, you must receive a referral from your primary care doctor before seeing any other doctor or obtaining special services. Referrals to a participating specialist are given at the primary care doctor's discretion; if nonPlan specialists or consultants are required, the primary care doctor will make arrangements for appropriate referrals.

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 FEHB 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 317/571/5320. 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 hospital benefit 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 *the "prior authorization" process.* Your physician must obtain prior authorization for coverage of services, including but not limited to:

- Elective Surgery
- Extended Care Facility/Skilled Nursing Facility/Home Health
- Durable Medical Equipment (DME)
- Habilitative and Rehabilitative Therapies
- Hospital admissions
- Infertility Services
- Organ/Tissue Transplants
- Biologic Products (Blood\Blood Products\Biologicals\Biotech Drugs) such as Growth Hormone Therapy
- Orthopedic and Prosthetic Devices

You must obtain authorization for Mental Health and Substance Abuse treatment prior to seeking services.

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 or pharmacy, etc. when you receive services. Example: When you see your primary care physician you pay a copayment of $10 copay per office visit and when you go in the hospital, you pay nothing per admission.
• **Deductible**	We do not have a deductible.
• **Coinsurance**	Coinsurance is the percentage of charges that you must pay for your care. Coinsurance doesn't begin until you meet your deductible. Example: In our Plan, you pay 50% coinsurance for covered infertility services, durable medical equipment and prosthetic devices.
Your out-of-pocket maximum	We do not have an out-of-pocket maximum. You simply pay the stated copayments and coinsurance in the brochure.

Section 5. Benefits Overview

(See page 7 for how our benefits changed this year and page 53 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 317/571-5320 or at our website at www.mplan.com.

Section 5 (a) Medical services & 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 do not have a 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	**You pay**
Professional services of physicians • In physician's office	$10 per office visit
• Office medical consultations • Second surgical opinion	$10 per office visit
• In an urgent care center	$25 per urgent visit
Professional services of physicians • During a hospital stay • Initial examination in the hospital of a newborn child • In a skilled nursing facility	Nothing
At home	$25 per visit
Lab, X-ray and other diagnostic tests	**You pay**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing

Preventive care, adult	You pay
Routine screenings, such as: • Blood Sugar • Cholesterol • Colorectal Cancer Screening, including – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 • Prostate Specific Antigen (PSA test) – one annually for men age 40 and older • Routine pap test • Routine mammogram – covered for women age 35 and older as follows: – From age 35 through 39, one during this five year period – From age 40 through 64, one every calendar year – At age 65 and older, one every two consecutive calendar years	$10 per office visit; Nothing for lab or diagnostic tests
Not covered: • *Physical examinations and related tests and reports for the purpose of obtaining or maintaining employment, insurance, governmental licensure, attending camp, participating in sports, admissions to school and for premarital purposes.* • *Employer requested annual physical examinations and other services or supplies that are not Medically Necessary for the maintenance or improvement of the health of a Member.*	*All charges*
Routine immunizations base on accepted medical practice, such as: • Tetanus-diphtheria (Td) booster • Pneumococcal vaccines	Nothing
Not covered: Immunizations for travel	*All Charges*
Preventive care, children	**You pay**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care charges for routine examinations, immunizations and care • Examinations, such as: – Eye exams through age 17 to determine the need for vision correction. – Ear exams through age 17 to determine the need for hearing correction – Examinations done on the day of immunizations	$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 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. A child born to a Subscriber or a Subscriber's eligible spouse is automatically Covered for the first thirty-one (31) days from date of birth. For Coverage beyond the first thirty-one (31) days, an Enrollment Application must be filed with the Plan and applicable premiums paid within the first thirty-one (31) days from the date of birth. • 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 the initial office visit; Nothing for remaining visits
Not covered: • *Routine sonograms to determine fetal age, size or sex* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Family planning	**You pay**
A broad range of voluntary family planning services, limited to: • Voluntary sterilization	$10 physician charge per procedure
• Surgically implanted contraceptives (such as Norplant) • Intrauterine devices (IUDs) • Diaphragms and cervical caps NOTE: We cover oral and injectable contraceptives under the Prescription Drug Benefits (Section 5(f))	50% of all covered charges 50% of all covered charges 50% of all covered charges
Not covered: • *reversal of voluntary surgical sterilization* • *genetic counseling*	*All charges*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI)	50% of covered charges
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* – *in vitro fertilization* – *embryo transfer, gamete GIFT and Zygote ZIFT* – *Zygote transfer* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Infertility drugs and infertility drug therapy including therapeutic injections for the treatment of infertility*	*All charges*
Allergy care	**You pay**
• Testing and treatment • Allergy injection	$10 per office visit
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 are limited to those transplants listed under Organ/Tissue Transplants on page 23. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Biologic Products (Blood\Blood Products\Biologicals\Biotech Drugs) such as Growth hormone therapy (GHT) NOTE: We will only cover GHT when we prior authorize the treatment. Your primary care physician or specialists to whom you have been referred will request prior authorization. We will ask your provider to submit information that establishes that the GHT is medically necessary. If we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$10 per office visit if procedure is performed in the physician's office; Nothing if procedure is performed in the hospital or ambulatory surgical center

Physical and occupational therapies	You pay
• Up to two consecutive months per condition for the services of each of the following: – qualified physical therapists and – occupational therapists. NOTE: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury. • Cardiac rehabilitation following a cardiac event, such as a heart transplant, bypass surgery or a myocardial infarction – Phase I - Inpatient – Phase II - Outpatient Qualified cardiac rehabilitation candidates have been diagnosed with coronary artery disease following a recent (within twelve (12) months) acute event such as acute myocardial infarction, coronary artery bypass graft surgery, percutaneous transluminal coronary angioplasty, cardiac transplantation, cardiac valve surgery, cardiac stent placement, or one course of therapy following the initial diagnosis of congestive heart failure. We cover cardiac rehabilitation in Phase I/Inpatient Stay and Phase II/Outpatient services are limited to thirty-six (36) sessions over a twelve (12) week period.	Nothing
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges*
Speech therapy	**You pay**
• Up to two consecutive months per condition	Nothing
Hearing services (testing, treatment, and supplies)	**You pay**
• Hearing testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges*

Vision services (testing, treatment and supplies)	You pay
Annual eye refractions when obtained through participating vision care providers	$ 5 per office visit
Not covered: • *Eyeglasses or contact lenses and examinations for them (for Post cataract lenses coverage see Orthopedic and Prosthetic Devices)* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*

Foot care	You pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See Orthopedic and Prosthetic devices for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*

Orthopedic and prosthetic devices	You pay
Orthopedic and Prosthetic devices are covered when Medically Necessary and authorized in accordance with the Plan's prior authorization process and are included on the Plan's Orthopedic and Prosthetic device list. • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Corrective appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • One pair of refractive lenses or contact lenses following crystalline lens removal (primary cataract surgery) or the congenital absence of the crystalline lens of the eye. Contact lenses as required for the treatment of corneal disease with prior authorization.	50% of all covered charges

• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants (initial device only), 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. • Surgical dressings NOTE: You may contact us for a list of covered orthopedic and prosthetic devices. Please call Member Services at 317/571-5320.	Nothing
Not covered: • *Items not included in the Plan's orthopedic and prosthetic device list.* • *Loss, theft, misuse or neglect of orthopedic or prosthetic devices*	*All charges*
Durable medical equipment (DME)	**You pay**
Durable Medical Equipment is covered when Medically Necessary and authorized in accordance with the Plan's prior authorization process and included on the Plan's Durable medical Equipment list, such as: • hospital beds; • wheelchairs; • crutches; • walkers. NOTE: You may contact us for a list of covered orthopedic and prosthetic devices. Please call Member Services at 317/571-5320.	50% of all covered charges
Not covered: • *Personal comfort or convenience items* • *Items not included on the Plan's DME list* • *Loss, theft or misuse of DME*	*All charges*
Home health services	**You pay**
• Home health services of nurses and health aides, in lieu of hospitalization when prescribed by your Plan doctor, who will periodically review the programs for continuing appropriateness and need • *Services include oxygen therapy, intravenous therapy and medications.*	Nothing No day limit

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**
We do not cover chiropractic treatments. **NOTE: Please refer to Section 5 (i). Non-FEHB benefits available to Plan members**	*All charges*
Alternative treatments	**You pay**
We do not cover alternative treatments. **NOTE: Please refer to Section 5 (i). Non-FEHB benefits available to Plan members**	*All charges*
Educational classes and programs	**You pay**
Coverage is limited to: • Diabetes self-management classes • Smoking Cessation - up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs.	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 do not have a 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 charge (i.e. hospital, surgical center, etc.).
- YOUR PHYSICIAN MUST GET PRIOR AUTHORIZATION OF SOME SURGICAL PROCEDURES. Please refer to the prior authorization information shown in Section 3 to be sure which services require precertification and identify which surgeries require prior authorization.

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 -- non-experimental treatment of morbid obesity provided that the morbid obesity has persisted for at least five (5) years and non-surgical treatment, supervised by your physician for at least eighteen (18) months, has been unsuccessful. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • 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.	$10 per office visit if procedure is performed in the physician's office; Nothing if procedure is performed in the hospital or ambulatory surgical center
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; 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 prosthesis and surgical bras and replacements (see Prosthetic devices) NOTE: If you need a mastectomy, you may have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$10 per office visit if procedure is performed in the physician's office Nothing if procedure is performed in the hospital or ambulatory surgical center
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; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$10 per office visit if procedure is performed in the physician's office Nothing if procedure is performed in the hospital or ambulatory surgical center
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 • Allogenetic (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 must authorize all transplant services in advance. **NOTE: We cover transplant services for the donor only when the transplant recipient is a Member of the Plan. Coverage for the donor includes the following:** 1. A Covered transplant predetermination work-up; and 2. Medical treatment directly related to a Covered transplant procedure prior to the transplant; and 3. Hospital, professional and related follow-up services for human organs and tissue transplants; and 4. Any Covered transplant related follow-up treatment incurred during the original twelve (12) month period provided by the transplant Physician. 5. If the donor is not a Member, Covered Services for the donor are limited to those services and supplies directly related to the transplant procedure (itself) including complications and are Covered only to the extent that services are not Covered by other health insurance.	Nothing
Not covered: • *Medical and hospital services of an organ donor or prospective donor when the recipient of the organ transplant is not a member of the Plan.* • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*

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

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We do not have a 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 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 PRIOR AUTHORIZATION OF HOSPITAL STAYS. Please refer to Section 3 to be sure which services require prior authorization.

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
Other inpatient 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 and other biologicals • Dressings, splints and sterile tray services • 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* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds and take home items* • *Private nursing care*	*All charges*

Outpatient hospital or ambulatory surgical center	You pay
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: – We cover hospital services and hospital supplies related to dental procedures when necessitated by a non-dental physical or mental impairment. We do not cover the dental procedures or dental supplies.	Nothing
Extended care benefits/skilled nursing care facility benefits	**You pay**
We cover up to 80 days per contract year with no dollar limit when full-time necessary and confinement in a skilled nursing facility is medically appropriate. The service must be prescribed by your Plan doctor and approved by us. All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.	Nothing
Not covered: Custodial care, nursing home care, rest cures, domiciliary care regardless of location or setting.	*All charges*
Hospice care	**You pay**
We cover supportive and palliative care for a terminally ill member in the home or hospice facility. Covered services billed by the hospice include inpatient and outpatient care, and family counseling. Hospice services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	**You pay**
• Professional ambulance transport service when medically appropriate	20% of covered charges

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 do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within or outside our service area: If you are in an emergency situation, please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, contact the local emergency system (e.g., the 911-telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify us. You or a family member should notify us within 48 hours unless it is not reasonably possible to do so. It is your responsibility to ensure that we have been timely notified.

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

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability, or significant jeopardy to your condition. To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan 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 care at an urgent care center	$25 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$25 per visit (waived if admitted to hospital)
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	**You pay**
• Emergency care at a doctor's office	$10 per visit
• Emergency care at an urgent care center	$25 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$25 per visit (waived if admitted to hospital)
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area* • *Routine care outside the service area*	*All charges*
Ambulance	**You pay**
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	20% of covered charges

Section 5 (e) Mental health and substance abuse benefits

IMPORTANT

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

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We do not have a 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 PRIOR AUTHORIZATION 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 office visit
• Diagnostic evaluation and psychological testing	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
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*

Prior authorization	To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes: Your provider directory lists the phone number of your network mental health provider. You must call for authorization prior to seeking care unless in an emergency. See Section 5(d) for instructions in an emergency. Your network provider will develop a treatment plan based on your needs and authorize a certain number of visits to a mental health or substance abuse professional. You do not need a referral from your primary care doctor.

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 do not have a 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 plan physician must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy or by mail for a maintenance medication only. Non-Select drugs are not available through the mail order program.
- **We use a three tier formulary.** Our three tier formulary consists of Generic, Select and Non-Select drugs that we have approved for dispensing through Plan pharmacies. Please contact Member Services at 317/571-5320 for our formulary list.
  - Generic equivalent drug refers to those prescription drugs whose name brand counterparts are no longer under patent protection. Generic equivalent drugs must contain the same active ingredients as their name brand counterparts and must be identical in strength, dosage form and route of administration. Generic drugs must also supply the same amount of the active ingredient in the body, at the same rate, as the name brand drug. Generic equivalent drugs can be marketed only after the product and its manufacturer has been approved by the Food and Drug Administration (FDA). This requires that generic equivalent drugs be produced in accordance with stringent government regulations called current Good Manufacturing Practices (GMP).
  - Select name brand drugs means those name brand prescription drugs which we have included on our Select name brand list.
  - Non-Select name brand drugs are those prescription name brand drugs which we have <u>not</u> included on our Select name brand list.
- **These are the dispensing limitations.** Plan pharmacies will dispense up to a 30-day supply or one commercially prepaid unit *(*i.e., one inhaler, one vial ophthalmic medication or insulin). Plan pharmacies will dispense generic equivalent drugs when substitution is permissible and your physician has not indicated "dispense as written" on the prescription. Prescriptions filled through the Plan's mail order program will be dispensed for up to a 90-day supply or three (3) times the retail quantity amount. Non-Select drugs are not available through the mail order program. All drugs will be dispensed within FDA guidelines.

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. • Disposable needles and syringes for the administration of covered medications • Diabetic supplies, including disposable needles, syringes and test strips • Oral and injectable contraceptives • Insulin with a copay applied to each vial *NOTE: If there is no generic equivalent available, you will still have to pay the appropriate Select or non-Select name brand copay.*	When your prescription is filled at a participating **retail** pharmacy, you pay: • $ 5 for up to a 30-day supply of generic drugs • $10 for up to a 30-day supply of Select name brand drugs • $30 for up to a 30-day supply of non-Select drugs • Diabetic supplies are covered at the Select name brand copay ($10 per prescription retail) When your prescription is filled through the Plan's **mail order program**, you pay: • $10 for up to a 90-day supply of generic drugs • $20 for up to a 90-day supply of Select name brand drugs
• Drugs used to treat sexual dysfunction	$30 per 30-day unit or refill (available through retail pharmacies only)
• Contraceptive devices, including diaphragms and cervical caps	50% of covered charges

Limited Prescription Drug Benefits	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 requests a Select name brand drug. • If your physician believes a Select name brand product is necessary or there is no generic available, your physician may prescribe a Select or Non-Select name brand drug. A list of Select 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, call the Plan at 317/571/5320 or visit the plan's web site at www.mplan.com.	
Not covered: • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Over the counter (OTC) medical supplies such as dressings and antiseptics; except diabetic supplies as ordered in writing by a participating provider and authorized and approved by the Plan* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance* • *Infertility drugs and infertility drug therapy including therapeutic injections for the treatment of infertility* • *Convenience items* • *Take home drugs from the hospital*	*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.
Services for the deaf and hearing impaired	A Telecommunication Device for the Deaf (TDD) is available for the deaf and hearing impaired by calling 317/580-4680.

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 providers or dentists must provide or arrange your care.
- *We have no calendar year deductible.*
- We cover hospital services and hospital supplies related to dental procedures when necessitated by a non-dental physical or mental impairment. We do not cover the dental procedures or dental supplies.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit

We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury. Services must be provided within 24 hours of the injury. You pay nothing.

Not covered:

- Services that you receive more that twenty-four (24) hours after the accident
- Injuries that happen when you are eating or chewing

Dental benefits

We have no other dental benefits.

NOTE: Please refer to Section 5 (i) Non FEHB benefits available to Plan members

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

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

Expanded Vision Care	• Participating providers will grant a 20% discount on eyeglasses and lenses
Expanded Dental Services	• Members receive a 25% discount on preventive, diagnostic services and minor restorative services when provided by a plan dentist.
	• Specialty dental care and orthodontia services are not covered.
	• All other services will be provided at a 15% discount.

★ **Members receive a 25% discount on acupunture, chiropractic, massage therapy and LASIK services.**

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical, Hospital and 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 317/571/5320.

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:

M•Plan Member Services
8802 N. Meridian Street, Suite 100
Indianapolis, IN 46260

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 prior authorization:

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: M•Plan, 8802 N. Meridian St., Suite 100, Indianapolis, Indiana 46260; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your medical 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, D.C. 20415-3630.

The Disputed Claims Process *(continued)*

Send OPM the following information:

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

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

NOTE: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must 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 prior authorization. This is the only deadline that may not be extended.

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

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

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

(a) We haven't responded yet to your initial request for care or prior authorization/prior approval, then call us at 317/571/5320 and we will expedite our review; or

(b) We denied your initial request for care or prior authorization/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. 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 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. 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 Primary Care Physician and us. We do not waive deductibles or coinsurance under the FEHB Plan.

(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 re-employed annuitant with the Federal government when… a) The position is excluded from FEHB	✓	
b) Or, 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		✓

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

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

- When we are the primary payer, we process the claim first.

- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically 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 317/571-5320 or visit our website at www.mplan.com.

We do not waive your out-of-pocket costs (copayments or coinsurance) when you have the Original Medicare Plan

- **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 -- 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 we will not waive any of our copayments, coinsurance, or deductibles. 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 Part B**

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

TRICARE

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

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.
- Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Coinsurance

Coinsurance is the percentage of covered charges that you must pay for your care. See page 11.

Copayment

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

Covered services

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

Custodial Care

These are non-health related services that do not seek to cure or which are provided during periods when the medical condition of the patient is not changing. Custodial care is primarily assistance with activities of daily living, transportation, meal preparation and companion 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. We do not have a deductible.

Experimental or investigational services

Medical technology or a new application of existing medical technology, including medical procedures, drugs and devices for treating a medical condition, illness or diagnosis that:

- Is not generally accepted by informed health care professionals in the United States as effective; or
- Has not been proven by scientific testing or evidence to be effective in treating the medical condition, illness or diagnosis for which its use is proposed.

Home Health Care

A program of care provided by a public agency or private organization which is primarily engaged in providing skilled nursing care services and other therapeutic services in the homes or places of residence of its patients.

Medical necessity

Services and/or supplies provided by a Hospital, Physician, or other provider to identify and treat an illness or injury which are:

1. Consistent with symptoms, or diagnosis and treatment of the condition, disease, ailment or injury;
2. Appropriate with regard to standards of good medical practice; and
3. Not primarily for the convenience of the patient, the patient's family, the Physician or the Provider.

Us/We

Us and we refer to M•Plan.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts & Coverage information

- **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, gives 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 his Plan during open season, your coverage begins on the first day of you're 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, you r employing office will tell you the date of coverage.

- **Your medical and claims records are confidential**

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

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

- **When you retire**

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

When you lose benefits

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

When FEHB coverage ends

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

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

- **Spouse equity coverage**

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

- **Temporary Continuation of Coverage (TCC)**

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

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI

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

- **Converting to individual coverage**

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

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

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

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

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) 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 HIPPA" frequently asked questions. These highlight HIPPA 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 have information about Federal and State agencies you can contact for more information.

Long Term Care 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:

Summary of benefits for M●Plan - 2002

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office.....	Office visit copay: $10 primary care; $10 specialist	13
Services provided by a hospital: • Inpatient ..... • Outpatient.....	 Nothing Nothing	25 25
Emergency benefits: • In-area ..... • Out-of-area	 $10 per doctor's office visit, $25 Urgent Care Center visit, or $25 Emergency Room visit	 27 27
Mental health and substance abuse treatment	Regular cost sharing. *{RV 8-9}*	29
Prescription drugs: 30-day or 100-unit supply from a Plan Retail Pharmacy..... Up to 90-day supply from Mail-order Program.....	 $5 generic drugs or $10 Select name brand drugs or $30 non-Select name brand drugs $10 generic drugs $20 Select name brand drugs	31
Dental Care..... No Benefit	All Charges	34
Vision Care..... Limited to one eye refraction annually	You pay $5	18
Special features: Flexible Benefit Option		34
Protection against catastrophic costs (your out-of-pocket maximum)	Stated copays and coinsurance for covered services	10

2002 Rate Information for M●Plan

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 w ho 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	IN1	$97.86	$41.66	$212.03	$90.26	$115.52	$24.00
Self and Family	IN2	$223.41	$96.75	$484.06	$209.62	$263.75	$56.41