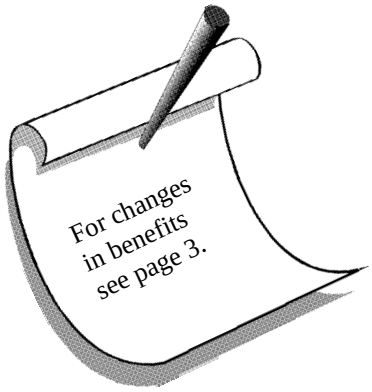
HARVARD PILGRIM HEALTH CARE, INC.

Harvard Pilgrim HealthCare

2000

A Health Maintenance Organization



Serving: Eastern and Western Massachusetts, Southern New Hampshire, Southern Vermont, Northwestern Connecticut, Southeastern Maine and Eastern New York.

Enrollment in this Plan is limited; see pages 4-6 for requirements.

Enrollment code:

681 Self Only
682 Self and Family

This Plan has Excellent Accreditation from NCQA.
See FEHB Guide for more information on NCQA.

Visit the OPM website at http://www.opm.gov/insure

and

this Plan's website at http://www.harvardpilgrim.org

Authorized for distribution by the:

United States Office of Personnel Management
Retirement and Insurance Services

Federal Employees Health Benefits Program

RI 73-021

Table of Contents

Introduction

Harvard Pilgrim Health Care
10 Brookline Place West
Brookline, Massachusetts 02146

This brochure describes the benefits you can receive from Harvard Pilgrim Health Care under its contract (CS 1331) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is 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.

OPM negotiates benefits and premiums with each plan annually. Benefit changes are effective January 1, 2000, and are shown on page 2. Premiums are listed at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. Health plan representatives and Office of Personnel Management staff have worked cooperatively to make portions of this brochure clearer. In it you will find common, everyday words, except for necessary technical terms; "you" and other personal pronouns; active voice; and short sentences.

We refer to Harvard Pilgrim Health Care as "this Plan" throughout this brochure even though in other legal documents, you will see a plan referred to as a carrier.

These changes do not affect the benefits or services we provide. We have rewritten this brochure only to make it more understandable.

We have not re-written the Benefits section of this brochure. You will find new benefits language next year.

How To Use This Brochure

This brochure has eight sections. Each section has important information you should read. If you want to compare this Plan's benefits with benefits from other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

1. **Health Maintenance Organizations (HMO).** This Plan is an HMO. Turn to this section for a brief description of HMOs and how they work.
2. **How we change for 2000.** If you are a current member and want to see how we have changed, read this section.
3. **How to get benefits.** Make sure you read this section; it tells you how to get services and how we operate.
4. **What to do if we deny your claim or request for service.** This section tells you what to do if you disagree with our decision not to pay for your claim or to deny your request for a service.
5. **Benefits.** Look here to see the benefits we will provide as well as specific exclusions and limitations. You will also find information about non-FEHB benefits.
6. **General exclusions – Things we don't cover.** Look here to see benefits that we will not provide.
7. **Limitations – Rules that affect your benefits.** This section describes limits that can affect your benefits.
8. **FEHB FACTS.** Read this for information about the Federal Employees Health Benefits (FEHB) Program.

Section 1. Health Maintenance Organizations

Health maintenance organizations (HMOs) are health plans that require you to see Plan providers: specific physicians, hospitals and other providers that contract with us. These providers coordinate your health care services. The care you receive includes preventative care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

When you receive services from our providers, you will not have to submit claim forms or pay bills. However, you must pay copayments and coinsurance listed in this brochure.

When you receive emergency services 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. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How We Change For 2000

Program-wide changes

This year, you have a right to more information about this Plan, care management, our networks, facilities, and providers.

If you have a chronic or disabling condition, and your provider leaves the Plan at our request, you may continue to see your specialist for up to 90 days. If your provider leaves the Plan and you are in the second or third trimester of pregnancy, you may be able to continue seeing your OB/GYN until the end of your postpartum care. You have similar rights if this Plan leaves the FEHB program. (See Section 3, "How to get benefits", for more information.)

You may review and obtain copies of your medical records on request. If you want copies of your medical records, ask your health care provider for them. You may ask that a physician amend a record that is not accurate, not relevant, or incomplete. If the physician does not amend your record, you may add a brief statement to the record. If they do not provide you your records, call us and we will assist you.

If you are over age 50, all FEHB plans will cover a screening sigmoidoscopy every five years. This screening is for colorectal cancer.

Changes to this Plan

Your share of the non-postal premium will increase by 54.2% for Self Only or 42.1% for Self and Family. See back cover.

Under Medical and Surgical Benefits, the office visit copay for primary and specialty care increases from $5 to $10. However, the copay for routine allergy shots, mental conditions and substance abuse will not change. See pages 12-21.

Under Prescription Drug Benefits, the copay increased from $5 to $15 for brand name formulary Drugs. The copay for brand name non-formulary Drugs increases from $10 to $35. See pages 19-20.

Under the Prescription Drug Benefits, coverage is provided for Norplant. See page 20.

Under Prescription Drugs, a limited Mail Order Program is being added. See page 20.

Under Hospital and Extended Care, a $100 copay per inpatient admission is being added. This copay does not apply to inpatient admissions covered under Mental Conditions/Substance Abuse Benefits. See pages 14-15.

Under Emergency Benefits, the emergency room copay will increase from $30 to $50. See pages 16-17.

Under Emergency Benefits, the copay increased from $5 to $10 for an in-network urgent care center, i.e. doctor's office, walk-in clinic. See page 16.

Under Medical and Surgical, Limited Benefits, following a mastectomy, breast prostheses and surgical bras, including their replacements are covered. See page 13.

The catastrophic limit has been reduced. See page 7.

Improved coverage is now available for the extraction of impacted teeth. See page 13.

A clarification on coverage for newborn screening tests is provided. See page 12.

Members covered under the Federal Employees Health Benefits Program do not have access to the entire Harvard Pilgrim Health Care provider network. See page 7.

Under Medical and Surgical, Limited Benefits, a clarification on coverage for nutritional formulas is provided in Enteral Formulas. See page 14.

Under Medical and Surgical, Limited Benefits, coverage is provided for the cost of wigs for cancer or leukemia patients. See page 13.

Section 3. How To Get Benefits

What is this Plan's service area?

To enroll with us, you must live in our service area or live in the geographic area described below. This is where our providers practice. Our service area is:

CONNECTICUT

Canaan	North Canaan	Salisbury	Sharon	Thompson
Norfolk				

MASSACHUSETTS

Abington	Cambridge	Framingham	Lenox	Nahant
Acton	Canton	Franklin	Leominster	Natick
Adams	Carlisle	Georgetown	Lexington	Needham
Alford	Carver	Gloucester	Lincoln	New Ashford
Amesbury	Charlemont	Grafton	Littleton	Newbury
Andover	Charlton	Great Barrington	Lowell	Newburyport
Arlington	Chelmsford	Groton	Lunenburg	New Marlboro
Ashby	Chelsea	Groveland	Lynn	Newton
Ashland	Cheshire	Halifax	Lynnfield	Norfolk
Attleboro	Chester	Hamilton	Malden	North Adams
Auburn	Chesterfield	Hancock	Manchester	North Andover
Avon	Clarksburg	Hanover	Mansfield	North Attleboro
Ayer	Clinton	Hanson	Marblehead	North Reading
Barnstable	Cohasset	Harvard	Marlborough	Northborough
Becket	Concord	Haverhill	Marshfield	Northbridge
Bedford	Cummington	Hawley	Mashpee	Norton
Bellingham	Dalton	Hindsdale	Maynard	Norwell
Belmont	Danvers	Hingham	Medfield	Norwood
Berkeley	Dedham	Holbrook	Medford	Oakham
Berlin	Dighton	Holden	Medway	Otis
Beverly	Douglas	Holliston	Melrose	Oxford
Billerica	Dover	Hopedale	Mendon	Paxton
Blackstone	Dracut	Hopkinton	Merrimac	Peabody
Blanford	Dudley	Hubbardston	Methuen	Pembroke
Bolton	Dunstable	Hudson	Middleborough	Pepperell
Boston	Duxbury	Hull	Middlefield	Peru
Bourne	East Bridgewater	Huntington	Middleton	Pittsfield
Boxborough	Easton	Ipswich	Milford	Plainfield
Boxford	Egremont	Kingston	Millbury	Plainville
Boylston	Essex	Lakeville	Millis	Plymouth
Braintree	Everett	Lancaster	Millville	Plympton
Bridgewater	Falmouth	Lanesboro	Milton	Princeton
Brockton	Fitchburg	Lawrence	Monroe	Quincy
Brookline	Florida	Lee	Monterey	Randolph
Burlington	Foxboro	Leicester	Mt. Washington	Raynham

Section 3. How To Get Benefits

What is this Plan's service area?
continued

MASSACHUSETTS *(continued)*

Reading	Savoy	Sudbury	Wareham	Westwood
Rehoboth	Scituate	Sutton	Washington	Weymouth
Revere	Sharon	Swampscott	Watertown	Whitman
Richmond	Sheffield	Taunton	Wayland	Williamstown
Rochester	Sherborn	Tewksbury	Webster	Wilmington
Rockland	Shirley	Tolland	Wellesley	Winchester
Rockport	Shrewsbury	Topsfield	Wenham	Windsor
Rowe	Somerville	Townsend	West Boylston	Winthrop
Rowley	Southborough	Tyngsboro	West Bridgewater	Woburn
Rutland	Spencer	Tyringham	West Newbury	Worcester
Salem	Sterling	Upton	West Stockbridge	Worthington
Salisbury	Stockbridge	Uxbridge	Westborough	Wrentham
Sandisfield	Stoneham	Wakefield	Westford	
Sandwich	Stoughton	Walpole	Westminster	
Saugus	Stow	Waltham	Weston	

NEW HAMPSHIRE

Amherst	Freemont	Kingston	Newfields	Sandown
Atkinson	Goffstown	Litchfield	Newton	Seabrook
Auburn	Greenfield	Londonderry	North Hampton	Sharon
Bedford	Greenland	Lyndeboro	Pelham	South Hampton
Brentwood	Greenville	Manchester	Peterborough	Stratham
Brookline	Hampstead	Mason	Plaistow	Temple
Chester	Hampton	Merrimack	Rye	Wilton
Danville	Hampton Falls	Milford	Salem	Windham
Derry	Hollis	Mount Vernon		
East Kingston	Hooksett	Nashua		
Exeter	Hudson	New Boston		
Francestown	Kensington	New Ipswitch		

NEW YORK

Ancram	Canaan	Hillsdale	North East	Stephantown
Austerlitz	Chatham	Nassau	North Petersburg	
Berlin	Copake	New Lebanon	Petersburg	

VERMONT

Bennington	Pownal	Readsboro	Stamford

Section 3. How To Get Benefits

This Plan accepts enrollments from this additional geographic area:

MAINE

Alna
Arrowsic
Arundel
Auburn
Baldwin

Bath
Berwick
Biddleford
Boothbay
Boothbay Harbor

Bowdoinham
Bridgton
Bristol
Brunswick
Buckfield

Buxton
Cape Elizabeth
Casco
Cumberland
Damariscotta

Dayton
Dresdon
Durham
East Waterford
Edgecomb

Eliot
Falmouth
Freeport
Gardner
Georgetown

Gorham
Gray
Greene
Harpswell
Harrison

Hebron
Hollis
Kennebunk
Kennebunkport
Kittery

Leeds
Lewiston
Lisbon
Litchfield
Lyman

Mechanic Falls
Minot
Monmouth
Naples
Newcastle

New Gloucester
North Berwick
North Yarmouth
Norway
Ogunquit

Old Orchard Beach
Otisfield
Oxford
Paris
Perkins

Phippsburg
Poland
Pownal
Raymond

Richmond
Sabattus
Saco
Scarborough
Sebago

South Berwick
South Bristol
South Portland
Southport
Standish

Topsham
Turner
Wales
Wells
West Bath

West Gardner
Westbrook
Westport
Windham
Winthrop

Wiscasset
Woolwich
Yarmouth
York

NEW HAMPSHIRE

Barrington
Dover
Durham

Epping
Lee
Madbury

New Castle
Newington

Newmarket
Portsmouth

Rollinsford
Somersworth

Section 3. How To Get Benefits

What is this Plan's service area?
continued

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

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. Many Out-of-area services are covered for eligible family members who attend school full-time outside the Service Area. Please see the Non-FEHBP Benefits Available to Plan Members for more information**.** 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.

How much do I pay for services?

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services, except for prenatal care, postpartum care, and immunizations when that is the only service at the office visit.

After you pay $2,000 in copayments or coinsurance per Self Only enrollment, or $4,000 per Self and Family enrollment, you do not have to make any further payments for certain services for the rest of the year. This is called a catastrophic limit. However, copayments or coinsurance for your prescription drugs and dental services do not count toward these limits and you must continue to make these payments.

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

Do I have to submit claims?

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

Who provides my health care?

Care is provided by Harvard Pilgrim Health Care (HPHC) doctors. HPHC has established a special provider network for FEHBP enrollees. This provider network consists of Harvard Vanguard Medical Associates, other multi-specialty group practices, and other group practices that have served the FEHBP community for many years

If the Primary Care Physician (PCP) you select is not part of the special network for FEHBP enrollees, HPHC will assign a PCP within the federal network.

HPHC's federal provider network does not include some community independent primary care physicians who may be Harvard Pilgrim participating providers. HPHC maintains the special federal provider network for FEHBP enrollees in order to continue offering affordable high quality health care coverage to the FEHBP community.

HPHC created a special Provider Directory for Federal Employees that lists primary care doctors (family practitioners, pediatricians, and internists) with their locations and phone numbers. These primary care doctors are part of the special provider network for FEHBP enrollees**.** Directories are provided to all enrollees shortly after enrollment or upon request by calling the Member Services Department at 1-888-333-4742, TDD 1-800-637-8257. Directories are subject to change without notice and are updated on a regular basis. If you are interested in receiving care from a specific provider, please contact our Member Services Department at 1-888-333-4742.

Usually for adults, your personal doctor will be a specialist in internal medicine; for children, a specialist in pediatrics. Or at some locations, you can choose a doctor in family practice for all covered family members. Your primary care doctor, who may work with a nurse practitioner, or physician assistant, supervises your care, providing advice and treatment, and arranging for laboratory tests, hospitalization, and the services of other specialists when required. Should you or a covered family member require care from a specialist, your primary care physician will refer you to a participating specialist. Referrals are usually made to those specialists affiliated with the same medical location or hospital as the primary care physician. In cases where the needed service is not available, you will be referred to a participating provider at another location in the HPHC HMO network.

Section 3. How To Get Benefits

What do I do if my primary care physician leaves the Plan?

Call us. We will help you select a new one.

What do I do if I need to go into the hospital?

Talk to your Plan physician. If you need to be hospitalized, your primary care physician or specialist will make the necessary hospital arrangements and supervise your care.

What do I do if I'm in the hospital when I join this Plan?

First, call our Member Service Department at 1-888-333-4742. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching 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 became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized

How do I get specialty care?

Your primary care physician will arrange your referral to a specialist.

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.

What do I do if I am seeing a specialist when I enroll?

Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, your doctor will probably recommend a specialist affiliated with his or her own practice. Typically, the doctor you see for primary care is associated with a group or network of providers. 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.

What do I do if my 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.

But, what if I have a serious illness and my provider leaves the Plan or this Plan leaves the Program?

Please contact us if you believe your condition is chronic or disabling. You may be able to continue seeing your provider for up to 90 days after we notify you that we are terminating our contract with the provider (unless the termination is for cause). If you are in the second or third trimester of pregnancy, you may continue to see your OB/GYN until the end of your postpartum care.

You may also be able to continue seeing your provider if your plan drops out of the FEHB Program and you enroll in a new FEHB plan. Contact the new plan and explain that you have a serious or chronic condition, or are in your second or third trimester. Your new plan will pay for or provide your care for up to 90 days after you receive notice that your prior plan is leaving the FEHB Program. If you are in your second or third trimester, your new plan will pay for the OB/GYN care you receive from your current provider until the end of your postpartum care.

Section 3. How To Get Benefits

How do you authorize medical services?

Your physician must get our approval before sending you to a hospital, referring you to a specialist, or recommending follow-up care. Before giving approval, we consider if the service is medically necessary, and if it follows generally accepted medical practice.

Services that do not require a referral

While in most cases you will need a referral from your primary care physician to get covered care from any other provider, you do not need a referral for the services listed below. However, you must get these services from an HPHC Provider. HPHC Providers are listed in the HPHC Provider Directory for Federal Employees. The Plan urges you to keep your primary care physician informed about such care so that your medical records are current and up-to-date. Your primary care physician should be aware of your entire medical situation.

Family Planning Services: Family planning consultation, including pregnancy testing; Contraceptive monitoring; Tubal ligation

Prenatal Services: Consultation for expectant parents; Prenatal care

Gynecological Services: Annual gynecological exam; Cervical cryosurgery; Colposcopy with biopsy; Excision of labial lesions; Laser cone vaporization of the cervix; Loop electrosurgical excisions of the cervix (LEEP); Treatment of amenorrhea; Treatment of condyloma

Dental Services: Pediatric preventive dental care for children through age 13; Emergency dental care; Extraction of impacted teeth

Other Services: Routine eye exam.

If your PCP is located at one of the Harvard Vanguard Medical Associates, your routine eye exam must be provided at a Harvard Vanguard Visual Services Department in order to be covered. Likewise, if your PCP is located at one of the Harvard Vanguard Medical Associates; your impacted tooth extractions must be provided at a Harvard Vanguard Dental Department in order to be covered.

How do you decide if a service is experimental or investigational?

A service, procedure, device, or drug will be deemed experimental or investigational by HPHC for use in the diagnosis or treatment of a particular medical condition if any of the following is true:

The service, procedure, device or drug is not recognized in accordance with generally accepted medical standards as being safe and effective for use in the evaluation or treatment of the condition in question. In determining whether a service has been recognized as safe or effective in accordance with generally accepted medical standards, primary reliance will be placed upon data from published reports in authoritative medical or scientific publications that are subject to peer review by qualified medical or scientific experts prior to publication. In absence of any such reports, it will generally be determined that a service, procedure, device, or drug is not safe and effective for the use in question.

In the case of a drug, the drug has not been approved by the United States Food and Drug Administration (FDA). (This does not include off-label uses of FDA approved drugs.)

Section 4. What To Do If We Deny Your Claim or Request For Service

If we deny services or won't pay your claim, you may ask us to reconsider our decision Your request must:

1. Be in writing,

2. Refer to specific brochure wording explaining why you believe our decision is wrong; and

3. Be made within six months from the date of our initial denial or refusal. We may extend this time limit if you show that you were unable to make a timely request due to reasons beyond your control.

We have 30 days from the date we receive your reconsideration request to:

1. Maintain our denial in writing;

2. Pay the claim;

3. Arrange for a health care provider to give you the service; or

4. Ask for more information

If we ask your medical provider for more information, we will send you a copy of our request. We must make a decision within 30 days after we receive the additional information. If we do not receive the requested information within 60 days, we will make our decision based on the information we already have.

When may I ask OPM to review a denial?

You may ask OPM to review the denial after you ask us to reconsider our initial denial or refusal. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service.

What if I have a serious or life-threatening condition and you haven't responded to my request for service?

Call us at 888/333-4742 and we will expedite our review

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What if you have denied my request for care and my condition is serious or life-threatening?

If we expedite your review due to a serious medical condition and deny your claim, we will inform OPM so that they can give your claim expedited treatment too. Alternatively, you can call OPM's Health Benefits Contract Division III at (202) 606-0755 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

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Section 4. What To Do If We Deny Your Claim or Request For Service

Are there other time limits?

You must write to OPM and ask them to review our decision within 90 days after we uphold our initial denial or refusal of service. You may also ask OPM to review your claim if:

1. We do not answer your request within 30 days. In this case, OPM must receive your request within 120 days of the date you asked us to reconsider your claim.
2. You provided us with additional information we asked for, and we did not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send OPM?

Your request must be complete, or OPM will return it to you. You must send the following information:

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

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

Who can make the request?

Those who have a legal right to file a disputed claim with OPM are:

1. Anyone enrolled in the Plan;
2. The estate of a person once enrolled in the Plan; and
3. Medical providers, legal counsel, and other interested parties who are acting as the enrolled person's representative. They must send a copy of the person's specific written consent with the review request.

Where should I mail my disputed claim to OPM?

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contract Division III, P. O. Box 436, Washington, D.C. 20044**.**

What if OPM upholds the Plan's denial?

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our 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 or supplies.

What laws apply if I file a lawsuit?

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 made its decision on your claim. You may recover only the amount of benefits in dispute.

You (or a person acting on your behalf) may not sue to recover benefits on a claim for treatment, services, supplies, or drugs covered by us until you have completed the OPM review procedure described above.

Your records and the Privacy Act

Chapter 89 of title 5, United States Code allows OPM to use the information it collects from you and us to determine if our denial of your claim is correct. The information OPM collects during the review process becomes a permanent part of your disputed claims file, and is subject to the provisions of the Freedom of Information Act and the Privacy Act. OPM may disclose this information to support the disputed claim decision. If you file a lawsuit, this information will become part of the court record.

Section 5. Benefits

Medical and Surgical Benefits
continued

What is covered?

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** a $10 office visit copay, but no additional copay for laboratory tests and X-rays. Within the service area, house calls will be provided if, in the judgment of the Plan doctor, such care is necessary and appropriate; **you pay** a $15 copay for a doctor, nurse practitioner or physician's assistant home visits. **You pay** nothing for home visits by nurses and health aides.

The following services are included and are subject to the office visit copay unless stated otherwise:

- Preventive care, including well-baby care and periodic check-ups
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness
- Routine immunizations and boosters (exempt from the office visit copay)
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays, and newborn screening tests such as metabolic disease screening tests, sickle cell disease test, and hearing impairment screening tests
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postpartum care by a Plan doctor. (Prenatal and postpartum care are exempt from office visit copay.) The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment
- The Plan covers services provided by a certified nurse midwife when the nurse midwife is listed in the Provider Directory for Federal Employees or practices with a participating Plan Provider.
- Voluntary sterilization and family planning services (including injectable contraceptive drugs)
- Diagnosis and treatment of infertility is covered; **you pay** a $10 office visit copay. The following types of artificial insemination are covered: intravaginal insemination (IVI); intracervical insemination (ICI) and intrauterine insemination (IUI); **you pay** a $10 office visit copay; cost of donor sperm is covered when medically indicated, the male partner is a Plan member and has not been voluntarily sterilized, and when the couple is diagnosed with male factor infertility. Fertility drugs are covered under the Prescription Drug Benefit. Other assisted reproductive technology (ART) procedures, such as in vitro fertilization (IVF), gamete intra fallopian transfer (GIFT), zygote intra fallopian transfer (ZIFT), and intracytoplasmic sperm injection (ICSI), are covered
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum). If only an allergy injection is provided, **you pay** a $5 office visit copay for routine allergy injection.
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints
- Bone marrow, cornea, heart, heart/lung kidney, liver, pancreas/kidney, and lung (single or double) transplants; 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. Breast cancer and multiple myeloma services may be provided through randomized or non-randomized clinical trials. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.

Section 5. Benefits

Medical and Surgical Benefits
continued

What is covered

- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- Lenses following cataract removal
- Home health physical, speech and occupational therapies; services of home health nurses and health aides, including intravenous fluids and medications, are covered under home health when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you.
- Oxygen

Limited Benefits

- **Oral and maxillofacial surgery** is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. **You pay** a $10 copay for extractions of impacted teeth. The service must be provided by a Plan provider; the procedure is covered in full when performed at a hospital outpatient department, day surgery, or inpatient basis. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome
- **Reconstructive surgery** will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.
- **Short-term rehabilitative therapy** (physical, speech and occupational) is provided on an inpatient or outpatient basis. Outpatient services required during a 90 consecutive day period per condition are covered for members over the age of 3 (the 90 consecutive day limit does not apply to children under age 3; **you pay** a $10 copay for each outpatient session. Inpatient services are provided for up to 100 days per calendar year. Speech therapy is limited to treatment for physical abnormality resulting from injury or disease. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.
- **Cardiac rehabilitation** following a heart transplant, bypass surgery or a myocardial infarction, is provided up to 3 months upon Plan approval**; you pay** a $10 copay per outpatient session.
- **Orthopedic devices**, such as braces; **prosthetic devices**, such as artificial limbs; breast prostheses, surgical bras and their replacement following mastectomy and durable medical equipment, such as wheelchairs and hospital beds are covered; **you pay** 20% of the charges up to a maximum of $1,000 per calendar year. There is no coverage after $5,000 in equipment cost has been paid, including member copayments. The $5,000 benefit maximum does not apply to breast prostheses, surgical bras and their replacement, respiratory equipment (including oxygen), glucometers or durable medical equipment ordered as part of authorized home health care.
- **Wigs** are covered up to $350 per member per calendar year when needed for hair loss suffered due to treatment for any form of cancer or leukemia. The Plan pays the first $350 in costs, **you pay** all charges thereafter.
- **Low protein foods** that are prescribed for a member's inherited diseases of amino acids and organic acids are limited to $2,500 per member per year.

Section 5. Benefits

Medical and Surgical Benefits
continued

Limited Benefits

- **Special infant formulas** are covered for the treatment of the following congenital conditions: phenylketonuria (PKU), homocystinuria, tyrosinemia, maple syrup urine disease, priopionic acidemia, methylemalonic acidemia. **You pay** nothing**.**
- Health education programs, such as Smoking Cessation and Stress management; you pay $4 per hour plus all charges for the cost of the materials
- **Enteral formulas** are covered for treatment of Crohn's disease, ulcerative colitis, gastroesophogeal reflux, gastrointestinal motility or chronic pseudo-obstructive disease.

What is not covered

- Physical examinations that are not necessary for medical reasons, (except premarital, school and sports examinations**)** such as those required for obtaining or continuing employment or insurance, governmental licensing or travel
- Reversal of voluntary, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Transplants not listed as covered
- Hearing aids
- Long-term rehabilitative therapy
- Chiropractic services
- Homemaker services
- Foot orthotics
- Blood and blood derivatives

Hospital/Extended Care Benefits

What is covered

Hospital Care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay** $100 per admission. **All necessary services are covered,** including:

- Semi-private room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units

Extended Care

The Plan provides a comprehensive range of benefits for up to100 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. **You pay** $100 per admission. 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

Hospice Care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Section 5. Benefits

Hospital/Extended Care Benefits
continued

What is covered
continued

Ambulance Services Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor.

Limited Benefits

Acute Inpatient Detoxification Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 18-19 for non-medical Substance Abuse Benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Custodial care, rest cures, domiciliary or convalescent care
- Hospitalization for dental procedures
- Blood and blood derivatives

Section 5. Benefits

Emergency Benefits

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 the Plan may determine are medical emergencies- what they all have in common is the need for quick action.

Emergencies within the 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 the Plan. You or a family member should notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been timely notified

If you need to be hospitalized, 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.

Plan pays... Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers

You pay... $50 per hospital emergency room visits; $10 per visit to an office-based setting, i.e., doctor's office, walk-in clinic or freestanding urgent care center. If the emergency results in admission to a hospital, you pay a $100 hospital admission copay. The emergency care copay is waived.

Emergencies outside the service are

Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness

If you need to be hospitalized, the Plan must be notified within 48 hours of your hospitalization. The telephone number is printed on the front of your ID card. The Plan covers inpatient care outside the service area only until your condition permits safe travel to the service area. To be covered, all follow-up care must be arranged by your primary care doctor

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.

Plan pays... Reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers.

You pay... $50 per hospital emergency room visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, **you pay** a $100 hospital admission copay. The emergency care copay is waived if you are admitted to a hospital.

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services
- Ambulance service approved by the Plan
- Emergency care for trauma, reduction of swelling and pain relief associated with a dental injury
- Prescription drugs obtained outside the service area because of unforeseen illness or injury

Section 5. Benefits

Emergency Benefits
continued

What is 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

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card.

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on pages 10-11.

Section 5. Benefits

Mental Conditions/Substance Abuse Benefits

If you need mental health care or drug or alcohol rehabilitation services, call the Mental Health Case Manager for your primary care site. He or she will assist you in determining the type of care you need, finding the appropriate providers and arranging the services you require. To get the name and telephone number of the Mental Health Care Manager, please call 1-888-777-4742. HPHC covered both inpatient and outpatient services. The Mental Health Case Manager will determine the service appropriate to your needs

Mental conditions

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, and the treatment of mental illness or disorders:

What is covered

- Diagnostic evaluation
- Psychological testing
- Psychiatric treatment (including individual and group therapy)
- Hospitalization (including inpatient professional services)

Outpatient care

Covered up to 25 visits per calendar year; within that limit, covered up to 20 visits for individual therapy and up to 25 visits for group therapy. **You pay** nothing for covered group therapy sessions. **You pay** a $5 copay for individual therapy sessions after visit 8, all charges thereafter.

If treatment is needed for both a psychiatric condition and a substance abuse disorder, you pay a $5 per visit copay for the first 16 visits with the remaining 4 visits (up to the 20 visit maximum) subject to the copay levels described above.

Outpatient visits for medication monitoring and evaluation are not subject to the 20-visit maximum; **you pay** a $5 copay per visit.

If a member has a severe psychiatric or substance abuse disorder, as determined by the Plan, certain recommended treatments, including individual case management and intensive outpatient care, will be provided with no visit or dollar limit; you pay a $5 per visit copay

Inpatient care

- Up to 60 days of hospitalization each calendar year; **you pay** nothing for the first 60 days — all charges thereafter. These 60 days of inpatient mental health coverage can be exchanged on a two for one basis for up to 120 days of day treatment.

What is not covered

- Care for psychiatric conditions that in the professional judgment of Plan doctors are not subject to significant improvement through relatively short-term treatment
- Psychiatric evaluation or therapy on court order or as a condition of parole or probation, unless determined by a Plan doctor to be necessary and appropriate
- Psychological testing that is not medically necessary to determine the appropriate treatment of a short-term psychiatric condition

Substance Abuse What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition, and, to the extent shown below, the services necessary for diagnosis and treatment.

Outpatient care

Up to 20 outpatient visits or $500 in benefit value per calendar year, whichever is greater, for evaluation, diagnosis, treatment and crisis intervention. **You pay** a $5 copay per visit for group therapy sessions. For individual therapy, **you pay** a $5 copay per visit for visits 1-8, a $25 copay per visit for visits 9-20 — all charges thereafter.

Section 5. Benefits

Mental Conditions/Substance Abuse Benefits

Substance Abuse
What is covered
continued

Inpatient care

Up to 30 days of substance abuse rehabilitation (intermediate care) per calendar year in an alcohol detoxification or rehabilitation center approved by the Plan. **You pay** nothing during the benefit period - all charges thereafter. These 30 days of inpatient substance abuse care can be exchanged on a two for one basis for up to 60 days of day treatment

What is not covered

Treatment that is not authorized by a Plan doctor

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and dispensed by a Plan pharmacy are covered. A copay will be charged for each prescription unit or refill up to a 30-day supply of medication. **Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Non-Formulary Drugs will be covered when prescribed by a Plan doctor.**

A small number of drugs require a Plan authorization. It is your doctor's responsibility to obtain the required authorization. If the doctor prescribes a medication without obtaining a Plan authorization, the medication will be dispensed by the Plan pharmacy and you pay the required copay.

The amount of the copay will vary as described below depending upon whether the prescription is "Generic Drugs", "Brand Name Formulary Drugs", Or "Brand Name Non-Formulary Drugs".

You pay a $5 copay for Generic Drugs.
You pay a $15 copay for Brand Name Formulary Drugs.
You pay a $35 copay for Brand Name Non-Formulary Drugs.

You may obtain a copy of the Harvard Pilgrim Formulary by calling the Member Service Department at 1-888-333-4742.

The copay must be paid to the pharmacy at the time of purchase.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Insulin
- Oral contraceptive drugs, contraceptive diaphragms, IUDs, and cervical caps
- Disposable needles and syringes needed to inject covered prescribed medication
- Diabetic supplies limited insulin syringes, needles and blood and urine testing products
- Nicotinic acid
- Fertility drugs (a $10 office visit copay applies for drugs administered by a Plan provider)
- Intravenous fluids and medication for home use, covered implantable drugs, and some injectable drugs, including injectable contraceptives (such as Depo Provera), are covered under Medical and Surgical Benefits.

Section 5. Benefits

Prescription Drug Benefits
continued

Limited benefits

- Sexual dysfunction drugs have dispensing limitations**.** Contact the Plan for details.
- There is a special $180 copay for Norplant®.
- Prescription smoking cessation drugs and medication, gum and patches are covered if the member is enrolled in a smoking cessation program, subject to prescription drug copay

Limited Mail Order Prescription Drug Service

A limited mail order prescription service is provided for certain covered medications. Only maintenance medications for which you require a 90-day supply may be obtained by mail. The copays for mail order service prescriptions differ from your standard prescription copays.

Under the Mail Service Program:

You pay a $10 copay for a 90-day supply of Generic Drugs.
You pay a $30 copay for a 90-day supply of Brand/Formulary Drugs.
You pay a $105 copay for a 90-day supply of Brand/Non-Formulary Drugs.

The following items may not be purchased through the mail service:

- compounded medications requiring the mixing of drugs by a pharmacist;
- any drugs for which mail order is prohibited by law; and
  prescriptions determined by HPHC to be excluded from the mail order service.

For further information, contact Member Services at 1-888-333-4742.

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Medical supplies such as dressings and antiseptics
- Vitamins
- Drugs for cosmetic purposes and weight loss
- Drugs to enhance athletic performance
- Drugs related to transsexual surgery
- Compound prescriptions that do not contain an agent that requires a prescription by law.

Changes and Exceptions to Drug Coverage Policies

HPHC's Pharmacy and Therapeutics Committee regularly reviews prescription drugs and may add drugs to the list of Brand Name Formulary Drugs at any time. The Committee will remove drugs from the list only in January of each year or in response to a FDA advisory recommending limitations on the use of a Brand Name Formulary Drug. Notice will not be sent to members of changes in the list of Brand Name Formulary Drugs.

The Committee may require prior authorization for coverage of certain drugs including Brand Name Formulary Drugs.

The Committee may add drugs to the list of drugs for which coverage is excluded or limited at any time without prior notice to members. HPHC Providers may request an exception on behalf of a member for coverage of any drug that is excluded or limited. Exceptions will be granted only for clinical reasons. Exceptions will not be granted to the limits on the coverage of Viagra.

HPHC will not grant members individual exceptions to the classification of a drug as a Brand/Non-Formulary Drug. Likewise, HPHC will not waive the applicable Copayment required of any Brand Name Non-Formulary Drug. However, HPHC Providers may request the review of a drug for designation as a Brand Name Formulary Drug at any time.

Section 5. Benefits

Other Benefits

Dental Care
What is covered

The following preventive services are provided for children through age 13 when received from Plan dentists, (up to two exams per year); **you pay** nothing:

- Oral examinations and X-rays
- Dental prophylaxis (cleaning)
- Scaling
- Topical application of fluoride
- Treatment of accidental dental injuries is covered under Emergency Benefits. See page15.

What is not covered

- Other dental services not shown as covered

Vision Care
What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, you are covered for one routine eye examination per calendar year (to provide a written lens prescription) and eye exercises which must be obtained from Plan providers. **You pay** a $10 copay per visit

What is not covered

- Corrective lenses and frames

Section 5. Benefits

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB, 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 or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Out-of Area Students

Out-of-area services are covered for eligible family members who attend school full-time outside the Service Area. Benefits are provided for the following:

Inpatient care

All inpatient services listed in this brochure are covered except for elective procedures. Elective procedures are services that can be delayed until the member returns to the Plan Service Area without permanent damage to the member's health.

Outpatient care for mental conditions

The outpatient mental health and substance abuse rehabilitation services listed in this brochure are each covered up to a maximum of 8 visits per calendar year to the extent such benefits have not been provided within the HPHC Service Area

Other outpatient care

All outpatient care is covered except the following care is not covered:

- Routine examinations and preventive care including immunizations
- Home health care, including maternity home care programs and house calls
- Health education programs
- Maintenance of or the replacement of prosthetic devices or durable medical equipment
- Cosmetic surgery
- Elective outpatient surgical procedures. Such procedures are services that can be delayed until the member returns to the Plan Service Area without permanent damage to the member's health
- Second opinions

Medicare + Choice Plan Enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 20, annuitants and former spouses with FEHB coverage and Medicare Part B may suspend their FEHB coverage and enroll in a Medicare + Choice plan when one is available in their area. They may then later re-enroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on suspending your FEHB enrollment and changing to a Medicare + Choice Plan.

Contact us at 1-800-779-7723 for information on the Medicare + Choice Plan and the cost of that enrollment.

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.

We do not cover the following

- Services, drugs or supplies that are not medically necessary;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits*)*;
- Experimental or investigational procedures, treatments, drugs or devices;
- Procedures, services, drugs and 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;
- Procedures, services, drugs and supplies related to sex transformations;
- Services or supplies you receive from a provider or facility barred from the FEHB Program; and
- Expenses you incurred while you were not enrolled in this Plan

Section 7. Limitations – Rules That Affect Your Benefits

Medicare

Tell us if you or a family member is enrolled in Medicare Part A or B. Medicare will determine who is responsible for paying for medical services and we will coordinate the payments. On occasion, you may need to file a Medicare claim form.

If you are eligible for Medicare, you may enroll in a Medicare+Choice plan and also remain enrolled with us.

If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare+Choice plan when one is available in your area. For information on suspending your FEHB enrollment and changing to a Medicare+Choice plan, 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.

If you involuntarily lose coverage, or move out of the Medicare+Choice service area, you may re-enroll in the FEHB Program at any time.

If you do not have Medicare Part A or B, you can still be covered under the FEHB Program and your benefits will not be reduced. We cannot require you to enroll in Medicare.

For information on Medicare+Choice plans, contact your local Social Security Administration (SSA) office or request it from SSA at 1-800/638-6833. For information on the Medicare+Choice plan offered by this Plan, see page 22.

HPHC's Coordination of Benefits for Medicare-covered services

If you are covered through HPHC and enrolled in Medicare Parts A & B or Medicare Part B only, HPHC will coordinate benefits as the secondary payer with Medicare. Medicare is the primary payer, for Medicare-covered services if:

- you are age 65 or over, have Medicare Parts A & B or Medicare Part B only, and **are not actively** employed by the Federal Government or another employer who insures you for health benefits
- you are under age 65, are not actively employed by the Federal Government or another employer who provides health benefit, and are eligible for Medicare on the basis of disability
- you are entitled to Medicare as a result of End Stage Renal Disease (permanent kidney failure). Medicare becomes the primary payer after 30 months of Medicare coverage, regardless of employment status.

When HPHC is the secondary payer, it is HPHC (not you) that is responsible for office visit and emergency room copayments for Medicare-covered services. Examples of Medicare-covered services include treatment of an illness or injury, preventive procedures such as influenza and pneumonia vaccinations, mammograms and pap smears.

Section 7. Limitations – Rules That Affect Your Benefits

Procedure

The following helps explain when you are responsible for the copayment:

Medicare Part A only — You pay an office visit or emergency room copayment
Medicare Part B only — You do not pay an office visit or emergency room copayment for Medicare-covered services
Medicare Parts A & B — You do not pay an office visit or emergency room copayment for Medicare-covered services
No Medicare coverage — You pay an office visit or emergency room copayment

If you have Medicare Parts A & B or Medicare Part B only, please bring your Medicare card with you and show it to the receptionist or billing clerk when you receive services. Please tell them to bill Medicare first if it is a Medicare-covered service. If Medicare covers the service, the provider's office will waive your copayment at the time of the visit, or collect the copayment and reimburse you after receiving payment for both Medicare and HPHC.

Other group insurance coverage

When anyone has coverage with us and with another group health plan, it is called double coverage. You must tell us if you or a family member has double coverage. You must also send us documents about other insurance if we ask for them.

When you have double coverage, one plan is the primary payer; it pays benefits first. The other plan is secondary; it pays benefits next. We decide which insurance is primary according to the National Association of Insurance Commissioners' Guidelines.

If we pay second, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage

Circumstances beyond out control

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness that another person caused, you must reimburse us for whatever services we paid for. 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.

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 are the primary payer. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determine they must provide;
- 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 the OWCP or similar agency has paid its maximum benefits for your treatment, we will provide your benefits

Medicaid

We pay first if both Medicaid and this Plan cover you.

Other Government Agencies

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

Section 8. FEHB FACTS

You have a right to information about your HMO.

OPM requires that all FEHB plans comply with the Patients' Bill of Rights, which gives you the right to information about your health plan, its networks, providers and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's website (**www.opm.gov**) lists the specific types of information that we must make available to you.

If you want specific information about us, call 1-888-865-4742, or write to us at 1200 Crown Colony Drive, Quincy, MA, 02169. You may also visit our website at **http://www.harvardpilgrim.org**.

Information that must be made available to you includes all of the following. The following information can be found in the HPHC Provider Directory for Federal Employees

- Number of primary care and specialty providers
- Name the name and geographic location of all contracting primary care providers, whether they are accepting new patients, and language(s) spoken.
- Names of hospitals where physicians have admitting privileges
- Names and geographic location of hospitals

The following information can be obtained from the following outside sources:

Administrators in Medicine website (www.docboard.org), Massachusetts Board of Registration in Medicine (800) 377-0550, or the Rhode Island Office of Medical Licensure and Discipline at (401) 222-3855.

- Name, education, and board certification status and geographic location of providers
- Names of hospitals where physicians have admitting privileges
- Years in practice as a physician and as a specialist if so identified
- Accreditation status
- Cancellation, suspension, or exclusion from participation in Federal programs or sanctions from Federal agencies; any suspension or revocation of medical licensure, Federal controlled substance license, or hospital privileges

If you are not able to obtain the information you need from the provider or facility, you may call 1-888-865-4742 and request an information sheet with the following:

- Customer satisfaction measures
- Provider compensation, including base payment method (e.g., capitation, salary, fee schedule) and additional financial incentives (e.g., bonus, withhold, etc.)
- Methods of compensation, ownership or interest in health care facilities
- Whether the facility's affiliation with a provider network would make it more likely that a consumer would be referred to health professionals or other organizations in that network
- name and geographic location of participating home health agencies, rehabilitation and long-term care facilities
- Disenrollment rates for 1998;
- Compliance with State and Federal licensing or certification requirements and the dates met. If noncompliant, the reason for noncompliance
- Accreditations by recognized accrediting agencies and the dates received
- Carrier's type of corporate form and years in existence
- Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records

Section 8. FEHB FACTS

You have a right to information about your HMO. *continued*

If you are not able to obtain the information you need from the provider or facility, you may call HPHC Member Services at (888) 333-4742 for assistance for the following

- Specific information on the availability of interpreters (for non-English speaking and those with communication disabilities) and whether the provider's office or facility is accessible to the disabled
- Name and geographic location of all contracting specialists
- Whether provider is accepting new patients, and language(s) spoken
- Corporate form of provider practice
- Experience with performing certain medical or surgical procedures (e.g., volume of care/services delivered), adjusted for case mix and severity
- Consumer satisfaction, clinical quality and service performance measures
- Accreditation status of hospitals, home health agencies, rehabilitation and long-term care facilities; whether they are accepting new patients; language(s) spoken, and availability of interpreters (for non-English speaking and those with communication disabilities), and whether they are accessible to the disabled
- Corporate form
- Consumer satisfaction, clinical quality and service performance measures
- Whether facility specialty programs meet guidelines established by specialty societies or other bodies
- Complaint procedures
- Whether facility has been excluded from any Federal health programs
- Volume of certain procedures performed
- Numbers and credentials of providers of direct patient care

Where do I get information about enrolling in the FEHB Program?

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
- The next Open Season for enrollment.

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.

When are my benefits and premium effective?

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

What happens when I 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, which is described later in this section

Section 8. FEHB FACTS

What types of coverge are available for my family and me?

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 or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get 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 you give birth or add the child to your family. The benefits and premiums for your Self and Family enrollment begin on the first day of the pay period in which the child is born or becomes an eligible family member.

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.

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

Are my medical and claims records 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 coordination 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.

Section 8. FEHB FACTS

Information for new members

Identification cards

We will send you an Identification (ID) card. Use your copy of the Health Benefits Election Form, SF-2809, or the OPM annuitant confirmation letter until you receive your ID card. You can also use an Employee Express confirmation letter.

What if I paid a deductible under my old plan?

Your old plan's deductible continues until our coverage begins.

Pre-existing conditions

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

When You Lose Benefits

What happens if my enrollment in this Plan 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 former spouse coverage or Temporary Continuation of Coverage

What is former spouse 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 more information about your coverage choices.

What is TCC?

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 TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

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

Key points about TCC:

- You can pick a new plan;
- If you leave Federal service, you can receive TCC for up to 18 months after you separate;
- If you no longer qualify as a family member, you can receive TCC for up to 36 months;
- Your TCC enrollment starts after regular coverage ends.
- If you or your employing office delay processing your request, you still have to pay premiums from the 32nd day after your regular coverage ends, even if several months have passed.
- You pay the total premium, and generally a 2-percent administrative charge. The government does not share your costs.
- You receive another 31-day extension of coverage when your TCC enrollment ends, unless you cancel your TCC or stop paying the premium.
- You are not eligible for TCC if you can receive regular FEHB Program benefits.

How do I enroll in TCC?

If you leave Federal service your employing office will notify you of your right to enroll under TCC. You must enroll within 60 days of leaving, or receiving this notice, whichever is later.

Children: You must notify your employing or retirement office within 60 days after your child is no longer an eligible family member. That office will send you information about enrolling in TCC. You must enroll your child within 60 days after they become eligible for TCC, or receive this notice, whichever is later.

Former spouses: You or your former spouse must notify your employing or retirement office within 60 days of one of these qualifying events:

- Divorce
- Loss of spouse equity coverage within 36 months after the divorce.

Your employing or retirement office will then send your former spouse information about enrolling in TCC. Your former spouse must enroll within 60 days after the event, which qualifies them for coverage, or receiving the information, whichever is later.

Note: Your child or former spouse loses TCC eligibility unless you or your former spouse notify your employing or retirement office within the 60-day deadline

How can I convert 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 if individual coverage is available. 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.

How can I get a Certificate of Group Health Plan Coverage?

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

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

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 1-888-333-4742 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE

202/418-3300

U.S. Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, D.C. 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 they:

- Try to obtain services for a person who is not an eligible family member; or
- Are no longer enrolled in the Plan and try to obtain benefits.

Your agency may also take administrative action against you.

Summary of Benefits for Harvard Pilgrim Health Care - 2000

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** $100 per admission	14-15
	Extended Care	All necessary services, for up to 100 days per calendar year. **You pay** $100 per admission	14
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions for up to 60 days of inpatient care per calendar year. **You pay** nothing.	18
	Substance Abuse	Up to 30 days per year in a substance abuse treatment facility. **You pay** nothing	19
Outpatient care		Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** a $10 copay per office visit; (copays are waived for prenatal and postpartum care); $15 per house call by a doctor and $5 per allergy injection visit	12-21
	Home Health Care	All necessary visits by nurses and health aides. **You pay** nothing	13
	Mental Conditions	Covered up to 25 visits per calendar year; within that limit, covered up to 20 visits for individual therapy and up to 25 visits for group therapy. **You pay** nothing for covered group therapy sessions. **You pay** a $5 copay for individual therapy visits 1-8, and a $25 copay for covered individual sessions after visit 8 --all charges thereafter. Outpatient visits for medication monitoring are provided without limit; **you pay** a $5 per visit copay. These visits do not count against the benefit limit	18
	Substance Abuse	Up to 20 visits or $500 per calendar year, whichever is greater. **You pay** a $5 copay for group therapy sessions. For individual therapy, **you pay** a $5 copay for visits 1-8, and a $25 copay for visits 9-20 -- all charges thereafter	18-19
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. Outside the service area, **you pay** a $50 copay for each emergency room visit. Within the service area, **you pay** a $10 copay to a doctor's office, or office-based walk-in clinic or urgent care center and a $50 copay to the hospital for each emergency room visit. **You pay** a $100 inpatient copay	16-17
Prescription drugs		Drugs prescribed by a Plan doctor and dispensed at a Plan pharmacy. For a 30-day supply, **you pay** a $5 copay for Generic Drugs, a $15 copay for Brand/Formulary Drugs, and a $35 copay for Brand/Non-Formulary Drugs.	19-20
Dental care		Up to two anual preventive dental care visits for children through age 13; per year through age 13, **you pay** nothing	21
Vision care		One routine eye examination each calendar year. **You pay** a $10 copay per visit	21
Out-of-pocket maximum		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $2,000.00 per Self only or $4,000.00 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include costs of prescription drugs or dental services	7

Notes

Notes

2000 Rate Information for Harvard Pilgrim Health Care, Inc.

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 most career U.S. Postal Service employees. In 2000, two categories of contribution rates, referred to as Category A rates and Category B rates, will apply for certain career employees. If you are a career postal employee but not a member of a special postal employment class, refer to the category definitions in "The Guide to Federal Employees Health Benefits Plans for United States Postal Service Employees" RI 70-2, to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must refer to the applicable "Guide to Federal Employees Health Benefits Plans."

		Non-Postal Premium				**Postal Premium A**		**Postal Premium B**	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Self Only	681	$78.83	$50.22	$170.80	$108.81	$93.06	$35.99	$93.26	$35.79
Self and Family	682	$175.97	$166.03	$381.27	$359.73	$207.74	$134.26	$201.02	$140.98