EMPIRE BLUECROSS BLUESHIELD

BLUECHOICE® HMO 2000

A Health Maintenance Organization

Serving: 28 Counties in Eastern New York
Enrollment in this Plan is limited; see page 6 for requirement

Albany area
Enrollment code:
5L1 Self Only
5L2 Self and Family

Downstate area
Enrollment code:
S71 Self Only
S72 Self and Family

Visit the OPM website at http://www.opm.gov/insure
and
this Plan's website at http://www.empirehealthcare.com

United States Office of Personnel Management

FEHB
Federal Employees Health Benefits Program

Table of Contents

Page

Introduction

Empire Blue Cross and Blue Shield, One World Trade Center, New York, New York 10048-0682

This brochure describes the benefits you can receive from Empire Blue Cross and Blue Shield BlueChoice HMO under its contract **(CS 1657)** 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 4. 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 **BlueChoice HMO** 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 to change for 2000

Program-wide changes

To keep your premium as low as possible OPM has set a minimum copay of $10 for all primary care office visits.

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 it. 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 for code 5L1 will increase by 9.8% and for code 5L2 by 11.5%.

Your share of the non-postal premium for code S71 will increase by 64% and for code S72 by 67.4%.

Blue Choice HMO has eliminated the Mid-Hudson rating region, Codes 5K1 and 5K2 and will no longer provide services to members who live or work in the following New York counties: Dutchess, Orange, Putnam, Sullivan and Ulster. (See page 5 for details)

The Private Duty Nursing benefit has been eliminated. Home health services of nurses and health aides are covered under the "Home Health" benefit which includes intravenous fluids and medications when prescribed by the Plan doctor, who will periodically review the program for continuing appropriateness and need. **You pay nothing**.

The Prescription Drug benefit will include coverage for enteral formulas when administered through feeding tubes for home use. Modified solid food products that are low in protein or contain modified protein are covered for treatment of certain inherited diseases of amino acid or organic metabolism.

Inpatient benefits for a mastectomy stay is covered for up to a minimum of 48 hours after the procedure and additional days as determined by the member and her doctor.

Benefits have been clarified to indicate that reconstructive surgery will include reconstruction of the breast on which a mastectomy was performed and the other breast to produce a symmetrical appearance in addition to coverage for surgical bras and prostheses.

Section 3. How to get benefits

What is this Plan's service area?

The service areas for this Plan, where Plan providers and facilities are located, are described below. You must live or work in the service areas listed below to enroll in the Plan. Benefits for care outside the service areas are limited to emergency services, as described on page 22, except for Urgent Care and Guest Membership which is covered through the HMO Blue USA Network.

The service area for this Plan includes the following:

Upstate Code 5L: Albany, Clinton, Columbia, Delaware, Essex, Fulton, Greene, Montgomery, Rennselaer, Saratoga, Schenectady, Schoharie, Warren and Washington.

Downstate S7: Bronx, Kings, Nassau, New York (Manhattan), Queens, Richmond, Rockland, Suffolk and Westchester.

The Plan offers its members expanded out-of-area coverage at participating Blue Cross and Blue Shield Association (BCBSA) HMOs nationwide, at no extra cost, through the HMO Blue USA network. If you need care when you are outside the service area, call 1-800-4-HMO-USA for information on the BCBSA HMO nearest you.

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

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.

Your out-of-pocket expenses for benefits under this Plan are limited to the stated copayments required for a few benefits.

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?

BlueChoice HMO is a Mixed Model Prepayment (MMP) plan. This means that all medical care is provided by doctors practicing in their own offices or in multispecialty medical groups located throughout 28 counties in Eastern New York State.

The BlueChoice HMO Select provider network contracts with more than 31376 leading doctors (primary care and specialty care) who represent a wide range of primary and specialty categories. BlueChoice HMO has more than 7677 primary care doctors and 110 hospitals in the BlueChoice HMO Select provider network.

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 authorized 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 customer service department at 1-800-453-0113. 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 they decide to refer you to a specialist, ask if you can see your current specialist. **You must receive a written referral from your primary care doctor before seeing any other doctor or obtaining special services**, with the following exceptions: a woman may see her OB/GYN and members may receive mental conditions and substance abuse services at anytime without the need for a referral**.** Referral to participating specialist is given at the primary care doctor's discretion; if non-Plan specialists or consultants are required, the primary care doctor will arrange appropriate referrals.

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. After that, the member must choose a network provider.

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.

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.

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

The Plan will not cover any treatment, procedure, drug, biological product or medical device (hereinafter "technology") or any hospitalization in connection with such technology if, in our sole discretion, it is not medically necessary in that such technology is experimental or investigational. Experimental or investigational means that the technology is:

Not of proven benefit for the particular diagnosis or treatment or your particular condition; or

Not generally recognized by the medical community as reflected in the published peer-reviewed medical literature as effective or appropriate for the particular diagnosis or treatment of your particular condition.

This exclusion does not apply to cancer drugs as required by section 4303(g) of the New York State Insurance Law.

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 1-800-453-0113 and we will expedite your review

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. Alternately, you can call OPM's health benefits Contract Division IV at (202) 606-0737 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.

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 to 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.

What address should I send my disputed claim to?

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division IV, 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

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 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 $10 copay for a doctor's house call and 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-child care up to age 19 (**you pay** nothing) and periodic check-ups;
- Mammograms are covered as follows: for women age 35 or over, one mammogram every year. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat you illness;
- Routine immunizations and boosters; **you pay** nothing;
- Consultations by specialists;
- Diagnostic procedures, such as laboratory tests and x-rays;
- Self-referral for routine obstetrical and gynecological care;
- Diagnosis and treatment of diseases of the eye;
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum) **you pay** nothing for allergy treatment visits, **you pay** a $10 copay for allergy testing visits.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. Copays are waived for maternity care and well baby care. Inpatient care by the mother and her newborn is covered for at least 48 hours after a regular delivery and 96 hours after a cesarean delivery, unless the mother elects to be discharged earlier. 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.

- Voluntary sterilization and family planning services;

- The insertion of internal prosthetic devices, such as pacemakers and artificial joints;

- Heart, heart-lung, kidney, liver, lung (single and double), pancreas and corneal 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-lymphoma, advanced neuroblastoma, breast cancer, multiple myeloma, epithelial ovarian cancer and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Related medical and hospital expenses of the donor are covered when the recipient is covered by the Plan. Transplants are covered when approved by the Plan's Medical Director;

- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital for a minimum of 48 hours after the procedure and additional days as determined by the member and her doctor.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

- Dialysis;

- Chemotherapy, radiation therapy, and inhalation therapy;

- Surgical treatment of morbid obesity;

- Orthopedic devices, such as braces; foot orthotics (except symptomatic complaints of the feet);

- Prosthetic devices, such as breast prostheses, surgical bras, and artificial limbs and lenses following cataract removal;

- Durable medical equipment, such as wheelchairs and hospital beds;

- Home health services of nurses and health aides, including intravenous fluids and medications, 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;

- Equipment, services, supplies and self-management education for the treatment of diabetes, which have been recommended or prescribed by the member's primary care physician or referred specialist and provided by a certified diabetes nurse educator, certified nutritionist, certified dietitian, or registered dietitian. This includes: blood glucose monitors, as well as monitors for the legally blind; testing strips for glucose monitors, including visual reading and urine testing strips; data management systems; insulin, syringes, injection aids, cartridges for the legally blind, insulin pumps and appurtenances and insulin infusion devices; and oral agents for controlling blood sugar; diabetes self-management education and diet information provided by a physician, certified nurse practitioner, or their staff, during an office or home visit, or provided in a group. **You pay** nothing;

- Medical supplies, such as surgical dressings, splints, and ostomy supplies; **you pay** nothing.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Limited Benefits

Oral and maxillofacial surgery is provided for non-dental 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. All other procedures involving 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 is 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 for up to 60 days per condition if significant improvement can be expected within two months; **you pay** a $10 copay per outpatient session. Speech therapy is limited to treatment of certain speech impairments of organic origin. 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.

Diagnosis and treatment of infertility is covered; **you pay** nothing. **Artificial insemination** is covered, **you pay** nothing. The following types of artificial insemination are covered: Intracervical insemination and Intrauterine insemination. Cost of donor sperm is not covered. Fertility drugs are not covered, except for clomiphene (tablets), and pergonal and metrodin (injectables); **you pay** a $10 copay. **Other assisted reproductive technology (ART) procedures**, such as in vitro fertilization and embryo transfer, are not covered.

Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is covered up to 36 sessions, usually 3 sessions in a week, in a single 12-week period; **you pay** nothing.

Chiropractic services are covered when needed in connection with the detection and correction of structural imbalance, distortion, or subluxation and for the purposes of removing nerve interference and the effects thereof. **You pay** a $10 copay per visit.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

What is *n*ot *c*overed?

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp or travel;
- Reversal of voluntary, surgical-induced sterility;
- Surgery primarily for cosmetic purposes;
- Hearing aids;
- Homemaker services;
- Long-term rehabilitative therapy

Hospital/Extended Care Benefits

What is *c*overed?

Hospital *c*are

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** nothing. All necessary services are covered, including:

- Semiprivate 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 a intensive care or cardiac care unit;
- The length of a hospital stay following a lymph node dissection, lumpectomy or mastectomy for the treatment of breast cancer will be determined by you and your doctor. However, Medical Management must precertify the actual hospital admission. Your PCP or other network physician is responsible for precertification arrangement.

Extended *c*are

The Plan provides a comprehensive range of benefits for up to 60 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** nothing. 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 *c*are

Supportive and palliative care for a terminally ill member is covered in a hospice facility for up to 210 days per lifetime. 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.

Ambulance *s*ervice

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

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

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 systems (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 20 for non-medical substance abuse benefits.

What is not covered?

- Personal comfort items, such as telephones and television;
- Custodial care, rest cures, domiciliary or convalescent care.

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 bonds. Others are emergencies because they are potentially life threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. An emergency can manifest itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: placing the health of the person afflicted with such condition in serious jeopardy; serious impairment to such person's bodily functions; serious dysfunction of any bodily organ or part of such person; or serious disfigurement of such person. 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 primary care doctor or the Plan. You or a family member should notify the primary care doctor or the Plan within 24 hours. It is your responsibility to ensure that the Plan has been timely notified.

Plan pays

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

You pay

$35 per hospital emergency room visit or urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital within 24 hours, the copay is waived.

Emergencies *o*utside the *s*ervice *a*rea

If you need to be hospitalized, the Plan **must** be notified within 24 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with an ambulance charges covered in full.

Plan *p*ays

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

You *p*ay

$35 per hospital emergency room visit or urgent care center visit for emergency services that are covered benefits of the Plan. If the emergency results in admission to a hospital within 24 hours, the copay is waived.

What is *c*overed?

- Emergency care at a doctor's office or an urgent care center;
- Emergency care as an outpatient or inpatient at a hospital, including doctor's services;
- Ambulance service approved by the Plan;
- Urgent care, outside the service area, when referred to an HMO Blue USA Network HMO.

What *i*s not *c*overed?

- 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 *c*laims 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 9-11.

Mental Conditions/Substance Abuse

Mental Conditions

What *is* *c*overed?

To the extent shown below, the Plan provides the following services necessary for the diagnosis and treatment of acute psychiatric conditions, including the treatment of mental illness or disorders. Coverage will only be provided when you are referred for care by the Plan's mental health care manager. A written referral in advance can be obtained by calling 1-800—635-6626 (24 hours a day, 7 days a week) or by calling or visiting your primary care doctor. Your primary care doctor will coordinate your referral with the mental health care manager.

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

Outpatient *c*are

Up to 60 visits to Plan doctors, consultants, or other psychiatric personnel each calendar year; **you pay** a $5 copay for each covered visit – all charges thereafter.

Inpatient *c*are

Up to 60 days of hospitalization each calendar year (less 1 day for each 2 days of day or night care received during the calendar year). **You pay** nothing for the first 60 days – all charges thereafter.

What is *n*ot *c*overed?

- 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.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Substance Abuse

What *i*s *c*overed?

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. Coverage will only be provided when you are referred for care by the Plan's mental health care manager. A written referral in advance can be obtained by calling 1-800-635-6626 (24 hours a day, seven days a week) or by calling or visiting your primary care doctor. Your primary care doctor will coordinate your referral with the mental health care manager.

Outpatient *c*are

Up to 60 outpatient visits for the treatment of either alcoholism and drug abuse to Plan providers each calendar year; **you pay** nothing for each covered visit – all charges thereafter. Up to 20 visits may be used for family counseling.

Inpatient *c*are

Up to 30 days per calendar year in a substance abuse rehabilitation (intermediate care) program in an alcohol or drug rehabilitation center approved by the Plan; **you pay** nothing during the benefit period – all charges thereafter.

What *i*s *n*ot *c*overed?

Treatment that is not authorized by a Plan doctor.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Prescription Drug Benefits

What *is c*overed?

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 30-day supply. You pay a $5 copay per prescription unit or refill for up to a 30-day supply or 90-unit supply, whichever is greater, for chronic drugs. Mail order prescription service is available for maintenance medications (chronic drugs and contraceptives) for up to a 90 consecutive day supply. A chronic drug is a drug which is: an antiarthritic; an anticoagulant; a cardiac drug; a hormone; or a thyroid preparation.

You pay a $5 copay per prescription unit or refill for generic drugs or for name brand drugs when generic substitution is not permissible. When generic substitution is permissible (i.e., a generic drug is available and the prescribing doctor does not require the use of a name brand drug), but you request the name brand drug, you pay the price difference between the generic and name brand drug as well as the $5 copay per prescription unit or refill.

Empire Pharmacy Management covers drugs listed on the Plan's drug formulary. A formulary is the preferred list of drugs covered by a prescription drug plan. It includes generic alternatives to more expensive brand-name drugs, as well as covered brand-name drugs for which there may or may not be an available generic alternative. If a physician prescribes a drug that is not on the formulary, but is medically necessary, you, your physician or your PCP may call Empire Pharmacy Management at 1-800-839-8442 and present a case for an exception. Otherwise, non-formulary drugs, as well as over-the-counter (OTC) drugs (even when prescribed by a doctor), are not covered. Please note that Empire regularly reviews this list of drugs and may adjust it.

Non-formulary drugs will be covered when prescribed by a Plan doctor. It is the Plan doctor's responsibility to obtain authorization for non-formulary drugs before they are dispensed.

Covered medications and accessories include:

- Drugs for which a prescription is required by law;

- Injectables (self-administered) including insulin and allergy serum (a copay charge applies to each vial);

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

- Enteral formulas is covered only when clearly medically necessary and proven effective for individuals who are or will become malnourished or suffer from illnesses, which, if left untreated, cause chronic disability, mental retardation or death. A legally authorized provider such as a physician must issue a written prescription for the (enteral) formula attesting to its medical necessity and proven effectiveness. Modified sold food products that are low in protein or contain modified protein are covered when medically necessary for treatment of certain inherited diseases of amino acid or organic acid metabolism. Annual limits may apply. Self-prescribed supplements, routine infant bottle formulas or over-the-counter food supplements are not covered.

- Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape, glucose monitors and test strips, Benedict's solution or equivalent and acetone test tablets (covered under "Medical and Surgical Benefits");

- Oral contraceptive drugs and diaphragms

- IUD's

- Clomiphene (tablets); pergonal and metrodin injectables;

- Disposable needles and syringes needed to inject covered prescribed medication;

- Intravenous fluids and medication for home use, covered implantable drugs, such as Norplant, and injectable drugs, such as Depo Provera, are covered under Medical and Surgical Benefits.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

What *i*s *n*ot *c*overed?

- Drugs available without a prescription or for which there is a non-prescription equivalent available;
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies;
- Vitamins and nutritional substances that can be purchased without a prescription (except where mandated by law);
- Fertility drugs (except clomiphene-tablets; pergonal and metrodin-injectables);
- Drugs for cosmetic purposes;
- Drugs to enhance athletic performance;
- Smoking cessation drugs and medication (except Nicorette gum) for a 90 consecutive day supply of nicotine transdermal patches only once in a lifetime.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Dental Benefits

Dental Care Benefits

Accidental *i*njury	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, occurring while the member is covered under the FEHB Program, and the care must be performed within 12 months of the accident. **You pay** nothing.
What *i*s not *c*overed?	Other dental services not shown as covered.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered nor guaranteed under the contract with the FEHB program, but are made available to all enrollees and family members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles or out-of-pocket maximums. These benefits are.

System Analysis Review and Assistance (SARA)
The System Analysis Review and Assistance Program or (SARA), is a feature of Empire's Early Risk Management program. Using a specialized computer program, SARA analyzes existing medical lab, pharmacy and hospital claims data to identify patients at risk for potentially serious medical conditions.

If SARA identifies a potential problem, an Empire Medicare Director, who is a physician, consults with specialist from leading academic medical centers to review the information. The Empire Medical Director discusses the results with the patient's treating physician to offer suggestions about the best course of treatment. Empire may also provide the physician with the latest educational and reference material, if appropriate. While treatment decisions remain the responsibility of the treating physician and member, this program gives our members access to an extra level of medical expertise. As always, the confidentiality of members' medical information is carefully protected at every step of the process.

Members of any of their eligible dependents who do not want to participate in SAR, much notify Empire in writing at the following address: SARA, Empire Blue Cross and Blue Shield, PO Box 3560, Church Street Station, NY, NY 10008-3560. Be sure to include your Empire Blue Cross and Blue Shield ID number and the names and dates of birth of any dependents.

Empire HealthLine
This service offers free healthcare information 24-hours a day, seven days a week to BlueChoice HMO members. Call 1-877-TALK2RN (1-877-825-5276) toll-free to speak with a trained registered nurse about a health concern. Empire HealthLine also offers access to more than 1,100 audio tapes with the latest health information.

Empire BabyCare
Empire BabyCare is our comprehensive maternity management program designed to promote health pregnancies and low-cost deliveries. Our program works in conjunctions with expectant mothers and their doctors to offer educational materials and other services that support the prenatal care plan. The program offers comprehensive interviews to identify potential high-risk pregnancies and, if appropriate, access to a network of physicians specially trained to deal with complicated pregnancies.

Away From Home Care
With HMO Blue USA, if you and your family are traveling or are away from home for an extended period of time and need medical care, you can receive the same quality benefits you enjoy from your HMO at home, through the Urgent Care and Guest Membership programs. Just call our toll-free number and an Away From Home Care Coordinator will put you in touch with a qualified physician you can trust in virtually every state across the country.

MBC-Empire
MBC – Empire, our behavioral health care management program, offers you and your family personal, confidential mental health and substance abuse services, 24-hours a day, 365 days a year. Whether you need help with day-to-day problems or more serious concerns, MBC-Empire gives you toll-free access to specially trained patient care coordinators who will refer you to an appropriate provider or program.

BENEFITS ON THIS PAGE ARE NOT A PART OF THE FEHB CONTRACT

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 26.

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.

Circum-stances beyond our 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 1-800-453-0113 or write to Empire Blue Cross and Blue Shield, P.O. Box 11806, Albany, New York 12211. You may also contact us by fax at 518-367-5455 or visit our website at http://www.empirehealthcare.com.

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 premiums 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.

What types of coverage are available for me and my 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 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, gives birth or adds 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 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.

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*** **f**rom 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 notifies 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 1-800-ALERTED 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 BlueChoice HMO - 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.**

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** nothing.....17

Extended *c*are

All necessary services for 60 days per member per calendar year. **You pay** nothing.....17

Mental *c*onditions

Diagnosis and treatment of acute psychiatric conditions for up to 60 days of inpatient care per year. **You pay** nothing....21

Substance *a*buse

Up to 30 days per year in a substance abuse treatment program. **You pay** nothing.....22

Outpatient *c*are

Comprehensive range of services such as diagnosis and treatment of illness or inquiry, including special'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 maternity care and well-child; $10 per house call by a doctor.....12

Home *h*ealth *c*are

All necessary visits by nurses and health aides. **You pay** nothing.....14

Mental *c*onditions

Up to 60 outpatient visits per year. **You pay** a $5 copay per visit.....21

Substance *a*buse

Up to 60 outpatient visits maximum per year for the treatment of alcoholism and substance abuse, **you pay** nothing.....22

Emergency *c*are

Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $35 copay to the hospital for each emergency room visit and any charges for services that are not covered by this Plan.....19

Prescription Drugs

Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $5 copay per prescription unit or refill.....23

Dental Care

Accidental injury benefit; **you pay** nothing.....26

Vision Care

No current benefit.

Out-of-Pocket Maximum

Your out-of-pocket expenses for benefits covered under this Plan are limited to the stated copayments which are required for a few benefits.....5

2000 Rate Information for
BlueChoice HMO

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
Downstate area									
Self Only	**S71**	**$78.83**	**$38.05**	**$170.80**	**$82.44**	**$93.06**	**$23.82**	**$93.26**	**$23.62**
Self and Family	**S72**	**$175.97**	**$137.47**	**$381.27**	**$297.85**	**$207.74**	**$105.70**	**$201.02**	$112.42
Albany area,									
Self Only	**5L1**	**$67.53**	**$22.51**	**$146.32**	**$48.77**	**$79.91**	**$10.13**	**$79.91**	**$10.13**
Self and Family	**5L2**	**$175.97**	**$60.13**	**$381.27**	**$130.28**	**$207.74**	**$28.36**	**$201.02**	**$35.08**