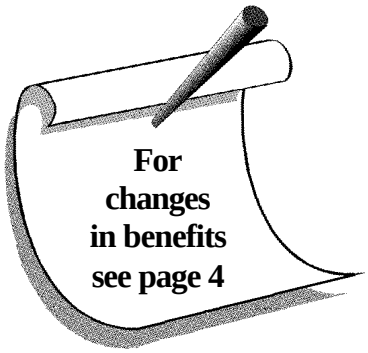
HMO Colorado/HMO Nevada

Independent Licensees of the Blue Cross and Blue Shield Association

2000

A Health Maintenance Organization with a Point-of-Service Product



Serving: Most of Colorado and Nevada

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

Colorado area:

Enrollment code:	**L21**	**Self Only**
	L22	**Self and Family**

Nevada area:

Enrollment code:	**VS1**	**Self Only**
	VS2	**Self and Family**

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

and

this Plan's website at http://www.bcbsco.com

Authorized for distribution by the:

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Retirement and Insurance Service

FEHB
Federal Employees Health Benefits Program

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Introduction

HMO Colorado/HMO Nevada
700 Broadway
Denver, CO 80273

This brochure describes the benefits you can receive from HMO Colorado/HMO Nevada under its contract **(CS2004)** 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 **HMO Colorado/HMO Nevada** 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 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 or point-of-service benefits (POS) as described on page 20 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

To keep you 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 give 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

Prescription Drug Benefits section has been changed to reflect a three-tiered copayment structure. Please refer to page 18 for complete details on the benefit changes.

For enrollment code L2, your share of the non-postal premium will increase by 23.8% for Self Only or 58.0% for Self and Family.

For enrollment code VS, your share of the non-postal premium will increase by 55.2% for Self Only or 54.4% for Self and Family.

Section 3 - How to get benefits

What is this Plan's service area?

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

In Colorado

Services are available from Plan providers in all counties except Eagle, Gunnison, Hinsdale, Jackson, Ouray, Pitkin, San Juan, and Summit counties. HMO Colorado strives to provide an extensive provider network and has a Network Access Plan available to ensure that the network meets the members needs. You may contact the carrier at 303/831-0161 or 800/334-6557 for a copy of this Plan.

In Nevada

Services from Plan providers are available in the following counties: Carson City, Clark, Douglas, Esmeralda, Eureka, Humboldt, Lincoln, Lyon, Nye, Storey, and Washoe counties. You may contact the carrier at 800/438-5270 for a copy of this Plan.

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 or point-of-service benefits. 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. HMO Colorado/HMO Nevada is part of a national network of Blue Cross and Blue Shield HMOs - HMO-USA and HMO-USA Guest Membership. Through HMO-USA, urgent care can be obtained in areas served by other Blue Cross and Blue Shield HMOs affiliated with HMO-USA. Through the HMO-USA Guest Membership, members become a guest member in another Blue Cross and Blue Shield HMO if they are temporarily assigned for 90 days or more in a geographic area which has another Blue Cross and Blue Shield HMO. Unlike HMO-USA, the Guest Membership allows members to receive covered routine care. If you would like more information about receiving care away from home, please call the Plan's member services department at 800/827-6422 in Colorado, or 800/438-5270 in Nevada. 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 emergency care**.**

After you pay $4,400 in copayments or coinsurance for one family member, or **$**10,500 for two or more family members, you do not have to make any further payments for certain services for the rest of the year. This is called a catastrophic limit. However, copayments or coinsurance for your prescription drugs, dental services and Point of Service benefits 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, or you use point-of-service benefits. 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?

HMO Colorado/HMO Nevada is a subsidiary of Blue Cross and Blue Shield of Colorado. In Colorado, the Plan offers a network of multi-specialty medical groups, family practice centers and independently practicing doctors located in Colorado. By requiring that you choose a Plan doctor convenient for you, within a 25-mile radius of where you live, HMO Colorado/HMO Nevada can assure that both routine and emergency health care is provided for you and your family in an efficient and effective manner.

In Nevada, the Plan offers multi-specialty primary medical groups (PMGs) and individual primary care physicians (PCPs). Selecting a group or physician within 25 miles of your residence or work assures routine and emergency health care is available to you and your family.

At the time of enrollment, each member must select a primary care doctor or group from whom all covered non-emergency medical services will be received. Members may select a different primary care doctor or group for each eligible family member.

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when there has been a referral by the member's primary care doctor or when you use POS benefits, with the following exception: a woman may see her Plan gynecologist for her annual routine examination without a referral.

Note: Primary care doctors in metropolitan areas are associated with specific specialists and hospitals. Please check with your primary care doctor to find out where you may be referred.

The Plan's provider directory lists primary care doctors (generally family practitioners, pediatricians, and internists) with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Customer Service Department at 303/ 831-0161 in the Metropolitan Denver area or 800/334-6557 from elsewhere in the state. In Nevada, call 800/438-5270. You can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: When you enroll in this plan, services (except for emergency benefits or POS benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider, cannot be guaranteed.

If you enroll, you will be asked to let the Plan know which primary care doctor(s) you've selected for you and each member of your family by sending a selection form to the Plan. If you need help choosing a doctor, call the Plan. Members may change their doctor selection by notifying the Plan 30 days in advance.

If you are receiving services from a doctor who leaves the Plan, the Plan will pay for covered services until the Plan can arrange with you for you to be seen by another participating doctor.

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 customer service department at 303/831-0161 or 800/334-6557 in Colorado or 800/438-5270 in Nevada. 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. Except in a medical emergency, or when a primary care doctor has designated another doctor to see his or her patients, or when you choose to see the Plan's POS benefits, you must receive a referral from your primary care doctor before seeing another doctor or obtaining special services. Referral to a participating specialist is given at the primary care doctor's discretion; if non-Plan specialist or consultants are required, the primary care doctor will arrange appropriate referrals.

When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation. All follow-up care must be provided or authorized by the primary care doctor. Do not go to the specialist for a second visit unless your primary care doctor has arranged for, and the Plan has issued an authorization for, the referral in advance.

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/she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

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.

How do you authorize medical services?

Reimbursement for services requires that your physician gets 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. The only exception, a woman may see her Plan gynecologist for her annual routine examination without a referral.

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

The criteria for determining whether a product or procedure is not experimental or investigational is as follows:

1. The technology must have final approval from the appropriate government regulatory bodies;
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
3. The technology must improve the net health outcome; which means that the technology's benefit effects on health outcomes should outweigh any harmful effects on health outcomes;
4. The technology must be as beneficial as any established alternatives; and
5. The research and experimental stage of development must be completed, and the improvement in net health outcome must be attainable outside the investigational settings.

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.

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

If your condition is serious or life threatening, call us. We will work with you to expedite the review of your claim. 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.

When may I ask OPM to review a denial?

You may ask OPM to review a 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 303/831-0161 in the Metropolitan Denver area or 800/334-6557 from elsewhere in the state. In Nevada, call 800/438-5270.

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

If we expedite your review due to serious medical condition and deny your claim, we will inform OPM so that that they can give your claim expedited treatment too. Alternatively, 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.

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.

Where should I mail my disputed claim to OPM?

Send you request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division IV, P O Box 436, Washington, DC 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 visit copay, but no additional copay for laboratory tests and x-rays when part of an office visit. Within the Service Area, house calls will be provided if in the judgement of the Plan doctor such care is necessary and appropriate; you pay nothing for doctors' house calls or for home visits by nurses and health aides. Office visits occurring after-hours or on weekends/holidays require a $20 copay per visit.

The following services are included:

- Preventive care, including well-baby care and periodic check-ups
- Mammograms for women are covered as follows: for women age 35 through age 39, one mammogram during these five years; and for women age 40 and over, one mammogram per calendar year. In addition to routine screening, mammograms are covered when prescribed by a Plan doctor as medically necessary to diagnose or treat an illness.
- Routine immunizations and boosters
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and X-rays (copay waived when other services provided)
- Outpatient surgery not performed in a doctor's office; you pay a $25 copay
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor (you pay the $100 hospital admission copay). New mothers may, at their option, remain in the hospital up to 48 hours after a regular delivery and up to 96 hours after a caesarean 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
- Voluntary sterilization; family planning services, including the fitting of a diaphragm, costs related to inserting and removing a Norplant device, and professional charges related to fitting, inserting or removing an IUD or cervical cap. The cost of the device is included. If such devices are not provided by a Plan provider, benefits are available under the Prescription Drug Benefit in this brochure.
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including test and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints
- Cornea, heart, heart/lung, single lung, double lung, kidney and liver 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 varian germ cell tumors. Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer must be preapproved by the Plan's Medical Director and performed in a Plan-

approved facility. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.

- Women who undergo mastectomies may, at their option, have their procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Coverage includes all stages of reconstruction of the breast on which the mastectomy was performed and surgery and reconstruction of other breasts to produce a symmetrical appearance. Treatment of physical complications of mastectomy, including lymphedemas, is also a covered benefit.

  Breast Prosthesis, including the surgical bra used for an external prosthesis, and necessary replacement protheses and bras are covered benefits.

  Dialysis

- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- Home health services of nurses and health aides, including home IV therapy, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- Depo Provera injections by the member's primary care physician for the purpose of birth control.
- 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.

Limited Benefits

Oral and maxillofacial surgery is provided for nondental surgical procedures and hospitalization 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 the teeth or intra-oral areas surrounding the teeth are not covered, including any medical or dental care involved in the 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.

Cryosurgery for localized prostrate cancer is considered to be an appropriate treatment and is a covered benefit when medically necessary. You pay $10 copay in office, $25 copay on an outpatient basis and $100 copay on an inpatient basis. This surgical procedure is still considered to be experimental and investigational for salvage therapy and is not covered for local failures after radical prostatectomy, external beam irradiation and brachytherapy.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two months per condition if significant improvement can be expected and services are provided within six months of illness or injury onset; you pay a $10 copay per visit. Speech therapy is limited to treatment of 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.

Treatment of congenital defects and birth abnormalities for children up to age 5 without regard to standard improvement will be entitled to this benefit.

Osteopathic manipulation is covered for up to six treatments **per year** when performed by the member's primary care physician or a Plan provider. You pay a $10 copay per visit.

Diagnosis and treatment of infertility is covered; **you pay** a $10 copay per visit. Artificial insemination is covered as follows: **you pay** a $10 copay for each of six attempts (one attempt per monthly cycle). After that, **you pay** 50% of charges for each additional attempt. Fertility drugs are not covered. Other assisted reproductive technology (ART) procedures, such as in-vitro fertilization and embryo transfer are not covered. **One ultrasound for infertility regardless of the number of attempts.**

Supplies, equipment and appliances, including oxygen, are covered; the Plan will pay a total of $1,000 per member per calendar year, **you pay** all charges thereafter, for the following: oxygen and oxygen equipment, orthopedic appliances, crutches, rental or purchase of durable medical equipment, medical supplies and prostheses when authorized by a primary care doctor.

What is not covered

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, surgically-induced sterility
- Surgery primarily for cosmetic purposes
- Hearing aids
- Chiropractic services
- Homemaker services
- Foot orthotics
- Blood and blood derivatives not replaced by the member
- Long-term rehabilitative therapy

Custodial care

- Transplants not listed as covered
- Cardiac rehabilitation
- Genetic counseling and testing
- Services related to refractive keratoplasty (surgery to correct nearsightedness), including radial keratotomy, or any procedure designed to correct farsightedness or astigmatism
- Medical supplies and devices available over-the-counter
- Air conditioners, humidifiers and purifiers, biofeedback equipment, exercise equipment, whirlpools and self-help devices

Deluxe equipment, such as motor-driven wheelchairs, when standard equipment is determined to be adequate by the Plan

- Cost of repairs that exceed the rental price of a replacement unit

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** a $100 copay per inpatient admission up to an annual hospital copayment maximum of one copay per Self Only and three per Self and Family enrollment ($300). (This maximum is separate and in addition to the copayment maximum of $100/$300 for mental conditions admissions.) This copay is waived if a member is re-admitted as an inpatient within 72 hours of a discharge for the original diagnosis or complications related to the original diagnosis. 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 as intensive care or cardiac care units
- Mastectomies may be performed on an inpatient basis with a 48-hour stay allowed if desired by the patient
- Maternity stays, at the option of the mother, may be up to 48 hours for a regular delivery and up to 96 hours for a caesarean delivery

Extended care

The Plan provides a comprehensive range of benefits for up to 30 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 care

Supportive and palliative care for a terminally ill member is covered in the home or a 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. This benefit is limited to an initial period of three months. Should the patient survive past the initial three month period, the Plan will provide up to two additional three month periods, but will not provide more than nine months of hospice care per member.

Ambulance service

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

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization or reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization and costs of services related to the medical condition; costs related to the dental procedures are not covered. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition unless anesthesia is needed for a child under specific conditions. You pay a $100 copay per admission up to annual maximum.

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. Benefits for detoxification services (usually limited to three to five days) do not include rehabilitation or long term care. You pay a $100 copay per admission up to annual maximum. See page 17 or nonmedical substance abuse benefits.

What is not covered

Personal comfort items, such as telephone and television

- Blood and blood derivatives not replaced by the member
- 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 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.

Urgent care: Situations that are not life threatening but require prompt medical attention to prevent serious deterioration in the health of an individual.

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 notified timely.

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.

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 visit or $20 per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, inpatient services are subject to the hospital admission copay of $100 and the emergency care copay is waived.

Emergencies outside the service area

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 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 any ambulance charges covered in full.

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 or $20 per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, inpatient services are subject to the hospital admission copay of $100 and the emergency care copay is waived.

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 doctor’s services

Ambulance service approved by the Plan

What is not covered

Elective care or nonemergency 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 to the applicable address:

COLORADO MEMBERS
HMO Colorado
700 Broadway
HB0642
Denver, CO 80273

NEVADA MEMBERS
HMO Nevada
P.O. Box 173690
Denver, CO 80217-5270

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 page 8.

Mental Conditions/Substance Abuse Benefits

Mental conditions

What is covered

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:

Diagnostic evaluation

Psychological testing

Psychiatric treatment (including individual and group therapy)

Hospitalization (including inpatient professional services)

Outpatient care

Up to 20 outpatient visits to Plan doctors, consultants, or other psychiatric personnel each calendar year; **you pay** a $10 copay per visit for each covered visit all charges thereafter. Outpatient visit maximums do not apply to members receiving treatment for the following diagnoses: schizophrenia, schizo-affective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, panic disorder, attention deficit disorder or Gilles de la Tourette's syndrome.

Inpatient care

Up to 45 days of hospitalization each calendar year; you pay $100 per admission, up to the mental conditions hospital copayment maximum of $100 per Self Only and $300 per Self and Family enrollment, for covered days - all charges thereafter. (This copayment maximum is separate from and in addition to the $100/$300 copayment maximum for other hospital admissions.) The hospital copay will be waived if a member is re-admitted as an inpatient within 72 hours of a discharge with the original diagnosis or complications related to the original diagnosis. Inpatient day limitations do not apply to members receiving treatment for the following diagnoses: schizophrenia, schizo-affective disorder, bipolar affective disorder, major depressive disorder, specific obsessive-compulsive disorder, panic disorder, attention deficit disorder, or Gilles de la Tourette's syndrome.

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 when 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 visits to a Plan provider each calendar year; **you pay** a $10 copay per visit for visits one through five and a $25 copay per visit for visits six through twenty.

Inpatient care

Up to two 28-day substance abuse rehabilitation (intermediate care) programs per member per lifetime in an alcohol detoxification or rehabilitation center approved by the Plan; you pay nothing during the benefit period - all charges thereafter.

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, listed on the Plan's drug formulary, and obtained at a Plan Pharmacy will be dispensed for up to a 34-day supply. You pay a $5 copay for Generic drugs, $15 copay for Brand Name drugs and $30 copay per prescription or refill for formulary drugs. If a formulary generic is available to the pharmacy and either the covered member of provider requests the brand name equivalent drug, the member will be responsible for paying the $15 copay plus the cost difference between the brand name and generic drugs. Emergency prescriptions are reimbursable at 100% of charges minus the copay. Non-formulary drugs may be covered only when the prescribing physician submits documentation of medical necessity and receives approval from the Plan prior to the member obtaining the drug.

HMO Colorado administers a drug formulary, which is developed by our Pharmacy and Therapeutics (P&T) committee. The P&T committee is comprised of physicians and pharmacists, and meets quarterly to evaluate drugs for formulary consideration. Formulary exceptions are handled on a cases-by-case basis. Providers may request coverage of non-formulary drugs by presenting evidence of medical necessity for the use of the non-formulary drug. The medical director or pharmacy direction makes the determination on non-formulary coverage exceptions based on the evidence provided by the prescriber.

Maintenance drugs by mail: You may receive up to a 90-day supply of maintenance drugs through the mail by using the Plan's Managed Prescription Mail Service Program. You pay one copay for a 30-day supply and two copays for either a 60-day or 90-day supply. If a formulary generic is available to the pharmacy and either the covered member of provider requests the brand name equivalent drug, the member will be responsible for paying the $15 copay plus the cost difference between the brand name and generic drugs. For more information on how to receive maintenance drugs by mail, call the Plan's Customer Service Department at 303/831-0161 in the metropolitan Denver area and 800/334-6557 elsewhere in the state. In Nevada, call 800/438-5270.

Covered medications and accessories include:

Drugs for which a prescription is required by Federal law.

- Insulin, disposable needles and syringes, and blood glucose test strips and supplies.
- Prescription oral contraceptives and contraceptive devices purchased from a plan pharmacy.

Limited Benefit

Intravenous fluids and medication for home use, covered implantable drugs and some injectable drugs are covered under Medical and Surgical Benefits.

Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits. You pay $5 copay up to the dosage limits and all charges above that.

What is not covered

- Drugs not listed in the Plan's formulary. Exceptions to this exclusion may be provided by HMO Colorado upon receipt of documentation of medical necessity from the prescribing provider.
- Drugs available without a prescription or for which there is a marketed non-prescription equivalent available.
- Drugs obtained at a non-Plan pharmacy except for emergencies.
- Nutritional substances.
- Medical supplies such as dressings and antiseptics.
- Therapeutic devices or appliances, such as support garments.
- Fertility drugs.
- Drugs for cosmetic purposes.
- Drugs to enhance athletic performance.
- Drugs to aid in smoking cessation.
- Appetite suppressants.

Other Benefits

Dental care

What is covered

This Plan provides the following program of dental services through participating Plan dentists. The emphasis is on prevention, with preventive and diagnostic dental services provided with no copayment.

The following dental services are provided by participating Plan dentists. **You pay** nothing up to annual benefit allowance of $750. If a provider or member needs to verify enrollment or has questions or concerns, please call 800/231-2583 for both Colorado and Nevada. In Nevada, providers and members should mail all claims to: Blue Cross and Blue Shield of Nevada, 555 Middle Creek Parkway, MS 420, Colorado Springs, CO 80921-3634.

DIAGNOSTIC	PREVENTIVE
Initial Oral Examination (at six month intervals)	Prophylaxis (cleaning)
Periodic oral examination (at six month intervals)	Fluoride treatment (to age 19) (at six month intervals)
Emergency oral examination (during regular office hours)	Oral hygiene instructions
Full mouth X-rays (one per year if necessary)	Consultation
Panoramic X-ray (one per year if necessary)	
Intra-oral periapical X-ray(s)	
Bitewing X-ray(s) (at six month intervals)	

Accidental injury benefit

Restorative services and supplies necessary to promptly repair, but not replace, sound natural teeth are covered when care is rendered within 72 hours of the accident. The need for these services must result from an accidental injury, not biting or chewing, occurring while the member is covered under the FEHB Program. You pay a $50 copay per visit.

What is not covered

Other dental services not shown as covered

- Dental care received later than 72 hours after an accident.

Point of Service Benefits

Facts about Point of Service

At your option, you may choose to obtain benefits covered by this Plan from any doctor or hospital whenever you need care, except for the benefits listed below under "What is not covered." **Benefits not covered under Point of Service Benefits must either be received from or arranged by Plan doctors to be covered.** When you obtain covered non-emergency medical treatment from a non-Plan doctor without a referral from a Plan doctor, you are subject to the deductibles, coinsurance and maximum benefit stated below.

Provider Choices

Participating Provider – A provider who has an agreement with Blue Cross and Blue Shield of Colorado/Nevada (BCBSCONV) to accept as payment in full the Plan's payment plus the member's deductible, copayment and penalty amounts, if any. When a participating provider is used, the member does not file a claim form.

Nonparticipating Provider - Providers and facilities that do not have an agreement with BCBSCONV. Members are responsible for paying all billed charges to the non-Plan provider, including any amount greater than the Plan's maximum allowable fee. Members must pay applicable deductibles, coinsurance, and penalty amounts. Members may have to file their own claim forms.

To receive a Participating Provider Directory, call the Plan's Customer Service Department at 303/831-0161 or 800/334-6557 in Colorado or 800/438-5270 in Nevada.

What is covered

Covered services are paid after you have satisfied the calendar year deductible of $250 per Self Only enrollment and $500 per Self and Family enrollment. After the deductible is met, the Plan will pay 70 percent of the first $2,500 of the maximum allowable fee per Self Only enrollment or the first $5,000 of the maximum allowable fee per Self and Family enrollment and 100 percent of the maximum allowable fee thereafter.

Precertification

Precertification ensures that benefits are provided for medically necessary care. The precertification process must be completed (and the deductible must be satisfied) for you to receive full POS benefits for: all non-emergency admissions, rehabilitative services, durable medial equipment and home health care. Please note: Failure by you to precertify these services from a non-participating provider will result in an additional obligation of 20 percent (for a total of 50 percent) coinsurance on the part of the member.

To precertify services, you must call the Plan's Health Services Department at 800/526-4662 in Colorado, Mountain Time, and 800/626-4666 in Nevada, Pacific Time, between the hours of 8 a.m. and 4:30 p.m.

Coinsurance

The member pays 30 percent of the maximum allowable fee and all charges above the maximum allowable fee (except where noted).

Maximum Benefit

Covered POS services are limited to $1,000,000 per member per lifetime.

What is not covered

The POS Benefit does not cover: ambulance service, inpatient and outpatient mental conditions and substance abuse, hospice care, diagnosis and treatment of infertility, organ transplants, skilled nursing facility care and preventive care services except an annual gynecological examination.

How to obtain benefits

Participating and Non-participating Blue Cross and Blue Shield of Colorado/Nevada providers should file your claims promptly to the applicable address:

COLORADO PROVIDERS
HMO Colorado
700 Broadway
HB0642
Denver, CO 80273

NEVADA PROVIDERS
HMO Nevada
P O Box 173690
Denver, CO 80217-3690

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, point of service maximum benefits or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedures.

Medicare prepaid plan enrollment:
This Plan offers Medicare recipients in Colorado the opportunity to enroll in the Plan through Medicare without payment of an FEHB premium. As indicated on page 28, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later reenroll 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 dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 303/831-3000 for information on the Medicare prepaid plan and the cost of that enrollment.

If you are Medicare eligible and interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan call 303/831-3000 for information on the benefits available under the Medicare HMO.

The above Medicare Product is not available from this Plan in Nevada.

Added values for Colorado and Nevada FEP enrollees:
HMO Colorado/HMO Nevada has contracted with Cole Vision to provide a large network where you may obtain a discounted vision exam and other services such as frames and lenses at a substantial discount. This replaces the exam once every two years and allows you to obtain routine exams whenever you wish. For information on the nearest provider in your area, please call 800/804-4384. Of course, if you need eye treatment because of a medical condition you should obtain a referral from your PCP just as you have in the past.

HealthAdvantage is an educational and self-help program to assist you in management of your own health conditions. A 24-hour "800" number is available, providing round-the-clock health information and counseling from an RN. You will receive the number with your enrollment information.

Added values for Colorado FEP enrollees only:
A voluntary comprehensive dental program is available which provides coverage in addition to the benefits shown on page 19 of this brochure. Coverage is available for certain oral surgery, endodontics, restorative, periodontal and prosthodontic services. There is a separate annual premium you must pay if you choose to take this additional coverage.
For more information, please call 800/231-2583.

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 or hospitals except for authorized referrals or emergencies (see Emergency Benefits) or eligible self-referred services (see Point of Service 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;
- Expenses you incurred while you were not enrolled in this Plan

Section 7 – Limitations – Rules that affect your benefits

Medicare
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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 Non-FEHB Benefits.

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 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, write or fax to:

COLORADO	NEVADA
800/334-6557 or 303/831-0161	800/438-5270
HMO Colorado	HMO Nevada
700 Broadway	P.O. Box 173690
Attn: CS0414	Denver, CO 80217-3690
Denver, CO 80273	
Fax: 303/839-8566	Fax: 303/764-7088

You may also visit our website at www.bcbsco.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, 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,
- 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.

What is former spouse coverage?

You may be eligible for former spouse coverage or Temporary Continuation of Coverage. If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your 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 are 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 800/334-6557 or 303/831-0161 in Colorado or 800/438-5270 in Nevada 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 HMO Colorado/HMO Nevada-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, AND SERVICES AVAILABLE AS POS BENEFITS, 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** a $100 copay per admission up to an annual hospital copay maximum of $100 per Self Only and $300 per Self and Family enrollment.	**13-14**
	Extended care	All necessary services for up to 30 days per year. You pay nothing	**13**
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 45 days of Inpatient care per year. **You pay** a $100 copay per admission up to an annual mental conditions hospital copay maximum of $100 per Self Only and $300 per Self and Family enrollment; this copayment maximum is separate from, and in Addition to, the annual hospital copay maximum	**13**
	Substance abuse	Two 28-day treatment programs per lifetime. **You pay** nothing	**17**
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; nothing per house call by a doctor	**10-12**
	Home health care	All necessary visits by nurses and health aides. **You pay** nothing	**11**
	Mental conditions	Up to 20 outpatient visits per year. **You pay** $10 copay per visit	**17**
	Substance abuse	Counseling visits with Plan providers. **You pay** a $10 copay per visit for Visits 1- 5 and a $25 copay for visits 6 – 20	**17**
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $50 copay to the hospital for each emergency room visit and any charges for services that are not covered by this Plan	**15-16**
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You may pay** a $5/$15/$30 copay per prescription unit or refill plus the difference in cost if a name brand drug is prescribed when a generic is available	**18**
Dental care		Accidental injury benefits; **you pay** a $50 copay per visit. Diagnostic and Preventive dental care; **you pay** nothing up to $750 annual Plan benefit per Person	**19**
Vision care		No current benefit	
Out-of-pocket maximum		Copayments are required for a few benefits; however the Plan has set a Maximum of $4,400 per Self Only or $10,500 per Self and Family enrollment per calendar year for total copays you must pay for services covered by the Plan. This copay maximum does not include the cost of prescription drugs	**5**

2000 Rate Information for
HMO Colorado/HMO Nevada

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
Most of Nevada									
Self Only	**VS1**	**$78.83**	**$36.51**	**$170.80**	**$79.10**	**$93.06**	**$22.28**	**$93.26**	**$22.08**
Self and Family	**VS2**	**$175.97**	**$99.53**	**$381.27**	**$215.65**	**$207.74**	**$67.76**	**$201.02**	**$74.48**
Most of Colorado,									
Self Only	**L21**	**$77.49**	**$25.83**	**$167.90**	**$55.96**	**$91.70**	**$11.62**	**$91.70**	**$11.62**
Self and Family	**L22**	**$175.97**	**$82.37**	**$381.27**	**$178.47**	**$207.74**	**$50.60**	**$201.02**	**$57.32**