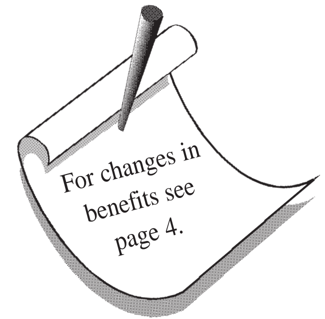
CHiP℠
Coordinated
Health Partners, Inc.

BlueCHiP, Coordinated Health Partners, Inc. 2000

A Health Maintenance Organization with a Point of Service Product



Serving: Rhode Island and portions of Southeastern Massachusetts
Enrollment in this Plan is limited; see page 5 for requirements.

Enrollment code:
DA1 Self Only
DA2 Self and Family

This Plan has a commendable status from the NCQA. See the 2000 Guide for more information on the NCQA.

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

Authorized for distribution by the:

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Introduction

BlueCHiP, Coordinated Health Partners
15 LaSalle Square
Providence, RI 02903

This brochure describes the benefits you can receive from Blue CHiP, Coordinated Health Partners under its contract (CS2328) 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 BlueCHiP, Coordinated Health Partners 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 or point-of-service benefits (POS) 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, or group of physicians, 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 your premium as low as possible, OPM has set a minimum copay of $10 for all primary care 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 BlueCHiP, Coordinated Health Partner's non-postal premium will increase by 13.1% for Self Only or 21.3% for Self and Family.

The copay for prescription drugs obtained at a Plan pharmacy is now $5 per prescription unit or refill for generic drug; $15 per prescription unit or refill for brand name drugs listed on the Plan's drug formulary, and $30 per prescription unit or refill for brand name drugs not listed on the Plan's drug formulary, unless you meet certain medical criteria for that prescription drug. For prescription drugs obtained at a non-participating pharmacy, you now pay a $30 copay plus 20% of the BlueCHiP, Coordinated Health Partners allowance. Previously, you paid a 20% coinsurance for all prescription drugs obtained at a Plan pharmacy and a 50% coinsurance for prescription drugs obtained at a non-Plan pharmacy.

Home health services are no longer covered under the POS benefits. All home health services must be obtained from network providers. Previously, home health services were covered under the POS benefit at 80% of the Plan's allowance.

Durable Medical Equipment (DME) is no longer covered under the POS benefits. All Durable Medical equipment must be obtained from the network provider. Previously, DME was covered under the POS benefit at 80% of the Plan's allowance.

Diagnostic procedures, such as laboratory tests and X-rays are no longer covered under the POS benefits. Diagnostic procedures must be obtained from network providers. Previously, diagnostic procedures were covered under the POS benefit at 80% of the Plan's allowance.

Anesthesia consultations are no longer covered under the POS benefits. All anesthesia consultations must be obtained form network providers. Previously, anesthesia consultations were covered under the POS benefit at 80% of the Plan's allowance.

Infertility services are no longer covered under the POS benefits. All infertility services must be obtained from network providers. Previously, infertility services were covered under the POS benefit at 80% of the Plan's allowance.

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: The State of Rhode Island and the following cities and towns in the state of Massachusetts: Acushnet, Attleboro, Bellingham, Blackstone, Dartmouth, Dighton, Fall River, Fairhaven, Foxborough, Franklin, Mansfield, Medway, Mendon, Millville, New Bedford, North Attleboro, Norton, Plainville, Raynham, Rehoboth, Seekonk, Somerset, Swansea, Taunton, Uxbridge, Westport, Wrentham.

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. BlueCHiP, Coordinated Health Partners offers the HMO USA Away from Home Care Guest Membership program. To enroll in this program, please contact Customer Service at 401/274-3500 or toll-free at 1-800-564-0888. If you or a family member move, you do not have to wait until the 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.

After you pay $2,294 in copayments or coinsurance for one family member, or $5,874 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 and dental services do not count toward these limits and you must continue to make these payments.

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

Do I have to submit claims?

You normally won't have to submit claims to us unless you receive emergency services from a provider who doesn't contract with us, 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?

BlueCHiP, Coordinated Health Partners is affiliated with Blue Cross & Blue Shield of Rhode Island. BlueCHiP, Coordinated Health Partners provides care through over 700 primary care doctors (internists, pediatricians and family practitioners) and over 1,200 specialists, along with a full range of hospitals and other health care providers across the state. When specialist services are needed, your primary care doctor will refer you to a BlueCHiP, Coordinated Health Partners specialist. All participating primary care doctors practice out of offices in the community. Each member selects a primary care doctor who acts as a personal doctor working with you to coordinate all of your health care needs.

BlueCHiP, Coordinated Health Partners has a POS product which offers members the flexibility of obtaining services outside of the primary care doctor system and receiving an allowance for services. For more information regarding this benefit, see pages 16 and 17.

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 continue to 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 401/274-3500 or toll-free at 1-800-564-0888. 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.

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

How do I get specialty care

If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan. When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation unless your doctor authorizes additional visits. All follow-up care must be provided or authorized by the primary care doctor. Do not go to the specialist unless your primary care doctor has arranged for the referral in advance.

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. 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?

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?

Experimental or investigational services include any treatment, procedure, facility, equipment, drug, device, supply or service (hereinafter referred to collectively as "service") when the service has progressed to limited human application, but has not been recognized as proven effective in clinical medicine. A service is considered experimental or investigational if the plan determines that one or more of the following circumstances are true: 1) the service is the subject of an ongoing clinical trial or is under study to determine the maximum tolerated dose, toxicity, safety, efficacy, or efficacy as compared with a standard means of treatment or diagnosis; or 2) the prevailing opinion among experts regarding the service is that further studies or clinical trials are necessary; or 3) the current belief in the pertinent specialty of the medical profession in the United States is that the service or supply should not be used for the diagnosis or indications being requested outside of clinical trials or other research settings because it requires further evaluation for that diagnosis or indications.

BlueCHiP will determine the applicability of this criterion based on: Published reports in authoritative, peer-reviewed medical literature; and reports, publications, evaluations, and other sources published by government agencies; or the service has FDA approval but the indication for the drug, device or dosage is not an accepted off-label use.

To the extent that BlueCHiP's definition of experimental or demonstrated reliable evidence conflicts with Rhode Island General Laws (Section 27.41-41,41.1 and 41.2) relating to "new cancer therapies", and Rhode Island General Laws Chapter 27-55 relating to off-label uses of prescription drugs, those statutory provisions will control.

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 401-274-3500 or 1-800-564-0888 and we will expedite our 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. Alternatively, you can call OPM's health benefits Contract Division 3 at 202-606-0755 between 8 am and 5 pm Eastern Time. 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 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.

Where should I mail my disputed claim to OPM?

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contract Division 3, 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 for primary care and specialist office visits, but no additional copay for laboratory tests or 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; you pay nothing for home visits by nurses and health aides.

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

- Preventive care, including well-baby care and periodic check-ups.
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through age 49, one mammogram every one or two years; for women age 50-64, one mammogram every year; for women age 65 and above, one mammogram every two years. In addition to routine screenings, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters.
- Consultations by specialists.
- Diagnostic procedures, such as laboratory tests and X-rays.
- Hearing exams when referred by the primary care doctor.
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. Copays are waived for maternity care after the initial visit. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 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; in addition, coverage of injury or sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities will be covered for the first 31 days of the newborn’s life; all care after the first 31 days will be covered only if the infant is covered under a Self and Family enrollment.

- Voluntary sterilization and family planning services.
- Infertility services (diagnosis and treatment), including artificial insemination and injectable fertility drugs; **you pay** 20% of BlueCHiP, Coordinated Health Partners' fee allowance. The following types of artificial insemination are covered: intravaginal insemination (IVI); intracervical insemination (ICI) and intrauterine insemination (IUI); cost of donor sperm is not covered. Non-injectable fertility drugs are covered under the prescription drug benefit.
- Short term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis if significant improvement can be expected. On an inpatient basis you pay nothing. On an outpatient basis, **you pay** $10 per session.
- Diagnosis and treatment of diseases of the eye.
- Allergy testing and treatment; including testing and treatment materials (such as allergy serum).
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints; also breast prostheses and surgical bras, including their replacements.
- Cornea, heart, heart-lung, kidney, liver, lung (single or double), and pancreas transplants; allogenic (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, and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors, and breast cancer, multiple myeloma and epithelial ovarian cancer. Treatment for breast cancer, multiple myeloma and epithelial ovarian cancer may be provided in a non-randomized clinical trial, subject to approval by the Plan's Medical Director. Additionally, such trials must be delivered at a facility that is a National Cancer Institute (NCI) funded National Cooperative Cancer study group institution that has been approved by the Cooperative Groups to conduct clinical research on HDC/ABMT treatment or an institution that has an NCI funded, peer reviewed grant to study HDC/ABMT. In the absence of an available clinical trial, the Plan will provide the same level of coverage for these transplants as any other transplant covered by the Plan. 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 this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis.
- Chemotherapy, radiation therapy, and inhalation therapy.
- Surgical treatment of morbid obesity.
- Podiatric services.
- Initial orthopedic devices, such as braces, initial prosthetic devices, such as artificial limbs and durable medical equipment, such as wheelchairs and hospital beds; **you pay** a $20 copay per item. The Plan will determine whether an item is to be rented or purchased.
- 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.

Limited Benefits

- **Oral and maxillofacial surgery** is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts; **you pay** a $10 copay for office visits. All other procedures involving the teeth or intra oral areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

- **Reconstructive surgery** will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by surgery; **you pay** nothing. 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.

- **Cardiac rehabilitation** following a heart transplant, bypass surgery or a myocardial infarction, is provided at a Plan facility for up to 32 visits; **you pay** nothing.

- **Chiropractic services,** when received from an in-network chiropractor, are covered for up to six self-referred visits per calendar year. **You pay** $10 per visit.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment, insurance, or attending school or camp, or travel.
- Blood and blood derivatives not replaced by the member.
- Reversal of voluntary, surgically-induced sterility.
- Surgery primarily for cosmetic purposes.
- Transplants not listed as covered.
- Hearing aids.
- Long-term rehabilitative therapy.
- Homemaker services or custodial care.
- Replacement orthopedic and prosthetic devices.
- Foot orthotics.

Hospital/Extended Care Benefits

What is covered

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:

Hospital care

- 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.

Extended care

The Plan provides a comprehensive range of benefits with no dollar or day limit when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is in lieu of hospitalization 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 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. **You pay** nothing.

Ambulance service

Benefits are provided for medically necessary ambulance services for emergency care. Non-emergent situations require a BlueCHiP authorization.

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 symptoms (acute detoxification) if the Plan Mental Health Administrator determines that outpatient management is not medically appropriate. See page 14 for non-medical 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.

CARE MUST BE RECEIVED FROM OR ARRANGED BY PLAN DOCTORS TO RECEIVE STANDARD HMO BENEFITS

Emergency Benefits

What is a medical emergency?

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

Emergencies within the service area

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

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

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition (except as shown on page 16).

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by Plan providers except as covered under POS benefits.

Plan pays...

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

You pay...

$25 per hospital emergency room visit for emergency services or $20 per urgent care visit at a Plan participating urgent care center for benefits covered under this Plan. If the emergency results in an admission to a hospital within 24 hours, 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.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by Plan providers except as covered under POS benefits.

Plan pays...

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

You pay...

$25 per hospital emergency room visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital within 24 hours, the emergency care copay is waived.

What is covered

- Emergency care at a doctor's office.
- Emergency care as an outpatient or inpatient at a hospital, including doctors' services.
- Ambulance service approved by the Plan.

What is not covered

- Elective care or non-emergency care except as covered under the POS Benefits.
- 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 except as covered under the POS benefits.

Filing claims for non-Plan providers

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

Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on pages 7 – 9.

Reciprocity

BlueCHiP, Coordinated Health Partners offers the HMO USA Away From Home Urgent Care program. When you or a covered member are traveling throughout the United States, and need medical care before you return home, call the Away From Home Coordinator at **1-800-4-HMO-USA (1-800-446-6872).** The Away From Home Care Coordinator will assist you with scheduling an appointment with a qualified doctor during normal business hours and give you directions to the doctor's office.

Mental Conditions/Substance Abuse Benefits

Mental conditions

Treatment for mental health conditions and substance abuse may be obtained directly from Continuum Behavioral Care or other mental health administrator, as determined by the Plan; the member must call 800/544-5977 or 401/276-4052 prior to services being rendered. Continuum Behavorial Care will determine and authorize the appropriate number of visits and determine the appropriate specialist. A referral from your PCP is not required.

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).
- Biological disorders of the brain that substantially limit the life activities of an individual including, but not limited to schizophrenia, schizoaffective disorder, delusional disorder, bipolar affective disorders, major depression and obsessive-compulsive disorder.

Outpatient care

Up to 20 outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; **you pay** a $10 copay for each covered visit - all charges thereafter.

Inpatient care

Up to 90 days of hospitalization each calendar year; **you pay** nothing for the first 90 days - all charges thereafter.

What is not covered

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

Substance abuse

What is covered

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

Outpatient care

Alcohol abuse - Up to 30 visits for each individual under treatment and 20 visits for other family members per calendar year for counseling; **you pay** a $10 per visit copay.

Other substance abuse - Up to 20 visits per calendar year for rehabilitation; **you pay** a $10 per visit copay.

These substance abuse benefits may be combined with the outpatient mental conditions benefits shown above, provided such treatment is necessary as a mental health service and is approved by the Plan, to permit an additional 20 outpatient visits per calendar year with the applicable mental conditions benefits coinsurance.

Inpatient care

Alcohol abuse - Up to 30 days per calendar year for rehabilitation, lifetime maximum of 90 days on all substance abuse care; **you pay** nothing.

Other substance abuse - Up to 30 days per calendar year for rehabilitation, lifetime maximum of 90 days on all inpatient substance abuse care; **you pay** nothing.

What is not covered

- Treatment that is not authorized by the Plan Mental Health Administrator.

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor will be dispensed for up to a 34-day supply for non-maintenance drugs or the greater of a 34-day supply or 100 units for maintenance drugs. For prescription drugs obtained at a Plan participating pharmacy, **you pay** a $5 copay per prescription unit or refill for generic drugs; a $15 copay per prescription unit or refill for brand name drugs listed on the Plan's drug formulary; or a $30 copay per prescription unit or refill for brand name drugs not listed on the Plan's drug formulary, unless you meet certain medical criteria for the prescription drug (see "note" below).

Note: There is a two-month grace period for non-formulary drugs, during which the member will only be charged only the $5 generic or $15 brand name copay, whichever applies. If you meet the pre-established medical criteria for the non-formulary drug, you will only be required to pay the applicable $5 generic or $15 brand name copay. If they do not meet the pre-established medical criteria or your physician does not submit the necessary information for medical necessity to be determined, you will be responsible for the $30 copay amount after the two-month grace period has ended.

Plan pharmacies include pharmacies from the Preferred Rx network, which is composed of CVS, Brooks and additional independent pharmacies. For prescription drugs obtained at a non-participating pharmacy, you are responsible for paying the non-participating pharmacy directly and the Plan will reimburse you once you have submitted the receipt, your name and identification number to BlueCHiP, 15 Lasalle Square, Providence, RI 02903.

Covered medications and accessories include:

- Diabetic supplies are covered under Medical and Surgical Benefits, **you pay** 20% of BlueCHiP, Coordinated Health Partner's fee allowance.
- Drugs for which a prescription is required by Federal law.
- Fertility drugs (non-injectables).
- All FDA approved contraceptive drugs and devices.
- Implanted time-release medications, such as Norplant (included with office visit copay covered under Medical/Surgical benefits).
- Insulin.
- Intravenous fluids and medication for home use, implantable drugs, and injectible drugs, **(excluding insulin)** are covered under Medical and Surgical Benefits.
- Needles and syringes when dispensed with insulin.

- Nicotine substitute prescriptions (the patch and gum); you pay all charges at the time of purchase (keep your receipts); you are reimbursed after you are smoke free for 12 months. You are reimbursed at 80% of BlueCHiP, Coordinated Health Partners' fee allowance after submitting to the Plan a sales receipt and physician's documentation that you are smoke free. This coverage is limited to a three-month treatment, one per lifetime maximum.
- Prenatal and other prescribed vitamins.

Limited benefits

- Drugs to treat sexual dysfunction are subject to dosage limitations. Contact the Plan for specific dosage limitations.

What is not covered

- Drugs available without a prescription or for which there is a nonprescription equivalent available.
- Drugs for cosmetic purposes.
- Drugs to enhance athletic performance.
- Injectable fertility drugs.
- Medical supplies such as dressings and antiseptics.
- Vitamins and nutritional substances that can be purchased without a prescription.

Other Covered Benefits

Dental care

Accidental injury benefit

Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth are covered. The need for these services must result from an accidental injury; you pay nothing.

Vision care

What is covered

In addition to the medical and surgical benefits provided for diagnosis and treatment of diseases of the eye, annual eye refractions (which include the written lens prescription) may be obtained from Plan Providers. **You pay** a $10 copay for office visits.

What is not covered

- Corrective lenses or frames.
- Eye exercises.

Facts about BlueCHiP, Coordinated Health Partners' POS

BlueCHiP, Coordinated Health Partners' POS

At your option, you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals or from Plan doctors without a referral whenever you need care, except for the benefits listed below under "What is not covered." Medical services and supplies not covered under Point of Service 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 annual deductible and coinsurance stated below. An annual out-of-pocket maximum is also stated below.

What is covered

Members may use providers who do not participate in the program or may self-refer to participating providers but are strongly encouraged to obtain care through the primary care doctor system.

Members may receive eligible services from any doctor, hospital, or other provider without referral from their primary care doctor. Some of the services are covered ONLY under the Plan's Standard HMO Benefits (See What is not covered below). However, members may choose to receive benefits using the POS benefit (i.e. receive medical services from providers without a PCP referral) and receive a lower allowance than when the standard HMO benefit is utilized.

Deductible

When the POS benefit is utilized, you pay a $250 deductible per member per calendar year or a $500 deductible per family per calendar year, for doctors' visits, other outpatient services, and for hospital services. The deductible is not reimbursable by the Plan. If you decide to use non-participating providers or self refer to a participant provider, this deductible applies to all covered benefits. Copays under the BlueCHiP, Coordinated Health Partners' POS benefits cannot be used to meet the calendar year deductible.

Coinsurance for participating providers

When you self refer to Plan participating providers, the Plan pays 80% of its fee allowance after the deductible is met; **you pay** 20% of the fee allowance.

Coinsurance for non-participating providers

When you self refer to non-Plan participating providers, the Plan pays 80% of its fee allowance after the deductible is met; **you pay** 20% of the fee allowance and all charges over and above the fee allowance.

Plan authorization

Services requiring Plan authorization under the Plan's Standard HMO benefits continue to require authorization under the POS benefit. When utilizing non-Plan participating providers, you are responsible for assuring that Plan Authorization is obtained in advance for such services.

Out-of-pocket maximum

Members are protected by an out-of-pocket maximum of $3,000 per person, per calendar year and $6,000 per family per calendar year. (This includes deductibles and copayments. Charges over the usual and customary allowance cannot be applied to the out-of-pocket maximum.)

Prescription drugs

You may have prescriptions filled when utilizing the POS benefit. The benefits and requirements are the same as those for the standard HMO Prescription Drug Benefit (see page 15)

What is not covered

- Anesthesia consultations (services are covered under the prepaid plan, see page 9)
- Chiropractic care (services are covered under the prepaid plan, see page 11)
- Diagnostic procedures such as laboratory tests and x-rays (services are covered under the prepaid plan, see page 9)
- Durable Medical Equipment (DME) and medical supplies (services are covered under the prepaid plan, see page 10)
- Emergency room visits (emergency services are covered under the prepaid plan, see page 12)
- Home health services (services are covered under the prepaid plan, see page 10)
- Infertility services (services are covered under the prepaid plan, see page 10)
- Mental conditions/substance abuse benefits (services are covered under the prepaid plan, see page 14)
- Outpatient physical, speech and occupational therapies, cardiac rehabilitation (services are covered under the prepaid plan, see pages 10 and 11)
- Rehabilitation hospitalizations (services are covered under the prepaid plan, see page 11)
- Skilled nursing facility care (services are covered under the prepaid plan, see page 11)
- Transplant coverage (services are covered under the prepaid plan, see page 10)
- Vision care benefits (services are covered under the prepaid plan, see page 16)

Non-FEHB Benefits Available to Plan Members

The benefits described on this page are neither offered or guaranteed under the contract with 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, POS maximum benefits, or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Medicare prepaid plan enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 19, annuitants and former spouses with FEHB coverage and Medicare 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 re-enroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those **without** Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 800/505-2583 for information on the Medicare prepaid plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 800/505-2583 for information on the benefits available under the Medicare HMO.

BENEFITS ON THIS PAGE ARE NOT 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) 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; 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 18.

Other group insurance

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 401/274-3500 or toll-free at 1-800-564-0888, or write to Customer Service, 15 LaSalle Square, Providence, RI 02903. You may also contact us by fax at 401-459-5089, or visit our website at www.bcbsri.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 my family and me?

Self-Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster or step children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also get coverage for a disabled child 22 years of age or older who is incapable of self-support which is also authorized by your employing or retirement office.

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. No new enrollment form is necessary.

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' Compensations 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

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

What happens if my enrollment in this Plan ends?

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

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

What is former spouse coverage?

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get more information about your coverage choices.

What is TCC?

Temporary Continuation of Coverage (TCC). If you leave Federal service or if you lose coverage because you no longer qualify as a family member, you may be eligible for TCC. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

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

Key points about TCC:

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

How do I enroll in TCC?

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

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

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

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

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

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

How can I convert to individual coverage?

You may convert to an individual policy if:

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

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

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

How can I get a Certificate of Group Health Plan Coverage

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

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

Inspector General Advisory:
Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 401-459-5500 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.

Notes

Notes

Summary of Benefits for Blue CHiP, Coordinated Health Partners - 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** nothing	11
	Extended care	All necessary services. **You pay** nothing	11
	Mental conditions	Diagnosis and treatment of acute psychiatric conditions for up to 90 days of inpatient care per calendar year. **You pay** nothing	14
	Substance Abuse	Up to 30 days for (lifetime maximum of 90 days) for alcohol abuse and up to 30 days (lifetime maximum of 90 days) for other drug abuse programs per calendar year. **You pay** nothing	14
Outpatient care		Comprehensive range of services such as preventive care, including well-baby care, periodic checkups, office visits for routine immunizations; primary care and specialist office visits or house calls by a doctor. You pay a $10 copay.laboratory tests, x-rays; complete maternity care, **you pay** nothing	9
	Home health care	All necessary visits by nurses and home health aides. **You pay** nothing	10
	Mental conditions	Up to 20 outpatient visits per calendar year. **You pay** $10 per visit	14
	Substance abuse	Up to 30 outpatient visits for alcoholism and up to 20 visits for other substance abuse per calendar year. **You pay** $10 per visit	14
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $25 copay to the hospital for each emergency room visit inside and outside the service area and any charges for services that are not covered benefits of this Plan	12
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at Plan pharmacy. **You pay $5 generic/ $15 brand name per prescription unit or refill for formulary drugs for a 34-day supply. Non-formulary drugs have a $30 copay unless medically necessary**	15
Dental care		Accidental injury benefit. **You pay** nothing	16
Vision care		One refraction every year. **You pay** a $10 copay for office visits	16
Point of Service Benefits		Services of non-Plan doctors and hospitals. Not all benefits are covered. You pay the annual deductible then coinsurance thereafter. **An annual out-of-pocket maximum also applies.**	16
Out-of-pocket maximum		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of **$2,294** per Self Only or **$5,874** per Self or Family enrollment per calendar year, covered benefits will be provided at 100%. This maximum does not include costs of prescription drugs or dental services.	5

Authorized for distribution by the:
United States Office of Federal Employee
Personnel Management

2000 Rate Information for BlueCHiP, Coordinated Health Partners, Inc.

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

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

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

		Non-Postal Premium				Postal Premium A		Postal Premium B	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Your Share
Self Only	DA1	$75.20	$25.06	$162.92	$54.31	$88.98	$11.28	$88.98	$11.28
Self and Family	DA2	$175.97	$80.72	$381.27	$174.89	$207.74	$48.95	$201.02	$55.67