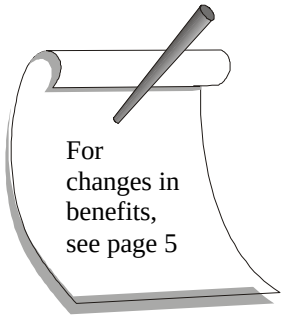
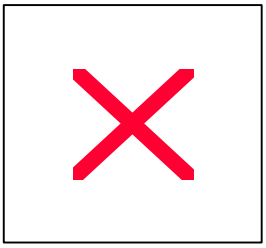
Blue Cross–HMO (CaliforniaCare) 2000

A Health Maintenance Organization



Enrollment in this Plan is limited; see page 6 for requirements.

Enrollment Code:
M51 Self Only
M52 Self and Family



This Plan has full accreditation from the NCQA. See the *2000 Guide* for more information on NCQA

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

Authorized for distribution by the:

UNITED STATES OFFICE OF
PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE

Federal Employees Health Benefits Program

RI 73-517

Table of Contents

Introduction

Blue Cross of California, P.O. Box 4089, Woodland Hills, Ca. 91365

This brochure describes the benefits you can receive from Blue Cross – HMO (CaliforniaCare) under its contract (CS 2514) 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 5. 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 Blue Cross - HMO (CaliforniaCare) 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. See Section 1. below 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 preventive care such as routine office visits, physical exams, well-baby care and immunizations, as well as treatment for illness and injury.

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

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us. Our providers follow generally accepted medical practice when prescribing any course of treatment.

Section 2. How we change for 2000

Program-wide changes

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

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

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

The copayment for physician office and home visits has been increased from $5 to $10. This $10 copayment now applies to each physician home or office visit including visits for preventive care, specialists consultations, family planning, allergy testing and treatment, acupuncture services, maternity visits, etc.

Changes to this Plan

The prescription drug copayment for name brand drugs and non-formulary generic drugs has been changed as follows:

--Name brand drugs and non-formulary generic drugs filled at a Blue Cross participating pharmacy will now require a $10 copayment.
--Name brand drugs filled at a non-participating pharmacy will be reimbursed at 50% minus a $10 copayment.
--Name brand drugs and non-formulary generic drugs received through the mail order program will now require a $20 copayment.
(See Section 5: Benefits - Prescription Drug Benefits)

Your share of the premium will increase by 21.8% for Self Only and 21.8% 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:

Northern California

--Amador	--Fresno	--Marin	--Nevada	--San Francisco	--Sonoma
--Alameda	--Humboldt	--Mendocino	--Placer	--San Joaquin	--Stanislaus
--Butte	--Kings	--Merced	--Plumas	--San Mateo	--Tehama
--Contra Costa	--Lake	--Modoc	--Sacramento	--Santa Cruz	--Tulare
--Del Norte	--Lassen	--Monterey	--San Benito	--Shasta	--Tuolumne
--El Dorado	--Madera	--Napa	--Santa Clara	--Solano	--Yolo

Southern California

--Imperial --Los Angeles --Orange --San Diego --San Louis Obispo
--Santa Barbara --Ventura

You may also enroll with us if you live or work in the Zip Codes of the following counties:

KERN: 93203, 93205-06, 93215-17, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93249-52, 93255, 93263, 93276, 93280, 93283, 93285, 93287, 93300-09, 93311-13, 93380-89, 93399, 93504-05, 93516, 93518-19, 93523-24, 93528, 93531, 93554, 93555, 93556, 93560-61, 93570, 93581-82, 93596

RIVERSIDE: 91718-20, 91752, 91753, 91760, 92201-03, 92210, 92211, 92220, 92223, 92230, 92234-36, 92240, 92241, 92253-55, 92258, 92260-64, 92270, 92276, 92282, 92292, 92303, 92320, 92330-31, 92343-44, 92348, 92353, 92355, 92360-62, 92367, 92370, 92379-81, 92383, 92387-88, 92390, 92395-96, 92500-09, 92513-19, 92521-23, 92530-32, 92542-46, 92548, 92550, 92552-57, 92562-64, 92567, 92570-72, 92581-87, 92589-93, 92595-96, 92599

SAN BERNARDINO: 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758, 91761-64, 91784-86, 91798, 92337, 92252, 92256, 92268, 92277-78, 92284-86, 92301, 92305, 92307-08, 92311-13, 92314-18, 92321-22, 92324-27, 92329, 92333-37, 92339-42, 92345-47, 92350, 92352, 92354, 92356-59, 92365, 92368-69, 92371-78, 92382, 92385-86, 92391-94, 92397, 92398, 92399, 92400-18, 92420, 92423-24, 92427

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency or urgent care services.

If you or a covered family member move outside of our service area, you can enroll in another plan. 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.

After you pay $1,000 in copayments or coinsurance for one family member, or $3,000 for three 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 or infertility treatment 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 or urgent case services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year

you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Who provides my health care?

When you enroll you should choose a primary care physician. Your primary care physician will be the first doctor you see for all your health care needs. If you need special kinds of care, this physician will refer you to other kinds of health care providers.

Your primary care physician will be part of a CaliforniaCare contracting medical group. There are two types of CaliforniaCare medical groups.

- A primary medical group (PMG) is a group practice staffed by a team of doctors, nurses, and other health care providers.
- An independent practice association (IPA) is group of doctors in private offices who usually have ties to the same hospital.

You and your family members can enroll in whatever medical group is best for you.

- You must live or work within 30 miles of the medical group.

You and your family members do not have to enroll in the same medical group.

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 800/235-8631. 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 may refer you to another doctor if you need special care. Your primary care physician must OK all the care you get except when you have an emergency or need urgent care.

Your physician's medical group has to agree that the service or care you will be getting from the other health care provider is medically necessary. Otherwise it won't be covered.

- You will need to make the appointment at the other physician's office.
- Your primary care physician will give you a referral form to take with you to your appointment. This form gives you the OK to get this care. If you don't get this form, ask for it or talk to your CaliforniaCare coordinator.
- You may have to pay a copay. You shouldn't get a bill, unless for a copay, for this service. If you do, send it to your CaliforniaCare coordinator right away. The medical group will see that the bill is paid.
- Your primary care physician may be able to send you to some health care providers without getting the OK from the medical group first.
- Ask your CaliforniaCare coordinator if your medical group takes part in a program, called "Speedy Referral."

Standing Referrals. If you have a condition or disease that:

- Requires continuing care from a specialist; or is
- Life-threatening;
- Degenerative; or
- Disabling;

your primary care physician may give you a standing referral to a specialist or specialty care center. The referral will be made if your primary care physician, in consultation with you, and a specialist or specialty care center, if any, determine that continuing specialized care is medically necessary for your condition or disease.

If it is determined that you need a standing referral for your condition or disease, a treatment plan will be set up for you. The treatment plan:

- Will describe the specialized care you will receive;
- May limit the number of visits to the specialist; and
- May limit the period of time that visits may be made to the specialist.

How do I get specialty care? (continued)

If a standing referral is authorized, your primary care physician will determine which specialist or specialty care center to send you to in the following order:

- First, a CaliforniaCare contracting specialist or specialty care center which is associated with your medical group;
- Second, any CaliforniaCare contracting specialist or specialty care center; and
- Last, any specialist or specialty care center.

That has the expertise to provide the care you need for your condition or disease.

After the referral is made, the specialist or specialty care center will be authorized to provide you health care services that are within the specialist's area of expertise and training in the same manner as your primary care physician, subject to the terms of the treatment plan.

Remember: We only pay for the number of visits and the type of special care that your primary care physician OK's. Call your doctor if you need more care. **If your care isn't approved ahead of time, you will have to pay for it (except for emergencies or urgent care.)**

If You Are A Woman

You can get OB-GYN services from a physician who specializes in caring for women (OB-GYN) or family practice doctor who does OB-GYN and works with your medical group.

- You can get these services without an OK from your primary care physician.
- Ask your CaliforniaCare coordinator for the list of OB-GYN health care providers you must choose from.

Direct Access

You may be able to get some special care without an OK from your primary care physician. We have a program called "Direct Access", which lets you get special care, without an OK from your primary care physician for:

- Allergy
- Dermatology
- Ear/Nose/Throat

Ask your CaliforniaCare coordinator if your medical group takes part in the "Direct Access" program. If your medical group participates in the Direct Access program, you must still get your care from a doctor who works with your medical group. The CaliforniaCare coordinator will give you a list of those doctors.

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 procedures are those that are mainly limited to laboratory and/or animal research. Investigative procedures or medications are those that have progressed to limited use on humans, but which are not generally accepted as proven and effective within the organized medical community. Any experimental or investigative procedures or medications are not covered under this Plan. Your medical group or we will determine whether a service is considered experimental or investigative.

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.

Review of Denials of Experimental or Investigative Treatment

If coverage for a proposed treatment is denied because we or your medical group determine that the treatment is experimental or investigative, you may ask that the denial be reviewed by an external independent medical review organization with which we contract. To request this review, please call us at the telephone number listed on your identification card or write to us at Blue Cross of California, P.O. Box 4089, Woodland Hills, Ca. 91365. To receive this review, all of the following conditions must be met:

- You have a terminal condition that has a high probability of causing death within two years.
- The proposed treatment must be recommended by either (a) a participating provider or (b) a board certified or board eligible doctor qualified to treat you who certifies in writing that the proposed treatment is more likely to be beneficial than standard treatment. This certification must include a statement of the evidence relied upon.
- If this review is requested either by you or by a qualified non-participating provider (as described above), the requestor must supply two items of acceptable medical and scientific evidence. This evidence consists of the following sources:

  -Peer-reviewed scientific studies published in medical journals with nationally recognized standards;
  -Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, and MEDLARS database Health Services Technology Assessment Research;
  - Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
  -The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
  -Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and
  -Peer reviewed abstracts accepted for presentation at major medical association meetings.

Within five days of receiving your request for review we will send the reviewing panel all relevant medical records and documents in our possession, as well as any additional information submitted by you or your doctor. Information we receive subsequently will be sent to the review panel within five business days. The external independent review organization will complete its review and render its opinion within 30 days of its receipt of request for review (or within seven days in the case of an expedited review). This timeframe may be extended by up to three days for any delay in receiving necessary records.

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 of life threatening condition and you haven't responded to my request for service?

Call us at 800/235-8631 and we will expedite your review.

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 did 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 do not answer within 30 days. In this case, OPM must receive your request within 120 days of the date we asked you for additional information.

What do I send to OPM?

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

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

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

Who can make the request?

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

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

What 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 II at (202) 606-3818 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.

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.

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 are provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** a $10 office visit copay, unless otherwise noted below but no additional copay for laboratory tests and X-rays by Participating providers. The $10 office visit copay is not charged for well-baby/well child care. Within the Service Area, house calls will be provided if, in the judgment of the Plan, such care is necessary and appropriate; **you pay** a $10 copay for a doctor's house call and nothing for visits by nurses and health aides.

The following services are included and the copayments indicated below will apply**:**

Physician office visits. $10 copay

Physician home visits, if within the Medical Group's area and medically necessary ..... $10 copay

Preventive care and periodic check-ups for the employee or annuitant and enrolled spouse ..... $10 copay

Well-baby care/child care (for all enrolled dependent children, regardless of age) ..... No copay

Routine mammograms as recommended by your Plan doctor and medically necessary mammograms to diagnose or treat an illness ..... No copay

Routine immunizations and boosters ..... No copay

Routine vision exams ..... No copay

Routine hearing exams ..... No copay

Consultations by specialists ..... $10 copay

Diagnostic procedures, such as laboratory tests and X-rays ..... No copay

Family planning services ..... $10 copay

Voluntary sterilization ..... $150 copay for tubal ligations
$50 copay for vasectomies

Section 5. BENEFITS - Medical and surgical benefits

Diagnosis and treatment of diseases of the eye..... $10 copay

Allergy testing and treatment, which includes..... .$10 copay
the cost of the testing and treatment materials
(such as allergy serum)

The insertion of internal prosthetic devices, such as pacemakers,
artificial joints, and breast prostheses following a mastectomy. ..... No copay

Mastectomy and lymph node dissection;
complications from a mastectomy
including lymphedema ..... No copay
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. Benefits for inpatient stays will be
extended if medically necessary

Reconstructive surgery performed to
restore symmetry following a mastectomy ..... No copay

Dialysis……..... No copay

Chemotherapy, radiation therapy,
and inhalation therapy ..... No copay

Surgical treatment of morbid obesity ..... No copay

Orthopedic devices such as braces..... No copay

Prosthetic devices, such as artificial limbs and lenses
following cataract removal ..... No copay

Home health services of nurses and health aides..... No copay
up to (3) two-hour visits each day, 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..... No copay

Acupuncture services
Benefits are only covered, if referred by the PCP and approved
by the medical group, for the treatment of chronic pain..... $10 copay

If referred by the PCP and approved by the medical group
for the treatment of substance abuse ..... see page 22
(covered under the Mental Conditions benefit) for copayment

Section 5. BENEFITS - Medical and surgical benefits

Complete obstetrical (maternity) care for ..... .$10 copay
all covered females, including prenatal, delivery and postnatal care by a Plan doctor. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Benefits for 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.

Cornea, heart, lung**,** kidney and pancreas..... $10 copay
transplants, and liver 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-lymphatic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkins lymphoma, advanced neuroblastoma, testicular, mediastinal, retroperitoneal, multiple myeoloma, epithelial ovarian cancer, and ovarian germ cell tumors and breast cancer, when approved by the Plan medical director. Related medical and hospital expenses of the donor are covered when the recipient is covered by this Plan.

Limited benefits

Oral and maxillofacial surgery is provided for non-dental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, the removal of impacted teeth, the treatment of fractures and the excision of tumors and cysts. 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 deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or creating a normal appearance. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis; **you pay nothing**. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Diagnosis and treatment of infertility is covered; you pay 50**%** of charges. The following types of artificial insemination are covered: intravaginal insemination (IVI); intracervical insemination (ICI); and intrauterine insemination (IUI). Other assisted reproductive technology (ART) procedures that enable a woman with otherwise untreatable infertility to become pregnant through other artificial conception procedures such as in vitro fertilization and embryo transfer are not covered. Cost of donor sperm is not covered. Drugs used primarily for the purpose of treating infertility are not covered under your Medical and Surgical Benefits.

Cardiac rehabilitation following a heart transplant, by pass surgery or a myocardial infarction, is provided for up to 60 days; **you pay nothing**.

Section 5. BENEFITS - Medical and surgical benefits

Durable medical equipment is covered up to $2,000 per calendar year, **you pay nothing**. Examples of covered durable medical equipment include standard wheelchairs, hospital beds and surgical bras.

Chiropractic services are covered up to 20 visits per calendar year, **you pay a $10 copay** per visit when services are provided by the American Specialty Health Network (ASHN).

In addition, the Plan will also provide up to $50 in rental or purchase charges for medical equipment and supplies which are ordered by an ASHN chiropractor, and pre-certified as medically necessary by ASHN. Such medical equipment includes: (1) elbow, back, thoracic, lumbar, rib or wrist supports; (2) cervical collars or pillows; (3) ankle, knee, lumbar, or wrist braces; (4) heel lifts; (5) hot or cold packs; (6) lumbar cushions; (7) orthotics; and (8) home traction units for treatment of the cervical or lumbar regions.

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
This exclusion does not apply to reconstructive surgery (that is, surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function or symptomatology or to create a normal appearance), including surgery performed to restore symmetry following mastectomy.

-- Transplants not listed as covered

-- Hearing aids

-- Long-term rehabilitative therapy

-- Homemaker services

-- Shoe insole

Section 5. BENEFITS - 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 nothing** per inpatient admission. 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

Extended care

The Plan provides a comprehensive range of benefits up to 100 days each calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is in lieu of hospitalization. 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 terminally ill members is covered in the home or hospice facility up to 180 days. 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.

mbulance service: The following ambulance services:

1. Base charge, mileage and non-reusable supplies of a licensed ambulance company for ground service to transport you to and from a hospital.

2. Emergency services or transportation services provided by a licensed ambulance company for ground service that is provided to you as a result of a "911" emergency response system* request for assistance if you have an emergency medical condition requiring ambulance transport.

   *If you have an emergency medical condition that requires ambulance transport services, please call the "911" emergency response system if you are in an area where the system is established and operating.

3. Base charge, mileage and non-reusable supplies of a licensed air ambulance company to transport you from the area where you are first disabled to the nearest hospital where appropriate treatment is provided if, and only if, such services are medically necessary and ground ambulance service is inadequate.

4. Monitoring, electrocardiograms (EKGs; ECGs), cardiac defibrillation, cardiopulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

Section 5. BENEFITS - Hospital/extended care benefits

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 doctor determines that outpatient management is not medically appropriate. See Page 22 for non-medical substance abuse benefits.

What is not covered

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

Section 5. BENEFITS - Emergency benefits

What is a medical emergency?

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

What is urgent care?

We provide coverage for medically necessary care provided by non-Plan providers to prevent serious deterioration of your health resulting from an unforeseen illness or injury when you are more than 20 miles from your Medical Group (or your Medical Group's enrollment area hospital if you are enrolled in an independent practice association), and seeking health services cannot be delayed until you return.

If you need urgent care you should seek medical attention immediately. If you are admitted to a hospital for urgently needed care, you should contact your primary care doctor or Medical Group within 48 hours, unless extraordinary circumstances prevent such notification. Follow-up care will be covered when the care required continues to meet our definition of "Urgent Care". Urgent care is defined as services received for a sudden, serious, or unexpected illness, injury or condition, which is not an emergency, but which requires immediate care for the relief of pain or diagnosis and treatment of such condition.

Emergencies within the area

If you are in an emergency or urgent situation, and you are within 20 miles of your Medical Group or 20 miles of your Medical Group's assigned hospital, please call your primary care doctor. 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 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.

Your primary care doctor will provide the necessary care, refer you to other Plan provider, or make arrangements with other providers. Benefits are available for care from non-Plan providers in a medical emergency or for urgent care only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

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

You pay $25 per hospital emergency room visit or urgent care center visit for emergency services which are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copay is waived.

Section 5. BENEFITS - Emergency benefits

Emergencies outside of area

If you need emergency treatment and you are more than 20 miles from your Medical Group or your Medical Group's assigned hospital, benefits are available for medically necessary health services that are 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 the Plan or provided by Plan providers.

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

You pay $25 per hospital emergency room visit or urgent care center visit for emergency services which are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copay is waived.

What is covered

--Emergency care or urgent care at a doctor's office or an urgent care center
--Emergency care or urgent 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/urgent care
--Emergency care or urgent care provided outside the service area if the need for care could have been foreseen before leaving the service area
--Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.

Filing claims for non-Plan providers

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

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

Section 5. BENEFITS - 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 or group therapy)
--Hospitalization (including inpatient professional services)
--Visits for rehabilitative care (such as physical therapy, occupational therapy, or speech therapy) when appropriate and medically necessary to treat conditions such as mental retardation and autism.

Outpatient care

Up to 40 outpatient visits to Plan doctors, consultant, or other psychiatric personnel each calendar year, **you pay** a $20 copay for each covered visit-all charges thereafter.

Inpatient Care

Inpatient hospital care if determined by a Plan doctor to be necessary and appropriate, **you pay nothing**.

What is not Covered

--Care for psychiatric conditions which 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. Outpatient visits to Plan providers for treatment are covered, as well as inpatient services necessary for diagnosis and treatment. The Outpatient Mental conditions benefits visit limitations apply to any covered substance abuse care. **You pay** a $20 copay for each covered visit-all charges thereafter. Inpatient mental condition benefit associated with substance abuse is limited to 30 days (except for detoxification). **You pay nothing**.

What is not covered

Treatment that is not authorized by a Plan doctor.

Section 5. BENEFITS - Prescription drug benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a pharmacy will be dispensed for up to a 30 day supply or 100 unit supply, whichever is less, or one commercially prepared unit (i.e., one inhaler, one vial ophthalmic medication or insulin). For prescription drugs used in the treatment of attention deficit disorder, the prescription must not exceed a 60-day supply. Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Under the terms of your Plan, only formulary drugs are covered at participating pharmacies and through the mail order program unless the prescriber has specified dispense as written. If you are prescribed a non-formulary drug without "dispense as written", you will pay the participating pharmacy's, or mail order program's full cost of the drug. You pay the following copays per prescription unit or refill:

For Blue Cross participating pharmacies:	
Formulary generic drugs:	**You pay** a $5 copay per prescription or refill
Name brand drugs and generic, non-formulary drugs if the prescriber has specified "dispense as written":	**You pay** a $10 copay per prescription or refill

For non-participating pharmacies:	
Generic drugs:	Reimbursement is at 50% of the Drug Limited Fee Schedule minus your $5 copay
Name brand drugs:	Reimbursement is at 50% of the Drug Limited Fee Schedule minus your $10 copay

For designated mail order pharmacies:	
Formulary generic:	**You pay** a $5 copay for up to a 90-day supply
Name brand drugs and generic, non-formulary drugs if the prescriber has specified "dispense as written":	**You pay** a $20 copay for up to a 90-day supply

Regarding formulary drugs:
Blue Cross of California uses a preferred list of drugs, sometimes called a formulary to help your doctor make prescribing decisions. This list of drugs is updated quarterly by a committee consisting of doctors and pharmacists so that the list includes drugs that are safe and effective in the treatment of disease. If you have a question regarding whether a drug is on the Blue Cross Preferred Drug List, please call 1-800-700-2541.

Section 5. BENEFITS - Prescription drug benefits

Covered medication and accessories include:

--Drugs for which a prescription is required by law.
--Oral and injectable contraceptive drugs-up to a three-cycle supply may be obtained for a single copay charge.
--Prescribed birth control devices which are approved by the Food and Drug Administration.
--Insulin, with a copay charge applied to each vial.
--Diabetic supplies including insulin syringes, needles, glucose test tablets and test tape.
Benedict's solution or equivalent and acetone test tablets.
--Disposable needles and syringes needed for injecting covered prescribed medication.
--Drugs used primarily for the purpose of treating infertility.
--Smoking cessation drugs and medications, only if a prescription is required by law.
--Intravenous fluids and medications for home use, implanted time-release medications, such as Norplant, and some injectable drugs, such as Depo Provera, are not covered under your Prescription Drug Benefits but are covered under Medical and Surgical benefits with no additional copay.

What is not covered

--Drugs available without a prescription or for which there is a non-prescription equivalent available.
--Vitamins and nutritional substances which an be purchased without a prescription.
--Medical supplies such as dressings and antiseptics.
--Drugs for cosmetic purposes.
--Drugs to enhance athletic performance.
--Select classes of drugs where non-formulary medications, which have therapeutic alternatives, have shown no benefit regarding efficacy or side effect over formulary drugs. However, this will not apply to non-participating pharmacies or if the prescriber denotes “dispense as written” or “do not substitute”.

Section 5. BENEFITS - Other benefits

Accidental injury benefit

What is covered
Restorative services and supplies necessary for the initial repair (but not replacement) of sound natural teeth.
You pay nothing.

What is not covered
-- Restoration of the damaged tooth when defined as cosmetic
-- Damage to teeth resulting from eating food

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** nothing.

What is not covered
-- Corrective lenses or frames
-- Eye exercises

Health Education and Wellness Programs

As part of our continuous effort to support the health and well being of our members, CaliforniaCare offers a wide range of Health Education and Wellness Programs at discounted rates. Separate copays may apply to some programs.

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/urgent care or eligible self-referred services;
- 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 37.

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 800-235-8631, or write to P.O. Box 4089, Woodland Hills, CA 91365. You may also contact us by fax at 818-712-6401, or visit our website at www.bluecrossca.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.

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.

Department of Defense/FEHB Demonstration Project

What Is the Department of Defense (DoD) and FHHB Program Demonstration Project?

The National Defense Authorization Act for 1999, Public law 105-261, established the DoD/FEHBP Demonstration Project. It allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years beginning with the 1999 Open Season for the year 2000. Open Season enrollments will be effective January 1, 2000. DoD and OPM have set-up some special procedures to successfully implement the Demonstration Project, noted below. Otherwise the provisions described in this brochure apply.

Who is Eligible?

DoD determines who is eligible to enroll in FEHB. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare,
- You are a dependent of an active or retired uniformed service member and eligible for Medicare,
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried, or
- You are a survivor dependent of a deceased active or retired uniformed service member, and
- You live in one of the eight geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

What are the Demonstration Areas?

- Dover AFB, Delaware
- Commonwealth of Puerto Rico
- Fort Knox, Kentucky
- Greensboro/Winston Salem/ High Point, North Carolina
- Dallas, Texas
- Humboldt County, California area
- Naval Hospital, Camp Pendelton, California
- New Orleans, Louisiana

When Can I Join?

Your first opportunity to enroll will be during the 1999 Open Season, November 8, 1999, through December 13, 1999. Your coverage will begin January 1, 2000. DoD has set-up an Information Processing Center (IPC) in Iowa to provide you with FEHB Program information, plan brochures, enrollment instructions and forms. The toll-free phone number for the IPC is 1-877-DOD-FEHB (1-877-363-3342).

You may select coverage for yourself (self-only) or for you and your family (self and family) during the 1999, 2000, and 2001 Open Seasons. Your coverage will begin January 1 of the year following the Open Season that you enrolled.

If you become eligible for the DoD/FEHBP Demonstration Project outside of Open Season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations and zip codes at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2000 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHBP Demonstration Project", on the OPM web site at www.opm.gov.

Am I Eligible for Temporary Continuation of Coverage

See Section 8, FEHB Facts, for information about TCC. Under this Demonstration Project the only individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unmarried former spouse under title 10, United States Code. For

(TCC)?

these individuals, TCC begins the day after their enrollment in the DoD/FEHBP Demonstration Project ends. TCC enrolment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHBP Demonstration Project.

TCC is not available if you move out of a DoD/FEHBP Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the demonstration project ends.

Do I have the 31-Day Extension and Right to Convert?

These provisions do not apply to the DoD/FEHBP Demonstration Project.

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 800/235-8631 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.

Non-FEHB Benefits Available to Plan Members

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

Optional Dental Benefits - Separate benefit package that requires an additional premium.

HERE'S AN OPPORTUNITY TO ENHANCE YOUR TOTAL HEALTH CARE PACKAGE BY ADDING COMPREHENSIVE DENTAL BENEFITS

Dental SelectHMO - Dental Maintenance Organization Option: A plan that offers members a broad range of dental coverage at a lower cost. Members choose their own dentist from a network of providers, and may change their dentist at any time. Once you have enrolled in Dental SelectHMO, your provider will perform preventive and diagnostic services and other dental services free of charge or at a greatly reduced rate.

Key Dental SelectHMO Advantages

- Diagnostic and Preventive Services are FREE
- No Deductibles and No Claim Forms
- Benefits include Orthodontic Coverage

Eyewear Savings Program for Blue Cross CaliforniaCare Members at no extra premium

- Instant savings on eyewear
  As a Federal Employee and a member of the CaliforniaCare HMO you are now entitled to special savings on frames, lenses (including contact lenses), as well as other important eye care accessories. These savings are available through optical departments located in selected Sears, Montgomery Ward and J.C. Penney stores.
- No Claim Forms
  There are currently more than 135 participating optical departments located throughout California. To receive your eyewear discount, just present your CaliforniaCare ID card to the optical department of the stores listed above.

Blue Cross Senior Secure - Medicare prepaid plan (HMO) provides complete coverage for medically necessary hospital and doctor services with no monthly premium, no deductibles and a prescription drug benefit.
Coverage includes:

•Prescription Drug	•Chiropractic Care	
	•Vision	•Hearing
	•Dental	•Podiatry

Blue Cross Senior Secure features all of the health coverage services offered by Medicare plus some extra services Medicare does not offer. Contact Customer Service, toll free 1-888-230-7338 to obtain detailed benefits and a list of providers in your area. As indicated on page 27, you may remain enrolled in FEHBP when you enroll in a Medicare Prepaid Plan.

Benefits on this page are not part of the FEHB contract

Summary of Benefits for Blue Cross – HMO (CaliforniaCare) 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 OR URGENT CARE, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.

Benefits	Plan pays/provides	Page
Inpatient Care	**Hospital** Comprehensive range of medical, 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	18
	Extended Care All necessary services. Up to 100 days per year. **You pay** nothing	18
	Mental Conditions Diagnosis and treatment of acute psychiatric conditions. **You pay** nothing	22
	Substance Abuse Up to 30 days per year. **You pay** nothing	22
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 (no copay), periodic check-ups and routine immunizations; laboratory tests and X-rays; complete maternity care. **You pay** a $10 copay per office visit; a $10 copay per house call by a doctor	14
	Home Health Care All necessary visits by nurses and health aides, up to **3 two hour** visits each day. **You pay** nothing	15
	Mental Conditions Up to 40 outpatient visits per year. **You pay** a $20 copay per visit	22
	Substance Abuse Covered under Mental conditions	22
Emergency Care	**You pay** a $25 copay to the hospital for each emergency room visit or urgent care center visit and any charges for services which are not covered benefits of this plan	20
Prescription Drugs	**You pay** a $5 copay for formulary generic and a $10 copay for name brand drugs when prescribed by a Plan doctor and obtained at Plan pharmacy. **You pay** a $5 copay for formulary generic and a $20 copay for name brand drugs when prescribed by a Plan doctor and provided through the mail order program	23
Out-of-Pocket Maximum	After your out-of-pocket expenses reach a maximum of $1,000 per Self Only or $3,000 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include prescription drug or infertility treatment services	6

2000 Rate Information for Blue Cross – HMO (CaliforniaCare)

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 is 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	
		Biweekly		Monthly		Biweekly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share	USPS Share	Yo Sh
Most of California									
Self Only	**M51**	**$67.71**	**$22.57**	**$146.71**	**$48.90**	**$80.12**	**$10.16**	**$80.12**	**$10.**
Self and Family	**M52**	**$172.76**	**$57.59**	**$374.32**	**$124.77**	**$204.44**	**$25.91**	**$201.02**	**$29.**