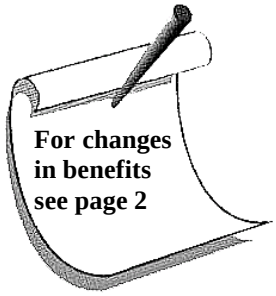
# Bluegrass Family Health 2000

**A Health Maintenance Organization**




**Serving: Central and Eastern Kentucky**
Enrollment in this Plan is limited; see page 4 for requirements.

**Enrollment Codes:**

2B1 Self only
2B2 Self and Family

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

Authorized for distribution by the:

**United States
Office of Personnel
Management**

Federal Employees
Health Benefits Program

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## Table of Contents

## Introduction

Bluegrass Family Health, Inc., 651 Perimeter Drive, Lexington, Kentucky 40517

This brochure describes the benefits you can receive from Bluegrass Family Health under its contract CS 2728 with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits on which you can rely. A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits.

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

## Plain language

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

We refer to Bluegrass Family Health 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.

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

## Section 2. How we change for 2000

**Program-wide changes**

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

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

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

## Section 2. How we change for 2000 (cont'd)

statement to it. If they do not provide you your records, call us and we will assist you.

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

**Changes to this Plan**

- Your share of the non-postal premium will increase by 30.7% for Self only or 6.6% for Self and Family .
- The following Kentucky counties have been added to the service area: Ballard, Calloway, Carlisle, Hickman, Livingston, Lyon, Marshall, and McCracken.
- The prescription drug copay has decreased to a $5 copay for up to a 31-day supply of generic drugs, and a $10 copay for up to a 31-day supply of name brand drugs. If you request the name brand medication, when your doctor allows a generic drug, you will pay your name brand copayment, plus the difference between the name brand drug and the generic.
- The Out-of-Pocket maximums have changed to: None for in-Plan network; $2250 Self only and $4500 Family for in-Plan self referral, and $4500 Self only and $9000 Family for Point of Service (POS).
- The ambulatory/hospital outpatient surgery copay has decreased to: $50 per procedure for in-Plan network; $75 per procedure for in-Plan self referral; and 30% of charges after Deductible for Point of Service
- The maternity visit copay has changed to: $10 per visit up to a max of $100 per pregnancy for in-Plan network; and $25 per visit up to a max of $250 per pregnancy for in-Plan self referral.
- Ambulance copays are waived if you are admitted. The POS copay has decreased to $50 per trip.
- The Inpatient Substance Abuse copay has decreased to $100 per admission for in-Plan network.
- Outpatient Substance Abuse visits have increased to 30 visits per calendar year for in-Plan network, in-Plan self referral and POS.
- The outpatient copay for physical, speech and occupational therapy has decreased to $10 per session for in-Plan network and $25 per session for in-Plan self referral.
- Cardiac rehabilitation and chiropractic services are limited to 30 visits each per calendar year.
- Home health care services are covered in full if substituted for hospitalization, except for POS which is 30% of charges.
- The copay has decreased and the number of covered days have increased for skilled nursing in an extended care facility to a $100 copay for up to 40 days per calendar year for in-Plan network and a $150 copay for up to 40 days per calendar year for in-Plan self referral.

## Section 2. How we change for 2000 (cont'd)

- The coinsurance for durable medical equipment, prosthetic and orthotic devices has decreased to 10% of charges.
- The copay has decreased for tubal ligations and vasectomies to $50 for in-Plan network and $75 for in-Plan self referral.

## 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 following counties in Kentucky: Adair, Anderson, Ballard, Bath, Bell, Bourbon, Boyle, Bracken, Breathitt, Calloway, Carlisle, Casey, Clark, Clay, Estill, Fayette, Fleming, Floyd, Franklin, Garrard, Grant, Green, Harlan, Harrison, Hickman, Jackson, Jessamine, Johnson, Knott, Knox, Laurel, Lee, Leslie, Letcher, Lincoln, Livingston, Lyon, Madison, Magoffin, Marion, Marshall, Mason, McCracken, McCreary, Menifee, Mercer, Montgomery, Morgan, Nicholas, Owen, Owsley, Pendleton, Perry, Pike, Powell, Pulaski, Robertson, Rockcastle, Rowan, Scott, Taylor, Washington, Whitley, Wolfe, and Woodford.

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. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

**How much do I pay for services?**

You must share the cost of some services. This is called either a copayment (a set dollar amount) or coinsurance (a set percentage of charges). Please remember you must pay this amount when you receive services, except for diagnostic testing (such as lab and x-ray) which doesn't have a separate copay amount unless you use a non-Plan provider with the POS option, and home health and hospice care which is covered in full unless you use a non-Plan provider with the POS option.

After you pay the following amounts in copayments or coinsurance for one family member or for two or more family members, you do not have to make any further payments for certain services for the rest of the calendar year: $2,250 Self only/$4,500 Family for in-Plan self referral and $4,500 Self only/$9,000 Family for Point-of-Service. This is called a catastrophic limit. However, copayments for

## Section 3. How to get benefits (cont'd)

your prescription drugs 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 from a non-Plan provider. 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?**

We are an Individual Practice Prepayment (IPP) HMO located in Lexington, Kentucky. Our provider network includes 52 participating hospitals and approximately 561 primary care doctors and over 1600 specialists who practice out of their own offices.

**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. If hospitalization is necessary, your Plan physician will make the arrangements and will continue to provide or supervise your care in Plan-affiliated hospitals. This Plan contracts with its affiliated hospitals on an independent contract basis. Where you are hospitalized will, depend on several factors: appropriateness for the particular treatment or procedure required, staff privileges of the physician, and, in some cases, quickest availability of a hospital bed.

Should a medical emergency require you to be hospitalized in a non-affiliated hospital, you must notify the Plan as soon as possible (no later than 24 hours or the next business day after your hospitalization) to assure coordination of and payment for your care. Coverage in a non-affiliated hospital will be provided only until your condition, permits you to be transferred to the care of a Plan physician at the nearest Plan-affiliated hospital.

## Section 3. How to get benefits (cont'd)

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

First, call our customer service department at 606/269-4475. If you are new to the FEHB Program, we will arrange for you to receive care. If you are currently in the FEHB Program and are switching to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center, or
- The day your benefits from your former plan run out, or
- The 92nd day after you became a member of this Plan; whichever happens first.

These provisions only apply to the person who is hospitalized.

**How do I get specialty care?**

Your primary care physician will arrange your referral to a specialist with the following exceptions: women may receive an annual gynecological examination from a participating gynecologist without a referral, or when you choose to use the Plan's POS benefits.

**Referrals (HMO benefit level only)**

Referrals will be covered if **ALL** of the following conditions are met:

- referral is for a covered services/benefit
- referral is made by your Primary Care Physician
- referral is approved by the Plan.

Referrals will not be covered if ANY of the following apply:

- referral is for non-covered services/benefit
- referral is not made by your Primary Care Physician
- referral is not approved by the Plan
- referral is to a non-participating provider (unless prior approval with the Plan is obtained)

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.

## Section 3. How to get benefits (cont'd)

**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?**

The Plan's Chief Medical Officer and the Director of Quality Improvement and Utilization determine what procedures and services are experimental/investigational using FDA guidelines and Hayes Technology, an outside consultant.

## 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 either (606) 269-5044 or (800) 787-2680 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 IV at (202) 606-0737 between 8 a.m. and 5 p.m. Serious or life-threatening conditions are ones that may cause permanent loss of bodily functions or death if they are not treated as soon as possible.

**Are there other time limits?**

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

## Section 4. What to do if we deny your claim or request for service (cont'd)

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 address should I send my disputed claim to?**

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

**What if OPM upholds the Plan's denial?**

OPM's decision is final. There are no other administrative appeals. If OPM agrees with our decision, your only recourse is to sue.

If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services or supplies.

## Section 4. What to do if we deny your claim or request for service (cont'd)

**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 in Network

**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. 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; nothing for home visits by nurses and health aides.

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

- Preventive care, including well-baby care and periodic check-ups
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women age 40 through 49, one mammogram every year; for women age 50 through 64, one mammogram every year, and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor as medically necessary to diagnose or treat your illness
- Routine immunizations and boosters.
- Consultations by specialists
- Diagnostic procedures, such as laboratory tests and x-rays; **you pay** $10 per testing session
- Ambulatory/hospital outpatient surgery; **you pay** a $50 copay per procedure

## Section 5. BENEFITS/Medical and Surgical Benefits in Network (cont'd)

- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. (The office visit copay is waived after the 10th visit). The mother, at her option, may remain n the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment
- Voluntary sterilization and family planning services including Norplant implantations. **You pay** $50 for a tubal ligation or vasectomy
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including testing and treatment materials (such as allergy serum); **you pay** a $5 copay per allergy injection given in the physician's office
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints
- Cornea, heart, heart/lung, pancreas, kidney and liver transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions; acute lymphocytic on non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer, multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Transplants are covered when approved 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
- Durable medical equipment including, but not limited to: wheelchairs, hospital beds, and apnea monitors. The rental/purchase of the equipment includes any necessary fittings, adjustments and delivery/installation of the Durable Medical Equipment. Items that are not considered Durable Medical Equipment include, but are not limited to: adjustments made to vehicles, air purifiers, ramps, stair glides and whirlpool baths. **You pay** 10% of charges.

- Home health services of nurses and health aides, including intravenous fluids and medications and when prescribed by your plan doctor, who will periodically review the program for continuing appropriateness and need. When home health care is substituted for hospitalization, **you pay** nothing.
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers.
- Prosthetic and orthotic devices and supplies which replace all or part of an absent body part (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning body part. This includes coverage for the purchase, fitting and any necessary adjustments and repairs, breast prostheses and surgical bras, as well as their replacement; **you pay** 10% of charges.
- Diabetic equipment, supplies, outpatient self-management training and education including medical nutrition therapy, and all medications for he treatment of insulin dependent diabetics, insulin using diabetics, gestational diabetics, and noninsulin using diabetics. This includes blood glucose monitors and testing strips, insulin syringes, injection aids, insulin infusion devices, oral agents for controlling sugar, and medically necessary insulin pumps and appurtenances.

**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. Surgical treatment for Temporomandibular Joint Disorder (TMJ) is provided for services included in a treatment plan authorized by the Plan prior to surgery. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered.

**Reconstructive surgery** will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery. A patient and her attending physician may decide whether to have breast reconstruction surgery following a mastectomy and whether surgery on the other breast is needed to produce a symmetrical appearance.

**Short-term rehabilitative therapy** (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two consecutive months per condition if significant improvement can be expected within two months; **you pay** a $10 copay per outpatient session. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

## Section 5. BENEFITS/Medical and Surgical Benefits in Network (cont'd)

**Cardiac rehabilitation and chiropractic services** are covered for up to 30 visits per calendar year. **You pay $10 per visit.**

**Diagnosis and treatment of infertility** is covered; **you pay** a $10 copay. The following types of artificial insemination are covered: intravaginal insemination (IVI) and intracervical insemination (ICI); **you pay** 50% of charges**.** Cost of donor sperm is not covered. Fertility drugs are not covered under the Prescription Drug Benefit. 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.

**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
- Transplants not listed as covered
- Blood and blood derivatives not replaced by the member
- Hearing aids
- Long-term rehabilitative therapy
- Homemaker services
- Foot orthotics
- Acupuncture
- Radial keratotomy

## Hospital/Extended Care Benefits In Network

**What is covered**

**Hospital care**

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay** a $100 copay per 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, limited to 40 days per calendar year when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. **You pay** a $100 copay per admission. **All necessary services are covered, including:**

- Bed, board and general nursing care
- Drugs biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor.

## Hospital/Extended Care Benefits In Network (cont'd)

**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**

Benefits are provided for ground ambulance transportation ordered or authorized by a Plan doctor. **You pay** a $50 copay per trip; waived if admitted.

**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, heart disease; the need for anesthesia, by itself is not such condition.

**Acute inpatient**

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 19 for non-medical substance abuse benefits.

**What is not covered**

- Personal comfort items, such as telephones and television
- Blood and blood derivatives not replaced by the member
- Custodial care, rest cures. Domiciliary or convalescent care.

## Emergency Benefits

**What is a medical emergency?**

A medical emergency is the sudden and unexpected onset of a condition or an injury you believe endangers your life or could result in serious injury or disability and that 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.

## Emergency Benefits (cont'd)

Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. Or a family member should notify the Plan within 48 hours unless it was 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.

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 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…** $50 per hospital emergency room visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copay is waived.

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

**Emergencies outside the service area**

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 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.

## Emergency Benefits (cont'd)

**You pay…** $50 per hospital emergency room visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, 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 if approved by the Plan

**What is not Covered**

- Elective care or nonemergency care except as covered under POS benefits
- Emergency care provided outside the service area if the need for care could have been foreseen before departing the service area except as covered under POS benefits.
- Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area, except as covered under 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, 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 26.

## Mental Condition/Substance Abuse

**Mental Conditions**

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

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

**Outpatient Care** Up to 40 outpatient visits to Plan doctors, consultants, or other psychiatric personnel each calendar year; **you pay** a $20 copay ($10 per group session) for each covered visit; all charges thereafter.

## Mental Condition/Substance Abuse (cont'd)

**Inpatient Care**

Up to 30 days of hospitalization each calendar year; **you pay** a $100 copay per admission; all charges thereafter. Inpatient days may be exchanged for outpatient day treatment at the rate of two treatment days for each inpatient day.

**What is not covered**

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

**Substance Abuse**

**What is covered**

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

**Outpatient Care**

Up to 30 outpatient visits to Plan providers for treatment each calendar year; **you pay** a $20 copay ($10 per group session) for each covered visit;-all charges thereafter.

**Inpatient Care**

Up to 30 days per calendar year in a substance abuse rehabilitation (intermediate care) program in an alcohol or drug rehabilitation center approved by the Plan; **you pay** a $100 copay per admission. Benefits are limited to one admission per 6 month period.

**What is not covered**

Treatment that is not authorized by the Plan.

## Prescription Drug Benefits

**What is covered**

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 31-day supply. **You pay** $5 per generic prescription unit or refill and $10 per name brand prescription unit or refill. If you request the name brand drug when your physician has ordered or approved a generic, you will pay the name brand copayment plus the cost difference between the name brand drug and the generic drug.

## Prescription Drug Benefits (cont'd)

Covered medications and accessories include:

- Cancer drugs if the drug prescribed is recognized as safe and effective in the official compendium or in medical literature.
- Drugs for which a prescription is required by Federal law
- Oral and injectable contraceptive drugs; contraceptive devices, diaphragms and IUDs
- Insulin; a copay charge applies to each vial
- Disposable needles and syringes and other diabetic supplies necessary for the treatment of diabetes

**Additional Benefits**

Implanted time-release medications, such as Norplant, are covered under the Medical and Surgical Benefits on page 10. For Norplant and other internally implanted time-release medication, **you pay** a $10 office visit copy. There is no charge when the device is implanted during a covered hospitalization.

There will be no refund of any portion of these copays if the implanted time-release medication is removed before the end of its expected life.

Intravenous fluids and medications for home use, implantable drugs such as Norplant, and some injectable drugs such as Depo Provera are covered under the Medical and Surgical Benefits

**Limited Benefits**

- Drugs to treat sexual dysfunction are limited. Contact the Plan for dose limits at 1-800-787-2680. **You pay** 50% of charges up to the dosage limits and all charges above that.

**What is not covered**

- Drugs available without a prescription or for which there is a nonprescription equivalent available
- Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Drugs for cosmetic purposes and to enhance athletic performance
- Smoking cessation drugs and medication, including nicotine patches
- Fertility drugs

## Other Benefits In Network

### Dental Care

| | |
|---|---|
| **What is covered** | |
| **Accidental injury benefit** | Restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury and must occur on or after your effective date. **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, this Plan provides eye refractions, including written lens prescriptions, from Plan providers every 12 month period for members up to age 17 and every 24 month period for members ages 18 and over. **You pay** a $10 copay per visit. |
| **What is not covered** | • Eye exercises<br>• Corrective glasses, frames, or contact lenses |

## Point of Service (POS) Benefits

| | |
|---|---|
| **Facts about this Plan's POS Option** | At your option, you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospital whenever you need care, **except** for the benefits listed below under "What is not covered." Benefits 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 deductibles, coinsurance and maximum benefit stated below.<br><br>As a member of a POS plan, you have benefits for both Plan and non-Plan doctors, except for the benefits listed below under "What is not covered." **You pay** a higher copayment or coinsurance amount if you self-refer to Plan doctors for covered services. **You pay** deductibles and higher coinsurance when you obtain covered services from non-Plan doctors, except life-threatening emergencies.<br><br>You will always pay higher copayments and coinsurance when you see non-Plan or Plan providers without Primary Care Physician referral. |

## Point of Service (POS) Benefits (cont'd)

**What is covered** **The following is a Schedule of Benefits for the POS Plan**

| Service | InPlan/Self-Referral Member Pays | Non-Plan Member Pays |
|---|---|---|
| Provider office visits (primary care and specialists) | $25 copay per visit | 30% of charges after Deductible |
| Diagnostic tests | No separate copay | 30% of charges after Deductible |
| Obstetrical care | $25 copay per visit to a maximum of $250 per pregnancy. | 30% of charges after Deductible |
| Allergy serum and injections | $7 copay per injection | 30% of charges after Deductible |
| Prosthetic devices | 25% of charges | 30% of charges after Deductible |
| Ambulatory/hospital outpatient surgery | $75 copay | 30% of charges after Deductible |
| Tubal ligation and vasectomy | $75 copay | 30% of charges after Deductible |
| Durable medical equipment | 25% of charges | 30% of charges after Deductible |
| Short-term rehabilitative therapy (speech, physical, occupation, chiropractic and cardiac rehab) (visit limits apply) | $25 copay | 30% of charges after Deductible |
| Inpatient hospital care | $200 copay per admission | 30% of charges after Deductible |
| Extended care (limits apply) | $150 copay per admission | 30% of charges after Deductible |
| Ambulance | $50 copay per trip, waived if admitted. | 30% of charges after Deductible |
| Hospital emergency room (true emergencies are always payable as in-Plan benefits) | $50 copay (waived if admitted) | 30% of charges after Deductible |
| Mental health/inpatient (limits apply) | $200 copay per admission | 30% of charges after Deductible |
| Mental health/outpatient (limits apply) | $30 copay per visit | 30% of charges after Deductible |
| Substance abuse/inpatient (limits apply) | $200 copay per admission | 30% of charges after Deductible |
| Substance abuse/outpatient (limits apply) | $30 copay per visit | 30% of charges after Deductible |
| Prescription drugs | $5 copay/generic;<br>$10 copay/name brand. If you request name brand, you must pay the difference. | 30% of charges after Deductible |

**Precertification**

The plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition. You Plan doctor must obtain the Plan's determination of medical necessity before you may be hospitalized, referred for specialty care, or obtain follow-up care from a specialist. If your Plan provider pre-authorizes services with non-Plan doctors, benefits may be paid at the HMO benefit level. If you are using your POS benefits or seeing non-Plan providers and receiving services that require authorization, **you** are responsible for verifying pre-certification requirements. To verify Precertification you may call 1-800-787-2680. If you receive covered services that require authorization but have not been authorized, **you pay** a Precertification penalty of $500. **SERVICES THAT ARE NOT MEDICALLY NECESSARY, ARE NOT COVERED**

## Point of Service (POS) Benefits (cont'd)

| | |
|---|---|
| **Deductible** | The Deductible applies to all covered services received from non-Plan providers except for hospital emergency treatment. The Deductible must be satisfied each Plan Year **before** benefits are paid. The Deductible does not apply to the out-of-pocket maximum. The Family Deductible is satisfied when one covered person satisfies an Individual Deductible in a Plan Year, and the remaining covered persons together satisfy an amount equal to one Individual Deductible in a Plan Year. **You pay** no Deductible for services received from a Plan doctor. **You pay** a $400 Deductible for Self only enrollment, and **you pay** $800 for Self and Family Enrollment for services received from non-Plan doctors. |
| **Coinsurance** | Coinsurance is calculated based on eligible expenses for services provided. **You pay** 30% of charges for most services received from non-Plan doctors. Coinsurance is subject to reasonable and customary limits. You are responsible for all charges that exceed the reasonable and customary limit. |
| **Maximum Lifetime Benefit** | There is no maximum lifetime benefit. |
| **Annual out-of-pocket limit** | The annual out-of-pocket is the maximum eligible expense that may be incurred by an individual or a family in a Plan Year. After the out-of-pocket limit is satisfied, the Plan pays 100% of eligible expenses for covered services. Expenses that apply to the out-of-pocket limit are copayments and coinsurance for covered services. Expenses that do not apply to the out-of-pocket limit include the Deductible, charges exceeding eligible expenses, all expenses for non-covered services, non-FEHB benefits and penalties for failure to obtain required pre-certification and compliance with Plan delivery system rules. There in no out-of-pocket maximum for HMO benefits. For In-Plan Self-Referral Benefits, **you pay** a maximum of $2,250 out-of-pocket for Self only Enrollment and **you pay** $4,500 out-of-pocket for Self and Family Enrollment if you receive care from a Plan doctor. If care is not received from a Plan doctor, **you pay** $4,500 for Self only Enrollment and **you pay** $9,000 for Self and Family Enrollment. |
| **Hospital/extended care** | The Plan provides a comprehensive range of benefits with no dollar limit when you are hospitalized under the care of a Plan doctor. **You pay** a $150 copay per admission for hospitalizations or extended care not arranged by your primary care doctor. **You pay** 30% of charges after any applicable Deductible when you are hospitalized in a non-Plan facility. This does not include any copayment or coinsurance that applies to doctor's services. |
| **Emergency Benefits** | **Emergencies are always paid as an In-Plan benefit.** |

## Other Benefits

| | |
|---|---|
| **Mental conditions/ substance abuse benefits** | Inpatient Mental conditions and substance abuse benefits are covered. **You pay** a $200 copay per admission for each benefit for plan doctors and **you pay** 30% of charges after any applicable deductible for non-Plan doctors. This condition is limited to 30 days per Plan year and 1 admission per 6 months for each benefit.<br><br>Outpatient Mental conditions are a covered benefit. **You pay** a $30 copay per visit, limited to 40 visits per year for Plan doctors and **you pay** 30% of charges after any applicable Deductible, limited to 40 visits per year for non-Plan doctors.<br><br>Outpatient substance abuse benefits are covered. **You pay** a $30 copay per visit, limited to 30 visits per Plan year for Plan doctors and **you pay** 30% of charges after any applicable Deductible, limited to 30 visits per Plan year for non-Plan doctors. |
| **What is not covered** | In addition to the above not covered services, preventive care and transplant benefits are not covered when received from non-Plan providers. |

# Non-FEHB Benefits Available to Plan Members

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

## Concordia PLUS Dental Plan

At Bluegrass Family health we know that dental health is an important part of your family's wellness. Therefore, Bluegrass Family Health is pleased to offer its members the opportunity to receive dental benefits through United Concordia. It is a comprehensive plan that emphasizes preventive and diagnostic care, generally by covering such services in full or with only a nominal copayment.

To enroll in this dental plan, you must be enrolled in Bluegrass Family Health and complete and sign the ConcordiaPLUS enrollment form. ConcordiaPLUS premiums are payable to United Concordia on an annual basis by check, Visa or MasterCard.

ConcordiaPLUS IIC covered services include preventive and diagnostic services such as, but not limited to, oral exams and bitewing x-rays. Restorative services include, but are not limited to, routine fillings, simple extraction and crowns.

This optional plan is available to Federal employees during the scheduled Federal open enrollment period for coverage effective January 1, 2000. Federal employees who do not enroll at this time will not be eligible for these dental benefits until the next open enrollment period. For more information regarding the ConcordiaPLUS dental health plan, please contact United Concordia at (800) 822-3368.

This is not a contract. For a complete schedule of benefits, please see your ConcordiaPLUS Certificate of Coverage.

## Bluegrass Family Health AHealth Helpers@

As a Bluegrass Family Health member, you are eligible for Health Helper discounts of 10% to 25% on Optical, Wellness and Dental needs from the providers listed on the Health Helper page of the Plan=s provider director.

### Optical Discounts

Optical services are not a covered benefit under the FEHB benefits program offered by Bluegrass Family health. To accommodate those Members who need optical services, BFH Members may obtain services such as vision exams, glasses, and contact lenses at a discounted fee from the providers listed on the Health Helper page of the Plan=s provider directory.

### Wellness Discounts

Bluegrass Family Health has made arrangements with businesses to give HMO Members a substantial discount on their fitness services. Wellness is a big part of our plan and Bluegrass Family Health has decided to do all we can to assist our Members in that area. All you need to do is show your ID Card and these discounts can be yours at the establishments listed on the Health Helper page of the Plan=s provider directory.

### Dental Discounts

Bluegrass Family Health Members can enjoy discounts on Dental services from certain dentists. Many dentists have agreed to supply preventive dental services at a discounted rate for orthodontic, restorative, surgical, and other dental needs. We, at Bluegrass Family Health, wish to assist our Members in any way we can to have the best possible treatment in all areas of your health and Health Helpers is how we are able to do this. Please refer to the list of dentists on the Health Helper page of the Plan=s provider directory.

***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;
- 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.

## Section 7. Limitations – Rules that affect your benefits (cont'd)

**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.

## Section 7. Limitations – Rules that affect your benefits (cont'd)

| | |
|---|---|
| **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. |
| **If you have a malpractice claim** | If you have a malpractice claim because of services you did or did not receive from a plan provider, it must go to binding arbitration. Contact us about how to begin our binding arbitration process. |

## 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 606/269-4475, or write to: 651 Perimeter Drive, Lexington, Kentucky 40517. You may also contact us by fax at 606/269-5044, or visit our website at www.bgfh.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.

## Section 8. FEHB FACTS (cont'd)

**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 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.

## Section 8. FEHB FACTS (cont'd)

**Are my medical and claims records confidential?**

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract,
- This plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims.
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions,
- OPM and the General Accounting Office when conducting audits,
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

### Information for new members

**Identification cards**

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

**What if I paid a deductible under my old plan?**

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

**Pre-existing conditions**

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

### When you lose benefits

**What happens if my enrollment in this Plan ends?**

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

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

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

## Section 8. FEHB FACTS (cont'd)

**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.

## Section 8. FEHB FACTS (cont'd)

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 606/269-4475 and explain the situation.
- If we do not resolve the issue, call or write:

**THE HEALTH CARE FRAUD HOTLINE**

**202/418-3300**
**U.S. Office of Personnel Management**
**Office of the Inspector General Fraud Hotline**
**1900 E Street, NW, Room 6400**
**Washington, D.C. 20415**

**Penalties for Fraud**

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if they:

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

Your agency may also take administrative action against you.

## Summary of HMO Benefits for Bluegrass Family Health 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 a day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** a $100 copy per admission | **13** |
| | **Extended care** | All necessary services up to 40 days per calendar year. **You pay** a $100 copy per admission | **13** |
| | **Mental conditions** | Diagnosis and treatment of acute psychiatric conditions for up to 30 **days of** inpatient care per year. **You pay** a $100 copy per admission | **17** |
| | **Substance abuse** | Up to 30 days per year in a substance abuse treatment program. **You pay** a $100 copy per admission | **17** |
| **Outpatient care** | | Comprehensive range of services such as diagnosis and treatment of illness or injury, including specialist care; preventive care, well-baby care, periodic check-ups and routine immunizations; laboratory tests and x-rays; complete maternity care. **You pay** a $10 copy per office visit and for a house call by a doctor. | **10** |
| | **Home health care** | All necessary visits by nurses and health aides. **You pay** nothing | **12** |
| | **Mental conditions** | Up to 40 outpatient visits per year. **You pay** a $20 copy ($10 per group session) per visit | **16** |
| | **Substance abuse** | Up to 30 outpatient visits per year. **You pay** a $20 copy ($10 per group session) per visit | **17** |
| **Emergency care** | | Reasonable charges for services and supplies required because of a medical emergency. **You pay** a $50 copy to the hospital for each emergency room visit and any charges for services that are not covered by this Plan | **14** |
| **Prescription drugs** | | Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** $5 copy per generic prescription unit or refill; $10 per name brand prescription unit or refill | **17** |
| **Dental Care** | | Accidental injury benefit; **you pay** nothing | **19** |
| **Vision Care** | | One refraction every 12 month period for members up through 17 and every 24 months period for members age 18 and over. **You pay** a $10 copy per visit | **19** |
| **Out-of-Pocket** | | Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a meaximum of $2,250 per Self only or $4,500 per Self and Family enrollment for in-Plan referrals and $4,500 per Self only or $9.000 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copy maximum does not include charges for prescription drugs. There is no out-of-pocket maximum for care received in-Plan Network | **21** |

# 2000 Rate Information for
# Bluegrass Family Health

**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 |
| Central/Eastern Kentucky | | | | | | | | | |
| Self Only | **2B1** | **$78.83** | **$28.12** | **$170.80** | **$60.93** | **$93.06** | **$13.89** | **$93.26** | **$13.69** |
| Self and Family | **2B2** | **$163.55** | **$54.52** | **$354.37** | **$118.12** | **$193.54** | **$24.53** | **$193.54** | **$24.53** |