



Vista Healthplan™

<http://www.vistahealthplan.com>

2003

A Health Maintenance Organization

Serving: South Florida (Miami-Dade, Broward, and Palm Beach counties)

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page 6 for requirements.



This Plan has Commendable accreditation
From the NCQA. See the 2003 Guide for
more information on accreditation.

Enrollment codes for this Plan:

3N1 Self Only
3N2 Self and Family

Authorized for distribution by the:



United States
Office of Personnel Management
Retirement and Insurance Service
<http://www.opm.gov/insure>



RI 73-421



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this Federal Employees Health Benefits (FEHB) Program plan brochure for 2003. The brochure explains all the benefits this health plan offers to its enrollees. Since benefits can vary from year to year, you should review your plan's brochure every Open Season. Fundamentally, I believe that FEHB participants are wise enough to determine the care options best suited for themselves and their families.

In keeping with the President's health care agenda, we remain committed to providing FEHB members with affordable, quality health care choices. Our strategy to maintain quality and cost this year rested on four initiatives. First, I met with FEHB carriers and challenged them to contain costs, maintain quality, and keep the FEHB Program a model of consumer choice and on the cutting edge of employer-provided health benefits. I asked the plans for their best ideas to help hold down premiums and promote quality. And, I encouraged them to explore all reasonable options to constrain premium increases while maintaining a benefits program that is highly valued by our employees and retirees, as well as attractive to prospective Federal employees. Second, I met with our own FEHB negotiating team here at OPM and I challenged them to conduct tough negotiations on your behalf. Third, OPM initiated a comprehensive outside audit to review the potential costs of federal and state mandates over the past decade, so that this agency is better prepared to tell you, the Congress and others the true cost of mandated services. Fourth, we have maintained a respectful and full engagement with the OPM Inspector General (IG) and have supported all of his efforts to investigate fraud and waste within the FEHB and other programs. Positive relations with the IG are essential and I am proud of our strong relationship.

The FEHB Program is market-driven. The health care marketplace has experienced significant increases in health care cost trends in recent years. Despite its size, the FEHB Program is not immune to such market forces. We have worked with this plan and all the other plans in the Program to provide health plan choices that maintain competitive benefit packages and yet keep health care affordable.

Now, it is your turn. We believe if you review this health plan brochure and the FEHB Guide you will have what you need to make an informed decision on health care for you and your family. We suggest you also visit our web site at www.opm.gov/insure.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay Coles James".

Kay Coles James
Director



Notice of the Office of Personnel Management's Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.
- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change. The privacy practices listed in this notice will be effective April 14, 2003.

Table of Contents

Introduction.....	4
Plain Language.....	4
Stop Health Care Fraud!.....	5
Section 1. Facts about this HMO plan.....	6
How we pay providers.....	6
Your Rights	6
Service Area	6
Section 2. How we change for 2003.....	7
Program-wide changes	7
Changes to this Plan	7
Section 3. How you get care	8
Identification cards	8
Where you get covered care	8
• Plan providers.....	8
• Plan facilities	8
What you must do to get covered care	8
• Primary care	8
• Specialty care	8
• Hospital care.....	9
Circumstances beyond our control	10
Services requiring our prior approval.....	10
Section 4. Your costs for covered services.....	11
• Copayments.....	11
• Deductible	11
• Coinsurance.....	11
Your catastrophic protection out-of-pocket maximum.....	11
Section 5. Benefits.....	12
Overview	12
(a) Medical services and supplies provided by physicians and other health care professionals	13
(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	22
(c) Services provided by a hospital or other facility, and ambulance services.....	26
(d) Emergency services/accidents.....	28
(e) Mental health and substance abuse benefits	30
(f) Prescription drug benefits.....	32
(g) Special features	34
• Flexible benefits option	
• Services for the deaf and hearing impaired	
• High risk pregnancies	

- Centers of excellence for transplants
- Travel Benefit/services overseas
- Congestive Heart Failure

(h) Dental benefits..... 35

(i) Non-FEHB benefits available to Plan members..... 36

Section 6. General exclusions -- things we don't cover 37

Section 7. Filing a claim for covered services..... 38

Section 8. The disputed claims process 39

Section 9. Coordinating benefits with other coverage 41

When you have other health coverage..... 41

- What is Medicare 41
- Medicare managed care plan 44
- TRICARE and CHAMPVA 44
- Workers' Compensation 45
- Medicaid 45
- Other Government agencies 45
- When others are responsible for injuries 45

Section 10. Definitions of terms we use in this brochure 46

Section 11. FEHB facts 47

Coverage information..... 47

- No pre-existing condition limitation 47
- Where you get information about enrolling in the FEHB Program..... 47
- Types of coverage available for you and your family 47
- Children's Equity Act 47
- When benefits and premiums start 48
- When you retire..... 48

When you lose benefits 48

- When FEHB coverage ends 48
- Spouse equity coverage..... 48
- Temporary Continuation of Coverage (TCC) 48
- Converting to individual coverage 49
- Getting a Certificate of Group Health Plan Coverage..... 49

Long term care insurance is still available 50

Index..... 51

Summary of benefits 52

Rates..... Back cover

Introduction

This brochure describes the benefits of Vista Healthplan under our contract (CS 2363) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for Vista Healthplan administrative offices is:

Vista Healthplan
300 S. Park Road
Hollywood, FL 33021

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2003, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on page 7. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; “we” means Vista Healthplan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud - Here are some things you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at 1-866-847-8235 and explain the situation.
 - If we do not resolve the issue:

**CALL -- THE HEALTH CARE FRAUD HOTLINE
202-418-3300**

OR WRITE TO:

The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

- Do not maintain as a family member on your policy:
 - your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, 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.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Vista Healthplan has been operational since 1985.
- Vista Healthplan has a commendable accreditation from NCQA and is licensed by the Department of Insurance and the Agency for Health Care Administration to conduct business in the State of Florida.
- Vista Healthplan is a for-profit entity.

If you want more information about us, call 1-866-847-8235, or write to Vista Healthplan, Inc., 300 South Park Road, Hollywood, FL 33021. You may also contact us by fax at 954-846-8873 or visit our website at www.vistahealthplan.com

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is: South Florida, i.e., Broward, Miami-Dade, and Palm Beach Counties.

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 benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

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.

Section 2. How we change for 2003

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- A Notice of the Office of Personnel Management's Privacy Practices is included.
- A section on the Children's Equity Act describes when an employee is required to maintain Self and Family coverage.
- Program information on TRICARE and CHAMPVA explains how annuitants or former spouses may suspend their FEHB Program enrollment.
- Program information on Medicare is revised.
- By law, the DoD/FEHB Demonstration project ends on December 31, 2002.

Changes to this Plan

- Your share of the non-Postal premium will increase by 26.9% for Self Only and 69.6% for Self and Family.
- We changed the specialist office visit copay from \$10 to \$20.
- We changed the outpatient surgery facility copay from *nothing* to \$50.
- We changed the hospital emergency room copay from \$50 to \$100.
- We changed the urgent care center copay from \$10 to \$25.
- We changed the prescription drug copays from \$5 generic, \$10 brand, \$35 non-formulary to \$10 generic, \$20 brand and \$40 non-formulary. The copay for drugs to treat sexual dysfunction will not change.
- Plan pharmacies will charge you the price difference between generic drugs and name brand drugs when generic substitution is medically appropriate but you choose the name brand drug over the generic. When name brand drugs are medically necessary, you will pay the name brand formulary or non-formulary copay only.
- We changed the limitation for physical, speech and occupational therapy from *up to 2 months per condition* to 60 visits per calendar year per condition. Rehabilitative therapy visits are subject to the \$20 copay.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-866-847-8235 or write to us at Vista Healthplan, Inc., 300 South Park Road, Hollywood, FL 33021. You may also request replacement cards through our website at www.vistahealthplan.com.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments and you will not have to file claims.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. Call us at 1-866-847-8235 or visit our website at www.vistahealthplan.com to select a primary care physician.

- **Primary care**

Your primary care physician can be a family practitioner, internist, or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you may see the following specialists without a referral:

- Obstetrician/Gynecologist for an annual well-woman examination
- Podiatrist
- Chiropractor
- Dermatology (for up to 5 visits per year)
- Mental Health/Substance abuse provider
- Dentist (for preventive dental services)
- Optometrist (for annual eye exam)

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will work with us to 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 (the physician may have to get an authorization or approval beforehand).
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your 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.
- If you have a chronic or disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause; or
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
 - reduce our service area and you enroll in another FEHB Plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

• **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-866-847-8235. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan 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 become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and preauthorization approval process the Member Advocacy Program (MAP). Your physician must obtain approval from us for certain services including but not limited to:

- Non-emergency Hospital Admissions
- Outpatient Hospital Services
- Inpatient or Outpatient Surgery
- Skilled Nursing Facility Stays
- Inpatient Mental Health or Substance Abuse Treatment
- Home Health Care
- Hospice Care
- Durable Medical Equipment and Prosthetic Devices
- Organ/Tissue Transplants
- Non-Emergency Ambulance Transportation
- Air Ambulance
- Growth Hormone Therapy
- Enhanced External County Pulsation
- Home Infusion and Injectibles
- Hyperbaric Treatments
- Infertility Assessment and Treatment
- Laboratory tests (outpatient) if you don't use Quest Diagnostic Laboratories
- Services provided by non-participating providers
- MRI
- PET Scan
- Rehabilitation Therapies (Physical, Occupational, and Speech)
- Sclerotherapy for varicose veins
- Wound Care

Generally, when you anticipate receiving any of these services, your participating physician will contact MAP for you. You may wish to call your physician's office to make sure this has been done.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

- **Copayments**

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

Example: When you see your primary care physician you pay a copayment of \$10 per office visit and when you go in the hospital, you pay \$250 per admission.

- **Deductible**

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. We do not have a deductible.

- **Coinsurance**

Coinsurance is the percentage of our negotiated fee that you must pay for your care. Coinsurance doesn't begin until you meet your deductible. We do not have coinsurance.

Your catastrophic protection out-of-pocket maximum

After your copayments total \$1,500 per person or \$3,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for prescription drugs do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments.

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

Section 5. Benefits -- OVERVIEW

(See page 7 for how our benefits changed this year and page 52 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 1-866-847-8235 or at our website at www.vistahealthplan.com.

(a) Medical services and supplies provided by physicians and other health care professionals	13-21
• Diagnostic and treatment services	• Speech therapy
• Lab, X-ray, and other diagnostic tests	• Hearing services (testing, treatment, and supplies)
• Preventive care, adult	• Vision services (testing, treatment, and supplies)
• Preventive care, children	• Foot care
• Maternity care	• Orthopedic and prosthetic devices
• Family planning	• Durable medical equipment (DME)
• Infertility services	• Home health services
• Allergy care	• Chiropractic
• Treatment therapies	• Alternative treatments
• Physical and occupational therapies	• Educational classes and programs
(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	22-25
• Surgical procedures	• Oral and maxillofacial surgery
• Reconstructive surgery	• Organ/tissue transplants
	• Anesthesia
(c) Services provided by a hospital or other facility, and ambulance services	26-27
• Inpatient hospital	• Extended care benefits/skilled nursing care facility benefits
• Outpatient hospital or ambulatory surgical center	• Hospice care
	• Ambulance
(d) Emergency services/accidents.....	28-29
• Medical emergency	• Ambulance
(e) Mental health and substance abuse benefits.....	30-31
(f) Prescription drug benefits.....	32-33
(g) Special features	34
• Flexible benefits option	• Medical case management
• Services for deaf and hearing impaired	• Social worker services
• High Risk pregnancies	• Travel benefit
• Centers of excellence for transplants	
(h) Dental benefits	35
(i) Non-FEHB benefits available to Plan members.....	36
Summary of benefits	52

Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

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Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians <ul style="list-style-type: none"> • In physician's office 	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist
Professional services of physicians <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility • Second surgical opinion 	Nothing
<ul style="list-style-type: none"> • In an urgent care center 	Nothing after the \$50 copay Urgent Care Center fee (See Section 5(d))
<ul style="list-style-type: none"> • At home 	Nothing
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG 	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist

Preventive care, adult	You pay
Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including <ul style="list-style-type: none"> – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50 	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist
Routine pap test Note: The office visit is covered if pap test is received on the same day; see <i>Diagnosis and Treatment</i> , above.	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 49, one every calendar year • At age 50 and older, one every two consecutive calendar years 	Nothing
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>
Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccine, annually • Pneumococcal vaccine, age 65 and over 	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist
<i>Not covered: Autogenous vaccines and adult immunizations related to foreign travel</i>	<i>All charges</i>
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (through age 22) • Examinations, such as: <ul style="list-style-type: none"> – Eye exams through age 17 to determine the need for vision correction. – Ear exams through age 17 to determine the need for hearing correction – Examinations done on the day of immunizations (through age 22) 	Nothing

Maternity care	You pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; see page 10 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	<p>Nothing</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex</i></p>	<p><i>All charges.</i></p>
Family planning	
<p>A broad range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary sterilization (See Surgical procedures Section 5 (b)) • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>NOTE: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$10 per office visit to your primary care physician or \$20 per office visit to a specialist</p>
<p><i>Not covered: reversal of voluntary surgical sterilization, genetic counseling,</i></p>	<p><i>All charges.</i></p>

Infertility services	You pay
Diagnosis and treatment of infertility, such as: <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> — <i>intra</i>vaginal insemination (IVI) — <i>intra</i>cervical insemination (ICI) — <i>intra</i>uterine insemination (IUI) 	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> <ul style="list-style-type: none"> — <i>in vitro</i> fertilization — <i>embryo transfer, gamete GIFT and zygote ZIFT</i> — <i>Zygote transfer</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Drugs to treat infertility</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<i>All charges.</i>
Allergy care	
Testing and treatment Allergy injection	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist
Allergy serum	Nothing
<i>Not covered: provocative food testing and sublingual allergy desensitization</i>	<i>All charges.</i>

Treatment therapies	You pay
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 25.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) <p>Note: Growth hormone is covered under the prescription drug benefit.</p> <p>Note: – We will only cover GHT when we preauthorize the treatment. Your physician must call us for preauthorization. We will ask for information that establishes that the GHT is medically necessary and meets our medical guidelines. Have your physician obtain approval before you begin treatment; otherwise, we will only cover GHT services from the date we approve GHT treatment. If we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. <i>See Services requiring our prior approval in Section 3.</i></p>	<p>\$10 per office visit to your primary care physician or</p> <p>\$20 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Chelation therapy • Any furniture, plumbing, electrical or other fixtures to perform dialysis at home. 	<p><i>All charges.</i></p>
Physical and occupational therapies	
<p>60 visits per calendar year for the services of each of the following:</p> <ul style="list-style-type: none"> – qualified physical therapists and – occupational therapists. <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p> <ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 36 sessions in a 12-week period. 	<p>\$20 per office or outpatient visit</p> <p>Nothing during a covered inpatient hospital admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • long-term rehabilitative therapy • exercise programs 	<p><i>All charges.</i></p>
Speech therapy	
<p>60 visits per year.</p>	<p>\$20 per office or outpatient visit</p> <p>Nothing during a covered inpatient hospital admission</p>

Hearing services (testing, treatment, and supplies)	You pay
<ul style="list-style-type: none"> • First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • all other hearing testing • hearing aids, testing and examinations for them 	<i>All charges.</i>
Vision services (testing, treatment, and supplies)	
Annual eye refraction to provide a written lens prescription for eyeglasses	\$15 per office visit
One pair of corrective eyeglasses per year from a special selection at participating provider	Copayment depends on lenses selected
Contact lens eye examination, fitting and 1 pair of Daily Wear contact lenses per year in lieu of eyeglasses	\$100
Contact lens eye examination, fitting and 1 pair of Extended Wear contact lenses per year in lieu of eyeglasses One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	\$140 \$20 per office visit
Eye exam to determine the need for vision correction for children through age 17 (see <i>Preventive care, children</i>)	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Eye exercises and orthoptics • Radial keratotomy and other refractive surgery; however discounts for lasik surgery are available from the Plan's participating providers – see Section 5(i) 	<i>All charges.</i>

Foot care	You pay
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$10 per office visit to your primary care physician or</p> <p>\$20 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<p><i>All charges.</i></p>
Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Initial orthopedic shoes in part of a foot brace. 	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>orthopedic shoes (if not the initial pair as part of a foot brace) and corrective shoes</i> • <i>arch supports</i> • <i>foot orthotics</i> • <i>heel pads and heel cups</i> • <i>lumbosacral supports</i> • <i>corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>prosthetic replacements provided less than 3 years after the last one we covered</i> • <i>Penile implants</i> 	<p><i>All charges.</i></p>

Durable medical equipment (DME)	You pay
<p>Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • hospital beds; • wheelchairs; • crutches; • walkers; • blood glucose monitors; and • insulin pumps. <p>Note: Call us at 1-866-847-8235 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>motorized wheel chairs</i> • <i>personal convenience items</i> 	<i>All charges.</i>
Home health services	
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide • Services include oxygen therapy, intravenous therapy and medications. 	Nothing
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>nursing care requested by, or for the convenience of, the patient or the patient's family;</i> • <i>Services primarily for Hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.</i> • <i>home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<i>All charges.</i>
Chiropractic	
<ul style="list-style-type: none"> • Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application 	\$20 per office visit

Alternative treatments	You pay
No benefits	All Charges
Educational classes and programs	
Coverage is limited to: <ul style="list-style-type: none"> • Smoking Cessation – one smoking cessation program per member per calendar year, including all related expenses such as drugs. • Diabetes self-management • Disease management programs for asthma, congestive heart failure, etc. 	Nothing
<ul style="list-style-type: none"> • Nutritional counseling 	\$20 per office visit

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

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Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION OF SOME SURGICAL PROCEDURES.** Please refer to the preauthorization information shown in Section 3 to be sure which services or surgeries require preauthorization.

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Benefit Description	You pay
<p>Surgical procedures</p> <p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization • Treatment of burns <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>\$10 per office visit to your primary care physician or</p> <p>\$20 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care.</i> 	<p><i>All charges.</i></p>

Reconstructive surgery	You pay
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> – the condition produced a major effect on the member’s appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. 	<p>\$10 per office visit to your primary care physician or</p> <p>\$20 per office visit to a specialist</p>
<ul style="list-style-type: none"> • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> – surgery to produce a symmetrical appearance on the other breast; – treatment of any physical complications, such as lymphedemas; – breast prostheses and surgical bras and replacements (see Prosthetic devices) <p>Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$10 per office visit to your primary care physician or</p> <p>\$20 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges.</i></p>

Oral and maxillofacial surgery	You pay
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>\$10 per office visit to your primary care physician or</p> <p>\$20 per office visit to a specialist</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> • <i>Dental care involved in the treatment of TMJ</i> 	<p><i>All charges.</i></p>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single or Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas <p>Note: You must receive preauthorization from our Medical Director for all organ/tissue transplant services. We cover related medical and hospital expenses of the donor when we cover the recipient.</p>	<p>\$10 per office visit to your primary care physician or</p> <p>\$20 per office visit to a specialist</p> <p>Note: There is a \$250 hospital admission copay. See Section 5 (c).</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Donor screening tests and donor search expenses, except those performed for the actual donor • Implants of artificial organs • Transplants not listed as covered 	<p><i>All charges.</i></p>
Anesthesia	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) • Hospital outpatient department • Ambulatory surgical center 	<p>Nothing</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Office 	<p>\$10 per office visit to your primary care physician or</p> <p>\$20 per office visit to a specialist</p>

Section 5 (c). Services provided by a hospital or other facility, and ambulance services

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Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PREAUTHORIZATION PREAUTHORIZATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require preauthorization.

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Benefit Description	You pay
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$250 per admission
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	Nothing (included in the inpatient hospital admission copay)
<i>Not covered:</i> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care 	<i>All charges</i>

Outpatient hospital or ambulatory surgical center	You pay
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	\$50 per outpatient surgery
<ul style="list-style-type: none"> • Diagnostic laboratory tests, X-rays, and pathology services 	Nothing
<i>Not covered: blood and blood derivatives replaced by the member</i>	<i>All charges.</i>
Extended care benefits/skilled nursing care facility benefits	
Skilled nursing facility (SNF): 60 days per calendar year	Nothing
<i>Not covered: custodial care</i>	<i>All charges.</i>
Hospice care	
<p>Hospice care: 210 days per lifetime</p> <p>Supportive and palliative care for a terminally ill member with a life expectancy of 6 months or less is covered in the home or in a hospice facility.</p>	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges.</i>
Ambulance	
<ul style="list-style-type: none"> • Local professional ambulance service when medically appropriate 	Nothing

Section 5 (d). Emergency services/accidents

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Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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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 we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

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

If you need to be hospitalized, the Plan must be notified within 48 hours or the first working day following your admission, unless it is not reasonably possible to notify the Plan in 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 ambulance charges covered in full.

Emergencies within our service area: Benefits are available for care from a non-Plan provider 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 or authorized by us.

Emergencies outside our service area: Benefits are available for any medically necessary service that is immediately required because of injury or unforeseen illness.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan in 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. Any follow-up care from non-Plan providers must be approved or authorized by us.

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none"> Emergency care at a doctor's office 	\$10 per office visit to your primary care physician or \$20 per office visit to a specialist
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$25 per visit
<ul style="list-style-type: none"> Emergency care at an outpatient or inpatient at a hospital, including doctors' services 	\$100 per visit Note: We waive this copay if you admitted as an inpatient into the hospital.
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>
Emergency outside our service area	
<ul style="list-style-type: none"> Emergency care at a doctor's office 	\$20 per office visit
<ul style="list-style-type: none"> Emergency care at an urgent care center 	\$25 per visit
<ul style="list-style-type: none"> Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$100 per visit Note: We waive this copay if you admitted as an inpatient into the hospital.
<i>Not covered:</i> <ul style="list-style-type: none"> <i>Elective care or non-emergency care</i> <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges.</i>
Ambulance	
<ul style="list-style-type: none"> Professional ambulance service when medically appropriate. Air ambulance, limited to situation where ground transportation is not medically appropriate – prior approval required Note: See 5(c) for non-emergency service.	Nothing
<i>Not covered: non-emergent ambulance transport</i>	<i>All charges.</i>

Section 5 (e). Mental health and substance abuse benefits

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When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

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Benefit Description	You pay
Mental health and substance abuse benefits	
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	<p>Your cost sharing responsibilities are no greater than for other illness or conditions.</p>
<ul style="list-style-type: none"> • Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management <p>Note: Services from psychiatrists, psychologists, clinical social workers, etc., are subject to the higher office visit copay because these providers are specialists.</p>	<p>\$10 per office visit to your primary care physician or</p> <p>\$20 per office visit to a specialist</p>

Mental health and substance abuse benefits - continued on next page

Mental health and substance abuse benefits <i>(continued)</i>	You pay
<ul style="list-style-type: none"> Diagnostic tests 	Nothing if you receive these services during your office visit; otherwise, \$20 per office visit
<ul style="list-style-type: none"> Services provided by a hospital or other facility Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment 	\$250 per admission
<p><i>Not covered: Services we have not approved.</i></p> <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All charges.</i>

Preauthorization

To be eligible to receive these benefits you must follow your treatment plan and all the following approval processes.

Prior to seeking mental health and substance abuse treatment, you must call Psych/Care at (800) 221-5487. Psych/Care is a managed behavioral health care firm with over 500 providers in our service area. You do not need a referral from your primary care physician or approval from us. A Psych/Care provider will evaluate you and develop a treatment plan.

Once the treatment plan has been approved, you must follow it. If you need inpatient care, your Psych/Care provider will arrange it for you. Call Psych/Care for a list of participating providers in your area.

Limitation

We may limit your benefits if you do not obtain a treatment plan.

Section 5 (f). Prescription drug benefits

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Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We do not have a calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed Plan physician or dentist must write the prescription .
- **Where you can obtain them.** You may fill the prescription at a participating pharmacy. Please see the complete listing of participating pharmacies in our provider directory.
- **We use a formulary.** The formulary is a list of medications, both brand and generic, that we approve as covered medication. Plan pharmacies dispense prescription medication to our members based on our formulary list. However, we cover non-formulary drugs prescribed by a Plan doctor. You must pay a higher copay for non-formulary drugs.
- **Plan pharmacies will dispense a generic when a generic is available and substitution is allowed or required by law.** When generic substitution is medically appropriate but you insist on the name brand drug, you will pay the difference in price between the name brand drug and generic drug in addition to the applicable name brand formulary or non-formulary copay. If you'd like a copy of our formulary, please call 866-847-8235.
- **These are the dispensing limitations.** You may obtain a 30-day supply at a Plan pharmacy or a 90-day supply via mail order. Mail order is available for maintenance medications only. A 90-day vacation supply may also be obtained from a Plan pharmacy once a year. Plan pharmacies will not dispense refills in excess of the number specified by the physician or refill medication more than 12 months after the original date of the prescription. You may obtain a refill up to 6 days before your prescription runs out. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand drug. When your physician requires a name brand drug, the physician must specify "Dispense as Written" on the prescription or you will have to pay the difference in cost between the name brand drug and the generic.
- **Why use generic drugs?** Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the name brand is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you -- and us -- less than a name brand prescription
- **When you have to file a claim.** There are no claims to file when you use a Plan pharmacy or our mail order program. If you have an emergency while outside our service area, and you fill a prescription at a non-Plan pharmacy, you must submit a claim for reimbursement. We will reimburse up to the amount we would have paid if you had used a plan pharmacy.

Benefit Description	You pay
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Disposable needles and syringes for the administration of covered medications • Diabetic supplies, including insulin syringes, needles, glucose test tablets, test strips, and solution • Contraceptive drugs and devices <p>Note: You may obtain up to a 90-day supply of certain maintenance medication by mail-order for 1 ½ time the Retail Pharmacy copay.</p>	<p>Retail Pharmacy (up to 30 day supply per prescription unit or refill):</p> <p>\$10 generic formulary, \$20 name brand formulary or 40 non-formulary</p> <p>Note: If there is no generic equivalent available, you will still have to pay the brand name or non-formulary copay.</p> <p>Or</p> <p>Plan's Mail-Order Pharmacy (up to a 90-day supply of maintenance medication):</p> <p>\$15 generic formulary, \$30 name brand formulary or \$60 non-formulary per prescription unit or refill</p>
<ul style="list-style-type: none"> • Drugs for sexual dysfunction <p>Note: These drugs have special dispensing limits and guidelines. Please contact us for details. These drugs are not available under our mail-order program.</p>	<p>\$15 per prescription or refill</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs for the treatment of infertility</i> • <i>Drugs and supplies for cosmetic purposes</i> • <i>Drugs to enhance athletic performance</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> • <i>Smoking cessation drugs and medication, including nicotine patches, unless in conjunction with participation in Psych/Care's smoking cessation program</i> • <i>Drugs given to you while you are a patient in a hospital, skilled nursing facility, convalescent hospital, hospice or other facility where drugs are ordinarily provided by the facility to its patients.</i> • <i>Refills in excess of the number specified by the physician or refills dispensed more than 12 months after the original date of the prescription</i> • <i>Drugs provided to you by this Plan, but which are lost, stolen, or destroyed</i> • <i>Drugs for the treatment of obesity, unless medically necessary for the treatment of morbid obesity</i> 	<p><i>All charges</i></p>

Section 5 (g). Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
Services for deaf and hearing impaired	<p>If you are hearing or speech impaired and use a telephone device for the deaf, you may call 1-888-444-7352 Monday through Friday from 8 a.m. to 6 p.m.</p>
High risk pregnancies	<p>Vista Healthplan offers a dedicated OB Case Management unit, coordinating and monitoring all phases of care through the member's pregnancy.</p>
Centers of excellence for transplants	<p>Vista Healthplan utilizes the United Resource Network (URN) for transplants. URN centers are utilized on a case by case basis. URN has centers of excellence nationwide for various transplants.</p>
Travel benefit/ services overseas	<p>You are covered for emergency care anywhere in the world.</p>
Congestive Heart Failure (CHF)	<p>Vista Healthplan offers members with congestive heart failure dedicated Case Management services. We also provide educational materials to the member to assist in the improvement of their condition.</p>

Section 5 (h). Dental benefits

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Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5 (c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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Accidental injury benefit	You pay
We cover 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.	Nothing
Dental benefits	
Preventive Services <ul style="list-style-type: none"> • Prophylaxis or cleaning (1 every 6 months) • Application of topical fluoride for children up to and including age 15 (1 every 6 months) Diagnostic Services <ul style="list-style-type: none"> • Periodic oral exam Bitewing X-rays (2) every 6 months	\$5 per office visit Note: the most you pay for these services is \$10 per visit
<i>Not covered: dental services not shown above</i>	<i>All charges</i>

Section 5 (i). Non-FEHB benefits available to Plan members

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or catastrophic protection out-of-pocket maximums.

- Health and Wellness Initiatives such as hepatitis C awareness intervention, smoking cessation, nutrition counseling.
- Disease Management Programs for asthma, diabetes, congestive heart failure patients.
- Case Management Programs for obstetrical, pediatrics, HIV/AIDS, catastrophic and transplant patients.
- Fitness Club Discounts.
- Lasik surgery services at preferred rates.
- Medicare Advantage (our Medicare+Choice plan) if you live in Miami-Dade, Broward, and Palm Beach counties and are entitled to Medicare Part A and enrolled in Medicare Part B. Our Medicare+Choice plan covers everything that Medicare covers, plus some items that Medicare does not cover, such as prescription drugs, hearing and vision screenings, routine foot care, dental services, over-the-counter vitamins and a fitness club incentive. Benefits, premiums and copayments vary by county. You may enroll at any time during the year. Call 1-866-847-8235 or TTY 1-888-444-7352 if you are hearing impaired for more information.

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, disease, injury, or condition** and we agree, as discussed under *What Services Require Our Prior Approval* on page 10.

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or 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
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services provided to you without charge or that would normally be provided without charge if you were not covered under this Plan or under any other insurance, and care rendered by your immediate family members.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 1-866-847-8235.

When you must file a claim -- such as for services you receive outside of the Plan's service area -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer -- such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to: Vista Healthplan, Inc.
PO Box 459011
Sunrise, FL 33345-9011

Prescription drugs

You do not file claims when you use Plan pharmacies or the plan's mail order service to fill your prescriptions. You use your identification card and pay the appropriate copay. If you fill a prescription at a non-Plan pharmacy in an emergency, you must file a claim for reimbursement. Include your itemized receipt from the pharmacy and explain why you filled the prescription at a non-Plan pharmacy. Prescription drug claim forms may be obtained by calling our Customer Service Department at 1-866-847-8235.

Submit your claims to: Vista Healthplan, Inc.
PO Box 459011
Sunrise, FL 33345-9011

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for prior approval:

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none">(a) Write to us within 6 months from the date of our decision; and(b) Send your request to us at: Vista Healthplan, Inc. ATT: FEHB Claims Dept. 1340 Concord Terrace Sunrise, Florida 33323 ; and(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none">(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or(b) Write to you and maintain our denial -- go to step 4; or(c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">• 90 days after the date of our letter upholding our initial decision; or• 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or• 120 days after we asked for additional information. <p>Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Health Benefits Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630.</p>

The Disputed Claims process (*Continued*)

Send OPM the following information:

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

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

- 5** OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.

If you do not agree with OPM's 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, drugs, or supplies or from the year in which you were denied preauthorization or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, 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 decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- (a) We haven't responded yet to your initial request for care or prior approval, then call us at 866-847-8235 and we will expedite our review; or
- (b) We denied your initial request for care or prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM's Health Benefits Contracts Division 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage You must tell us if you or a covered family member have coverage under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

- **The Original Medicare Plan (Part A or Part B)**

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan -- You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. You will not need to do anything. To find out if you need to do something to file your claim, call us at 1-866-847-8235.

We do not waive any costs if the Original Medicare Plan is your primary payer.

The following chart illustrates whether the Original Medicare Plan or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and ...	Then the primary payer is...	
	Original Medicare	This Plan
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when... a) The position is excluded from FEHB, or b) The position is not excluded from FEHB (Ask your employing office which of these applies to you)	✓	
		✓
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and...		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and...		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or	✓	
		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

- **Medicare managed care plan** If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do waive some of the copayments for your FEHB coverage.

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, 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 unless you involuntarily lose coverage or move out of the Medicare managed care plan's service area.

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, 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 unless you involuntarily lose coverage under the program.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- 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 OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, 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 unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, 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.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 11.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 11.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care which does not require the continuing attention of trained medical personnel, including any services which an average individual without medical training can learn and provide. For example: <ul style="list-style-type: none">• Help with activities of daily living such as feeding, dressing, and personal hygiene; or• Administering oral medications, changing dressings or preparing special diets; or• Help with walking or getting in or out of bed.
Experimental or investigational services	Services, supplies, drugs and procedures which have not demonstrated to be safe, effective, medically appropriate for use in the treatment of illness or injury. Also include service, supplies, drugs and procedures that are determined to be the subject of clinical trials.
Group health coverage	Healthcare insurance that covers a group of people (e.g. FEHB) under one master contract.
Medical necessity	Services which are necessary and appropriate for the treatment of an illness or injury according to professionally recognized standards of practice and services which are consistent with Vista Healthplan's medical policies.
Us/We	Us and we refer to Vista Healthplan
You	You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, 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 your FEHB coverage. These materials tell you:

- 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
- When the next open season for enrollment begins.

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.

Types of coverage available for you and your 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 children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue 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 that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

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, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB) Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;

- if you have a Self only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- if you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to self only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot make any changes after retirement. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you 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 (TCC).

When you lose benefits

- **When FEHB coverage 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 spouse equity coverage or Temporary Continuation of Coverage.

- **Spouse equity coverage**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's website, www.opm.gov/insure.

- **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 Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. 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 or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB 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 of your right to convert. 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.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group 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. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans. For more information, get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Still Available!

Open Season for Long Term Care Insurance

- You can protect yourself against the high cost of long term care by applying for insurance in the Federal Long Term Care Insurance Program.
- Open Season to apply for long term care insurance through LTC Partners ends on December 31, 2002.
- If you're a Federal employee, you and your spouse need only answer a few questions about your health during Open Season.
- If you apply during the Open Season, your premiums are based on your age as of July 1, 2002. After Open Season, your premiums are based on your age at the time LTC Partners receives your application.

FEHB Doesn't Cover It

- Neither FEHB plans nor Medicare cover the cost of long term care. Also called "custodial care", long term care helps you perform the activities of daily living such as bathing or dressing yourself. It can also provide help you may need due to a severe cognitive impairment such as Alzheimer's disease.

You Can Also Apply Later, But...

- Employees and their spouses can still apply for coverage after the Federal Long Term Care Insurance Program Open Season ends, but they will have to answer more health-related questions.
- For annuitants and other qualified relatives, the number of health-related questions that you need to answer is the same during and after the Open Season.

You Must Act to Receive an Application

- Unlike other benefit programs, YOU have to take action – you won't receive an application automatically. You must request one through the toll-free number or website listed below.
- Open Season ends December 31, 2002 – act NOW so you won't miss the abbreviated underwriting available to employees and their spouses, and the July 1 "age freeze"!

Find Out More – Contact LTC Partners by calling **1-800-LTC-FEDS (1-800-582-3337)** (TDD for the hearing impaired: **1-800-843-3557**) or visiting www.ltcfeds.com to get more information and to request an application.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

- Accidental injury 35
Allergy tests 16
Alternative treatment 21
Allogeneic (donor) bone marrow transplant 25
Ambulance 29
Anesthesia 25
Autologous bone marrow transplant 25
Biospies 22
Blood and blood plasma 26
Breast cancer screening 14
Casts 22
Catastrophic protection out-of-pocket maximum 11
Changes for 2003 7
Chemotherapy 17
Childbirth 15
Chiropractic 20
Cholesterol tests 14
Claims 38
Coinsurance 11
Colorectal cancer screening 14
Congenital anomalies 23
Contraceptive devices and drugs 33
Coordination of benefits 41
Covered providers 8
Crutches 20
Definitions 46
Dental care 35
Diagnostic services 13
Disputed claims review 39
Donor expenses (transplants) 25
Dressings 26
Durable medical equipment (DME) 20
Educational classes and programs 21
Effective date of enrollment 48
Emergency 28
Experimental or investigational 46
Eyeglasses 18
Family planning 15
Fecal occult blood test 14
Fraud 5
General Exclusions 37
Hearing services 18
Home health services 20
Hospice care 27
Home nursing care 20
Hospital 26
Immunizations 14
Infertility 16
Inhospital physician care 26
Inpatient Hospital Benefits 26
Insulin 33
Laboratory and pathological services 13
Machine diagnostic tests 13
Magnetic Resonance Imagings (MRIs) 13
Mail Order Prescription Drugs 33
Mammograms 14
Maternity Benefits 15
Medicaid 45
Medically necessary 46
Medicare 41
Mental Conditions/Substance Abuse Benefits 30
Newborn care 15
Non-FEHB Benefits 36
Nurse
 - Licensed Practical Nurse 20
 - Nurse Anesthetist 26
 - Registered Nurse 20Nursery charges 15
Obstetrical care 15
Occupational therapy 17
Ocular injury 18
Office visits 14
Oral and maxillofacial surgery 24
Orthopedic devices 19
Ostomy and catheter supplies 26
Out-of-pocket expenses 11
Outpatient facility care 27
Oxygen 26
Pap test 14
Physical examination 14
Physical therapy 17
Physician 13
Pre-admission testing 26
Precertification 10
Preventive care, adult 14
Preventive care, children 14
Prescription drugs 32
Preventive services 14
Prior approval 10
Prostate cancer screening 14
Prosthetic devices 19
Psychologist 30
Psychotherapy 30
Radiation therapy 17
Renal dialysis 17
Room and board 26
Second surgical opinion 13
Skilled nursing facility care 27
Smoking cessation 21
Speech therapy 17
Splints 22
Sterilization procedures 15
Subrogation 45
Substance abuse 30
Surgery 22
 - Anesthesia 25
 - Oral 24
 - Outpatient 27
 - Reconstructive 23Syringes 33
Temporary continuation of coverage 48
Transplants 25
Treatment therapies 17
Vision services 18
Well child care 14
Wheelchairs 20
Workers' compensation 45
X-rays 13

Summary of benefits for the Vista Healthplan 2003

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians: <ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office..... 	Office visit copay: \$10 primary care; \$20 specialist	13
Services provided by a hospital: <ul style="list-style-type: none"> • Inpatient • Outpatient..... 	\$250 per admission copay \$50 per outpatient surgery	26 27
Emergency benefits: <ul style="list-style-type: none"> • In-area • Out-of-area 	\$25 per urgent care cent visit \$100 per visit hospital emergency room visit	29 29
Mental health and substance abuse treatment	Regular cost sharing.	30
Prescription Drugs Retail Pharmacy (Up to 30-day supply)	\$10 generic formulary / \$20 Name brand formulary/ \$40 non-formulary	32
Mail-Order Pharmacy (90-day supply).....	\$15 generic formulary/ \$20 name brand formulary/ \$40 non-formulary	
Dental Care <ul style="list-style-type: none"> • Accidental injury • Preventive..... 	Nothing \$5 per service up to a \$10 maximum per visit	35
Vision Care <ul style="list-style-type: none"> • Annual eye refraction 	\$15 copay for eye exam – 1 exam per year	18
Special features: Flexible benefits option; Services for deaf and hearing impaired, High risk pregnancies; Centers of excellence for transplants; Travel benefit/services overseas; Congestive heart failure		34
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum).....	Nothing after \$1,500/Self Only or \$3,000/Family enrollment per year Some costs do not count toward this protection	11

2003 Rate Information for Vista Healthplan

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 career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and a special FEHB guide is published for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable FEHB Guide.

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Location Information: South Florida (*Miami-Dade, Broward, and Palm Beach Counties*)

High Option Self Only	5E1	\$103.33	\$34.44	\$223.88	\$74.62	\$122.27	\$15.50
High Option Self and Family	5E2	\$249.62	\$134.77	\$540.84	\$292.01	\$294.70	\$89.69