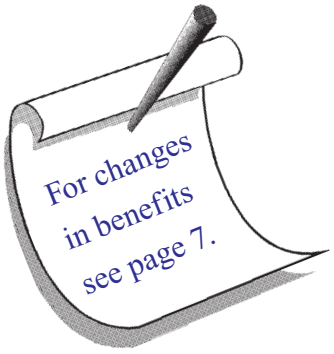
PREFERRED CARE

Preferred Care

http://www.preferredcare.org

2003

A Health Maintenance Organization



Serving: Greater Rochester and Surrounding 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 excellent accreditation from the NCQA. See the *2003 Guide* for more information on accreditation.

Enrollment codes for this Plan:

GV1 Self Only
GV2 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

FEHB
Federal Employees
Health Benefits Program

RI 73-467

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,

Kay Coles James
Director

CON 131-64-4
September 1993

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

Preferred Care
259 Monroe Avenue
Rochester, New York 14607

This brochure describes the benefits of Preferred Care under our contract (CS 2371) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The address for Preferred Care administrative offices is:

Preferred Care
259 Monroe Avenue
Rochester, New York 14607

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 for 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 Preferred Care.
- 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' brochure 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, D.C. 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 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 professional 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 (585) 325-3113 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 dependent 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 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 the 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 or coinsurance 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 or coinsurance.

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.

More than 3,500 doctors and area health professionals participate with Preferred Care to provide primary care as well as specialty services to the membership. In addition to doctors, the Plan has arranged for hospital, skilled nursing facility, home health, and other covered health services.

All members must choose a primary care doctor who will provide, arrange, and coordinate all medically necessary services. All female members are strongly encouraged to select an obstetrician/gynecologist in addition to a primary care doctor. The obstetrician/gynecologist will treat you for any gynecological or obstetrical condition. Members do not need a referral from their primary care doctor to see their obstetrician/gynecologist. A women's obstetrician/gynecologist is considered an additional primary care doctor. New York State law does provide coverage with Nurse Midwives and the Plan maintains Nurse Midwives on the provider panel. Plan members may elect a Nurse Midwife instead of an obstetrician/gynecologist.

If you want more information about us, call us at (585) 325-3113, toll free at (800) 950-3224 or write to 259 Monroe Avenue, Rochester, New York, 14607. You may also contact us by fax at (585) 327-2298, or our e-mail address at memberservices@preferredcare.org, or visit our website at www.preferredcare.org.

Service Area

To enroll in this plan, you must live or work in our Service Area. This is where our providers practice. Our service area is: Monroe, Genesee, Livingston, Ontario, Orleans, Seneca, Wayne, Wyoming, and Yates Counties in New York State.

Ordinarily, you must get care from providers who contract with us. If you receive care outside our service area, we will pay only for urgent or emergency care. Students attending school or college outside of the service area are covered for follow up care if required after emergency or urgent care treatment. With prior authorization from the student's primary care physician and Plan, follow up care for students is covered.

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 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.

Changes to this Plan

- Your share of the non-Postal premium will decrease by 8.4% for Self Only or 22.6% for Self and Family.
- You have no copay for primary care physician visits for children under the age of 5.
- Your copay for the following services will be $15 per visit:
  - Professional services rendered in a physician's office; office medical consultations and second surgical opinions;
  - X-Rays, CAT scans, MRIs, Ultrasound, Electrocardiograms and EEGs;
  - Eye exams for routine refraction and disease of the eye;
  - Family planning services limited to voluntary sterilization, surgically implanted contraceptives, intrauterine devices and diaphragms;
  - Infertility services including intravaginal insemination, intracervical insemination, and intrauterine insemination;
  - Allergy care testing and treatment;
  - Treatment therapies;
  - Physical, occupational, speech and cardiac therapy;
  - Growth hormone therapy;
  - Routine foot care;
  - Chiropractic care;
  - Professional services for outpatient nicotine dependency;
  - Surgical procedures performed in a physician's office;
  - Emergency care at a physician's office;
  - Accidental injury benefit covering services and supplies necessary to promptly repair sound natural teeth;
  - Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers and medication management;
  - Local professional ambulance;
  - Sigmoidoscopy screenings;
  - Colonoscopy screenings.
- Your copay for home health care will be $15 per day.
- Your copay for the following services will be $10 per visit:
  - Periodic adult physicals;
  - Bi-annual gynecological examinations.
- Your copay for all pre- and post-natal care visits will be $50 per pregnancy.
- You are covered for up to 60 visits per therapy, per calendar year, for physical, occupational, and speech therapy.
- You are covered for infertility benefits if you are between the ages of 21 and 44.

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 obtain 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 (585) 325-3113 or (800) 950-3224, or if you have access to TTY equipment (585) 325-2629, or write to us at 259 Monroe Avenue, Rochester, NY 14607.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copays and/or coinsurance, 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 to ensure that they meet strict standards of quality.

We list Plan providers in the provider directory, which we update periodically. This list is also on our website at www.preferredcare.org.

- **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.

To select a primary care physician, either choose one from our provider directory or contact a Preferred Care Member Services representative who will assist you.

- **Primary care**

Your primary care physician can be a family or general practitioner, an internist or a pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist. Women may choose an obstetrician/gynecologist in addition to their primary care physician.

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 (you may see an obstetrician/gynecologist without a referral). 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 an optometrist or opthamologist for routine eye exams without referral.

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 develop a treatment plan that allows you to see your specialist for a certain number of visits or a certain period of time without additional referrals. Your primary care physician will use our criteria when creating your treatment plan and will obtain approval, when required, 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 primary care physician or obstetrician/gynecologist based on the above circumstances, you can continue to see your primary care physician or obstetrician/gynecologist 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 Preferred Care's Member Services Department immediately at (585) 325-3113. 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 hospital benefit of the hospitalized person; we cover your other non-hospital care.

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 approval process "precertification". Your primary care physician is familiar with the procedures that require a prior approval and will make all necessary arrangements on your behalf.

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.

Example: When you see your primary care physician, you pay a copayment of $15 per office visit.

• Deductible

We do not have a deductible.

• Coinsurance

Coinsurance is the percentage of our negotiated fee that you must pay for your care.

Example: In our Plan, you pay 20% of our allowance for durable medical equipment.

Your catastrophic protection out-of-pocket maximum for coinsurance and copayments

After your copayments and coinsurance total $3,300 per person or $8,400 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for this service:

- Prescription Drugs.

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

Section 5. Benefits – OVERVIEW

(See page 7 for how our benefits changed this year and page 50 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 claims forms, claims filing advice, or more information about our benefits, contact us at (585) 325-3113 or (800) 950-3224 or if you have access to TTY equipment (585) 325-2629 or visit our website at www.preferredcare.org.

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

IMPORTANT

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 have no 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.

IMPORTANT

Benefit Description	You Pay
Diagnostic and treatment services	**You Pay**
Professional services of physicians • In physician's office	$15 per visit (no primary care physician copay for children under the age of 5)
• In an urgent care center • During a hospital stay • In a skilled nursing facility	Nothing
• Office medical consultations • Second surgical opinions	$15 per visit
• At home	$15 per visit
Lab, X-ray and other diagnostic tests	**You Pay**
• X-rays • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	$15 per visit

Diagnostic and Treatment Services continued on next page.

Lab, X-ray and other diagnostic tests *(Continued)*	**You Pay**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • Non-routine Mammograms	Nothing

Preventive care, adult	**You Pay**
Periodic Adult Physicals	$10 per visit
Routine screenings, such as: • Complete Blood Count • Total Blood Cholesterol • Colorectal Cancer Screening, including - Fecal occult blood test	Nothing
- Sigmoidoscopy Screenings – every five years starting at age 50	$15 per visit
- Colonoscopy Screenings	$15 per visit
• Prostate Specific Antigen (PSA test)	Nothing
• Two gynecological visits per year	$10 per visit
• Routine pap test (annually)	Nothing
Routine mammograms – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • At age 40 and older, one every year	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccines, annually • Pneumococcal vaccines, annually, age 65 and over	$15 per visit

Preventive care, children	You Pay
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care charges for routine examinations, immunizations and care (through age 18)	Nothing
• Examinations, such as:	
•• Eye exams to determine the need for vision correction.	$15 per visit
•• Ear exams as part of a well-child care visit through age 18 to determine the need for hearing correction.	Nothing
•• Examinations done on the day of immunizations (through age 18)	Nothing

Maternity care	You Pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • 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).	$50 per pregnancy
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*

Family planning	You Pay
A broad range of voluntary planning services, limited to: • 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 Note: You must be between the ages of 21 and 44 to be covered for infertility benefits. Note: We cover oral contraceptives under the perscription drug benefit.	$15 per visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling	*All charges*

Infertility services	You Pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI)	$15 per visit
• Fertility drugs Note: Self-administered and oral fertility drugs are covered under the prescription drug benefit. Drugs for infertility treatment after a medical condition has been corrected. Pergonal/Metrodin and other FDA approved drugs, only after unsuccessful treatment with Clomiphene and only when very specific clinical indications are met.	
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* – *in vitro fertilization* – *embryo transfer, gamete GIFT and zygote ZIFT* – *zygote transfer* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*

Allergy care	You Pay
Testing and treatment Allergy injection	$15 per visit
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*

Treatment therapies	You pay
• Chemotherapy and radiation therapy. Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under Organ/Tissue Transplants on page 22. • Respiratory and inhalation therapy • Dialysis-Hemodialysis and peritoneal dialysis • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit. Note: We will only cover GHT when your physician pre-approves the treatment. Your physician will submit information that establishes that the GHT is medically necessary. Your physician must authorize GHT before you begin treatment. If your physician does not pre-approve or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies.	$15 per visit
• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	Nothing

Physical and occupational therapies	You pay
• 60 visits per therapy per calendar year for the services of each of the following: - qualified physical therapists and - occupational therapists. 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.	$15 per office visit Nothing for outpatient visit Nothing per visit during covered inpatient admission
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infraction, is provided for up to 36 visits.	$15 per visit
Not covered: • *Long-term rehabilitative theraapy* • *Exercise programs*	*All charges*

Speech therapy	You pay
• 60 visits per therapy per calendar year for medically necessary speech therapy to restore or acquire functional speech	$15 per office visit Nothing for outpatient visit Nothing per visit during covered inpatient admission

Hearing services (testing, treatment, and supplies)	You Pay
• Hearing aids for children through age 18, up to $600 once every three years	Nothing
• Hearing screenings as part of a well-child care visit through age 18.	Nothing
Not covered: • *all other hearing testing* • *hearing aids for adults over age 18.*	*All charges*

Vision services (testing, treatment, and supplies)	You pay
• One pair of eyeglasses or contact lenses to correct impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts).	20% of plan allowance.
• One pair of prescription eyeglasses (frames and lenses) or prescription daily-wear contact lenses, per member once every year at plan providers. Children under age 12 may obtain eyewear as required by prescription change of at least .5 diopter.	The remaining cost after a discount of 20% and a credit of $60.
• Annual eye refraction, including lens prescriptions.	$15 per visit
Not covered: • *Radial keratotomy and other refractive surgery.* • *Eye exercises and orthoptics.*	*All charges*

Foot care	You Pay
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$15 per visit
Not covered: • *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* • *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)*	*All charges*

Orthopedic and prosthetic devices	You Pay
• Custom made shoe inserts up to $250 (One pair every three years)	Nothing
• Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device	Nothing
• Orthotic devices • Artificial limbs and eyes; stump hose • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. • Orthopedic devices, such as braces. Note: External prosthetic and orthopedic devices are covered up to a maximum per person payment of $15,000 per calendar year.	20% of plan allowance
• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy	20% of plan allowance with no maximums
Not covered: • *arch supports* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*

Durable medical equipment (DME)	You pay
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: • hospital beds; • wheelchairs; • walkers; • insulin pumps.	20% of plan allowance.
Not covered: • *Motorized wheel chairs, unless medically necessary* • *Air conditioners, dehumidifiers, humidifiers* • *Breast pumps* • *Electric hospital bed (unless medically necessary)* • *Hypo-allergenic bedding* • *Visual aids (e.g., CCTV, magnifying glasses)* • *Environmental control units, such as control units to turn on a television or air conditioner, etc.*	*All charges*

Home health services	You Pay
• 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.	$15 per day
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.*	*All charges*
Chiropractic	**You Pay**
• The detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purposes of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation or in the vertebral column.	$15 per visit.
Not covered: • *Maintenance treatment for conditions that does not result in significant clinical improvement or lead toward resolution of the condition.*	*All charges*
Alternative treatments	**You Pay**
Acupuncture - by a doctor of medicine or osteopathy for: anesthesia, pain relief up to 10 visits per calendar year	50% of plan allowance.
Not covered: • *naturopathic services* • *hypnosis*	*All charges*
Educational classes and programs	**You Pay**
Smoking Cessation • Professional services for outpatient nicotine dependency, including diagnostic evaluations to determine the nature and extent of illness, counseling and therapy. Note: Prescriptions that are smoking deterrents and FDA approved such as Zyban, Nicotrol, and Habitrol are covered under the prescription drug benefit.	$15 per visit
• Diabetes self management	$15 per visit

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

IMPORTANT

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 have no 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.
- 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.).

IMPORTANT

Benefit Description	You Pay
Surgical procedures	**You Pay**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopic 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 braces and prosthetic devices for device coverage information.	$15 per office visit; nothing for inpatient or outpatient hospital procedures.
• Voluntary sterilization • Treatment of burns	$15 per office visit; nothing for inpatient or outpatient hospital procedure.
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges*

Reconstructive surgery	You Pay
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: – 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.	$15 per office visit. Nothing for inpatient/outpatient surgery.
• All stages of breast reconstruction surgery following a mastectomy, such as: – surgery to produce a symmetrical appearance on the other breast; – treatment of any physical complications, such as lymphoedemas;	Nothing
– breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need to have a mastectomy, you may choose to have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	20% of plan allowance
Not covered: • *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* • *Surgeries related to sex transformation*	*All charges*

Oral and maxillofacial surgery	You Pay
Oral surgical procedures, limited to: • 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.	$15 per outpatient surgery Nothing for inpatient surgery
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*

Organ/tissue transplants	You Pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – Double • Pancreas • Allogeneic 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 Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**You Pay**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

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

IMPORTANT

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 and you must be hospitalized in a Plan facility.
- We have no 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.
- 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 Section 5(a) or (b).

IMPORTANT

Benefit Description	You Pay
Inpatient hospital	**You Pay**
Room and board, such as • 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.	Nothing
Other hospital services and supplies, such as: • 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 • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home.	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes and schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*

Outpatient hospital or ambulatory surgical center	You Pay
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • 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 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.	Nothing
Extended care benefits/skilled nursing care facility benefits	**You pay**
Skilled nursing facility (SNF): 120 days per calendar year. Covered services include: • Bed, board, and general nursing care. • Drugs, biologicals, supplies, and equipment.	Nothing
Not covered: custodial care	*All charges*
Hospice care	**You Pay**
Care for terminally ill patients (life expectancy of 6 months or less). • Covered services include dietary counseling, home health aid, occupational therapy, speech therapy, and skilled nursing. • Drugs and medical supplies.	Nothing
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	**You Pay**
• Local professional ambulance service when medically appropriate	$15 per visit

Section 5(d). Emergency services/accidents

IMPORTANT	**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. • We have no 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.	IMPORTANT

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:

Emergencies within/outside our service area: Emergencies, as defined above, do not require prior authorization. Even so, we encourage you to always contact your primary care physician for direction and advice before seeking medical treatment. In the event, however, that you are faced with a situation you are sure is an emergency as defined above, you should go directly to the emergency room.

In the event that you are faced with a situation that you are not sure is an emergency as defined above, you should contact your primary care physician first. Your primary care physician will help you determine the most appropriate course of treatment. As your partner in health care, your primary care physician needs to be kept informed of any health care services that you receive. We require that you contact your primary care physician to facilitate his or her ability to oversee your health care and ensure that you may receive any necessary follow-up treatment in connection with your emergency room visit.

Urgent Care within/outside our service area: Urgent care is intended to treat minor illness or injury-a sprain, a minor cut or burn, the flu, or other ailment that is not quite an emergency but does require prompt care. It differs from emergency care, which is designed to treat sudden, serious health problems (for example, a heart attack or stroke). When used correctly, urgent care is an appropriate, convenient, and affordable alternative to emergency care.

You are required to obtain a referral from your primary care physician before going to an urgent care center. Without a referral, you may be responsible for all costs incurred.

Benefit Description	You Pay
Emergency within our service area	**You Pay**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services	$15 $25 $50 (waived if admitted)
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	**You Pay**
• Emergency care at a doctor's office • Emergency care at an urgent care center • Emergency care as an outpatient at a hospital, including doctors' services	$15 $25 $50 (waived if admitted)
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.*	*All charges*
Ambulance	**You Pay**
Professional ambulance service when medically appropriate. See 5 (c) for non-emergency service.	$15 per visit
Not covered: Air ambulance, unless determined to be medically necessary and approved by our medical director.	*All charges*

Section 5(e). Mental Health and Substance Abuse Benefits

IMPORTANT

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:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no 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.

IMPORTANT

Benefit Description	You Pay
Mental health and substance abuse benefits	**You Pay**
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. 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.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$15 per visit
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, full-day hospitalization, and facility based intensive outpatient treatment	Nothing
Not covered: Services we have not approved. *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.*	*All charges*

Preauthorization

To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following authorization processes:

For mental health treatment, you or your primary care physician are required to contact Preferred Care's Behavioral Health Services Unit and speak with a mental health specialist who will ask basic information about your mental health history to determine the need for a referral for outpatient care. For inpatient care, your primary care physician makes a referral to Preferred Care's Preauthorization Department for inpatient hospitalization or partial hospitalization (day treatment).

For chemical dependency treatment, you are required to contact the Preferred Care Behavioral Health Services Unit and speak with an intake coordinator who will ask basic information about your chemical dependency history to determine the need for an assessment. If an assessment is appropriate, an appointment for you will be arranged with an independent Preferred Care Chemical Dependency Assessor. Once the assessment is completed, a clinical quality coordinator will contact you to make specific recommendations for treatment, and will arrange inpatient or outpatient services as needed.

The Behavioral Health Services Unit telephone number is (585) 327-2477 or (800) 836-1430 ext. 477. For the names of plan providers or a provider directory, contact a Preferred Care Member Services representative at (585) 325-3113 or (800) 950-3224 or visit our website at www.preferredcare.org.

Limitation

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

Section 5(f). Prescription drug benefits

IMPORTANT	**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 have no 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.	IMPORTANT

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a Plan pharmacy, a non-network pharmacy, or by mail for medications that are available through the mail order program.
- **We use a formulary.** A formulary is a list of selected FDA approved prescription medications. Use of formulary helps control out of pocket costs. The Preferred Care formulary is an open, clinically comprehensive guide that was developed by nationally recognized independent group of clinicians and reviewed by Preferred Care's P & T Committee (a group of local physicians, pharmacists, and Preferred Care clinical pharmacy and medical personnel). Our formulary provides access to all FDA approved drugs with various coverage levels.
- **These are the dispensing limitations.** You may purchase up to a 90-day supply at a Plan or non-network pharmacy and are required to pay a copayment for each 30-day supply you purchase. The amount you pay is based upon a three-tier copayment structure. The tiers determine the amount you pay for each 30-day supply purchased. The three tiers are categorized as Generic Drugs; Preferred Brand Name Drugs; and Other Brand Name Drugs.

  You may purchase certain medications for up to a 90-day supply through the mail order pharmacy. A list of therapeutic categories of prescriptions, that may be purchased through the mail order program, is available by contacting Medco Health at (800) 233-7063 or a Preferred Care Member Services Representative at (585) 325-3113 or (800) 950-3224, or by visiting our website at www.preferredcare.org.

  You are required to pay a copayment for each 90-day supply purchased through the mail order pharmacy. The amount you pay for medications purchased through the mail order pharmacy is also based upon the three-tier copayment structure. The tiers are categorized as Generic Drugs, Preferred Brand Name Drugs, and Other Brand Name Drugs. You may obtain a list of the medications covered through the mail order program by contacting Medco Health at (800) 233-7063 or a Preferred Care Member Services Representative at (585) 325-3113 or (800) 950-3224 or by visiting our website at www.preferredcare.org.

  When an A-rated generic drug can be substituted for a name brand drug, the patient's drug benefit will be based upon the cost of the generic drug. If the name brand drug is dispensed, the patient will pay the generic copayment plus the difference in cost between the lower priced generic drug and the higher priced name brand drug. If there is no A-rated generic substitute, the patient's drug benefit will be based upon the cost of the name brand drug less the name brand copayment.

  We reserve the right to determine Medical Necessity for all drugs, and may require Prior Justification of certain drugs. Prior justification may occur prior to the drug being dispensed in any amount or only if more than a standard quantity limit is prescribed. To learn more about this process you may contact Medco Health at (800) 233-7063 or a Preferred Care Member Services Representative at (585) 325-3113 or (800) 950-3224.
- **Why use generic drugs?** Generic drugs are typically lower priced drugs that are the therapeutic equivalent to more expensive name brand drugs. They must contain the same active ingredients and must be equivalent in strength and dosage to the original brand name product. Generics cost less than the equivalent name brand drug.

The U.S. Food and Drug Administration sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as name brand drugs.

- **When you have to file a claim.** If you use a non-plan pharmacy or do not present your identification card at a plan pharmacy, you are required to submit a claim. You must submit original receipts along with a claim form. You will be reimbursed at the network rate less the applicable copayment.

Benefit Description	You Pay
Covered medications and supplies	**You Pay**
We cover the following medications and supplies prescribed by a licensed physician and obtained from a Plan pharmacy or non-network pharmacy, or through our mail order program: • FDA approved medications for FDA approved indications that by Federal law of the United States require a physician's prescription for their purchase. • Compounded prescriptions are a covered item only if the main therapeutic ingredient is a Federal Legend Drug with a National Drug Code (NDC) Number. • Disposable needles and syringes for the administration of covered medications. • Drugs for sexual dysfunction have dispensing limits. Contact us for details. • Contraceptive drugs. • Drugs for infertility treatment after a medical condition has been corrected. Pergonal/Metrodin and other FDA approved drugs, only after unsuccessful treatment with Clomiphene and only when very specific clinical indications are met. • Growth hormone.	**At a Pharmacy (for each 30 day supply)** $10 per generic prescription. $20 per preferred brand name prescription. $35 per other brand name prescription. **At Mail Order Pharmacy (for each 90 day supply)** $20 per generic prescription. $40 per preferred brand name prescription. $70 per other brand name prescription. Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Diabetic Drugs & Supplies: • Insulin and oral agents • Supplies, including disposable needles and syringes	$15 for each 30-day supply $15 for each 90-day supply from the mail order pharmacy.
• Diabetes education (see Educational Classes and Programs (Page 19))	$15 per session
• Diabetic medical equipment (including glucose monitors)	$15 per unit
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins and nutritional supplements that can be purchased without a prescription.* • *Nonprescription medicines* • *Drugs to enhance athletic performance* • *Non-FDA approved medications (i.e. foreign medications, etc.)*	*All Charges*

Section 5(g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • 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	• If you have access to TTY equipment, you may contact us at (585) 325-2629.
Travel benefits/services overseas	• Urgent and emergency care only.

Section 5(h). Dental Benefits

IMPORTANT

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 have no deductible.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; 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.

IMPORTANT

Benefit Description	You Pay
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. Benefits are provided only for a course of treatment that has begun within 12 months of the injury.	$15 per visit
Dental Benefits	
We have no other dental benefits.	

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 out-of-pocket maximums.

HealthPerksssm from Preferred Care are courses, resources, and discounts available to all members of the Plan. **HealthPerks**ssm provides connections to traditional and complimentary providers, all geared to giving Plan members' tools to make appropriate health and wellness decisions for themselves and their families. Our **HealthPerks**ssm program was developed to encourage appropriate participation in healthful activities focusing on preventive care to aid in improving the health status of our members.

Courses, programs and workshops cover areas such as:

- CPR & First Aid,
- Diet & Nutrition,
- Smoking Cessation,
- Women's Issues, and
- Childbirth & Parenting.

Discounts are provided for purchasing health related, recreation or leisure merchandise or services from:

- Weight Watchers,
- Play It Again Sports,
- Muxworthy's,
- G&G Fitness,
- Lori's Natural Foods,
- and Rock Ventures to name a few.

Over twenty clubs provide plan members discounted arrangements. Discounts and schedules vary by participating vendor.

Additional **HealthPerks**ssm programs are:

- Discounts on massage therapy,
- 20% discount on LASIK laser eye surgery at select locations,
- Safe driving and safe boating courses at select locations,
- 20% discount on teeth whitening at participating dentists,
- 20% discount on sunglasses and safety glasses at select locations.

To receive a **HealthPerks**ssm brochure, call Preferred Care's Member Services Department at (585) 325-3113 or toll free at (800) 950-3224. Members with access to TTY equipment may call (585) 325-2629. **www.preferredcare.org**. Preferred Care's website provides valuable health information, frequently asked questions, **HealthPerks**ssm offerings, physician listings, and important links to other sites that can provide you with the most up to date information on health and wellness.

This plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 41, annuitants and former spouses with FEHB coverage may enroll in a Medicare managed care plan when one is available in their area. They may then later enroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare managed care plan. Contact us at (585) 327-5760 for information on the Medicare managed care plan and the cost of that enrollment.

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.**

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;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive while in active military service.

Section 7. Filing a claim for covered services

When you receive services from 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 or coinsurance.

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 (585) 325-3113.

When you must file a claim – such as for out-of-area care – 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, address, and Federal Tax ID # 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:

Preferred Care, 259 Monroe Avenue, Rochester, New York, 14607

Prescription drugs

Submit your claims to:

Medco Health Solutions, Inc.
P.O. Box 2187
Lee's Summit MO 64063-2187

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 preauthorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: 259 Monroe Avenue, Rochester, N.Y. 14607; 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	We have 30 days from the date we receive your request to: (a) Pay the claim (or 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	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. 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. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 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. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, D.C. 20415-3630. 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 different claims, 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 precertification 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 preauthorization/prior approval, then call us at (585) 325-3113 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim ex pedited treatment too, or
- You can call OPM's Health Benefits Contracts Division 3 at (202) 606-0737 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 are covered or if a family member has coverage under another group health plan or has 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 whatever is left up to the plan allowance or our regular benefit, whichever is less. We will not pay more than our allowance. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

- **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 premiums-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 Social Security or 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 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 a Medicare plan 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. You must use our providers.

When Medicare is the primary payer, we will waive some of your out of pocket costs, such as copays and coinsurance.

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 many cases, your claims will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claims, call us at (585) 325-3113 or visit our website at www.preferredcare.org.

Section 9. Coordinating benefits with other coverage, continues on page 41.

Primary Payer Chart appears on the next page.

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	✓	
b) Or, 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, a) And are an annuitant, or	✓	
b) Are an active employee, 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 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). We will waive our copayments, and/or coinsurance when we are the secondary payer. You are required to use Plan providers. 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 Medicare or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in 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.

Worker's 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-approved program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in 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 10.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 10.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Care that could be provided safely and reasonably by people without professional skills or training that is primarily to help the member with daily living activities or meet personal needs.

Experimental or investigational

This Plan considers a drug, device, treatment, or procedure to be experimental or investigational if it meets one or more of the following criteria:

1. It cannot be lawfully marketed without the approval of the FDA and such approval has not been granted at the time of its use.
2. It is the subject of a current investigational new drug or device application on file with the FDA.
3. It is being provided pursuant to a Phase I or Phase II clinical trial or as the experimental or research arm of a clinical trial.
4. It is being provided pursuant to a written protocol which describes among its objectives, determination of safety, or efficacy in comparison to conventional alternatives.
5. The predominant opinion among experts as expressed in the published peer review literature is that further research is necessary in order to define safety compared with conventional alternatives.
6. It is not experimental or investigational in itself, but is being used in conjunction with a drug, device, treatment, or procedure that is experimental or investigational.

Group health coverage

Health care coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies.

Medically necessary

Medically necessary means that the use of services and supplies required to diagnose or treat you are:

- Consistent with the symptoms or diagnosis and treatment of your condition, disease, ailment or injury, supported by a thorough examination, history, and tests;
- Appropriate, safe, and effective with regard to generally accepted standards of medical or surgical practice prevailing nationally or in the geographic locality, where and when the service or item is ordered;

- Supported by a thorough, reasonable consideration of the treatment options available and a reasonable potential for therapeutic gain, and not solely for appearance or recreation, or for your convenience, the convenience of your health professional, hospital, or other provider; and
- Furnished in the least intensive, most cost effective health care setting required. When applied to inpatient care, it further means that your medical symptoms or condition require that the diagnosis or treatment cannot be safely provided to you as an outpatient or in a less intensive environment.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Our plan allowance is generally based upon a fee we negotiate with Plan providers. In some instances, our plan allowance may be based upon submitted charges or reasonable and customary charges.

Us/We

Us and we refer to Preferred Care.

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:

- 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 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. Annuitant's 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 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 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 HIPPA" frequently asked questions. These highlight HIPPA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPPA, 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 does not explain your benefit coverage.

Summary of Benefits for Preferred Care - 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: • Diagnostic and treatment services provided in the office	Office visit copay: $15 primary care; $15 specialist	12
Services provided by a hospital: • Inpatient ..... • Outpatient	 Nothing Nothing	 23 24
Emergency benefits: • In-area ..... • Out-of-area	 $50 copay (waived if admitted) $50 copay (waived if admitted)	 26 26
Mental health and substance abuse treatment	Regular cost sharing	27
Prescription drugs	**At a Pharmacy** **(for each 30 day supply)** $10 per generic prescription $20 per preferred brand name prescription $35 per other brand name prescription **At Mail Order Pharmacy** **(for each 90 day supply)** $20 per generic prescription $40 per preferred brand name prescription $70 per other brand name prescription	29
Dental Care	Limited benefits	32
Vision Care: • Annual eye refraction, including lens prescriptions • One pair of prescription eyeglasses or contact lenses	 $15 per visit The remaining cost after a discount of 20% and a credit of $60	17
Special features: • Flexible benefits option • Services for deaf and hearing impaired • Travel benefits/services overseas		31
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $3,300 per person or $8,400 per family enrollment per year Some costs do not count toward this protection	10

2003 Rate Information for
Preferred Care

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.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Serving Greater Rochester and Surrounding Counties							
Self Only	GV 1	$ 81.65	$27.21	$176.90	$ 58.96	$96.61	$12.25
Self and Family	GV2	$217.97	$72.66	$472.28	$157.42	$257.93	$32.70