BlueCHiP, Coordinated Health Partners, Inc.

http://www.bcbsri.com

2003

A Health Maintenance Organization with a Point of Service Product

Serving: *Rhode Island and portions of Southeastern Massachusetts*

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 an accreditation status of Excellent from NCQA. See the *2003 Guide* for more information on accreditation.

Enrollment codes for this Plan:

DA1 Self Only
DA2 Self and Family

Authorized for distribution by the:

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

Federal Employees Health Benefits Program

RI 73-489

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 it 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 an 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 year. Despite its size, the FEHB Program is not immune to such market forces. We have worked with the 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 http://www.opm.gov/insure

Sincerely,

Kay Coles James
Director

2003 BlueCHiP, Coordinated Health Partners

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.

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- 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.

2003 BlueCHiP, Coordinated Health Partners

Table of Contents

Introduction

This brochure describes the benefits of BlueCHiP, Coordinated Health Partners, Inc. under our contract (CS2328) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This Plan is underwritten by Coordinated Health Partners, Inc. The address for Coordinated Health Partners' administrative offices is:

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

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

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

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2003, and changes are summarized on page 8. 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 *BlueCHiP, Coordinated Health Partners, Inc.*
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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

Stop Health Care Fraud!

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

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

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

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.

- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
    - Call the provider and ask for an explanation. There may be an error.
    - If the provider does not resolve the matter, call us at 401-274-3500 from within the State of Rhode Island or 1-800-564-0888 from outside Rhode Island and explain the situation.
    - If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
The United state Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400,
Washington, DC 20415.

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

Section 1. Facts about this HMO plan

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

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

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

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

We also have Point-of-Service (POS) benefits:

Our HMO offers Point-of-Service (POS) benefits. This means you can receive covered services from a participating provider without a required referral, or from a non-participating provider. These out-of-network benefits have higher out-of-pocket costs than our in-network benefits.

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. BlueCHiP, Coordinated Health Partners is affiliated with Blue Cross and Blue Shield of Rhode Island. BlueCHiP, Coordinated Health Partners contracts with over 1000 primary care doctors (family and general practitioners, internists, pediatricians, and some obstetrician/gynecologists who have chosen to participate as a primary care doctor) and over 1700 specialists, along with a full range of hospitals across the State of Rhode Island and Southeastern Massachusetts. All participating primary care doctors practice out of offices in the community. Each member selects a primary care doctor who acts as a personal doctor working to coordinate all of your health care needs. When specialist services are needed, your primary care doctor will refer you to a BlueCHiP, Coordinated Health Partners specialist. You must receive a referral from your primary care doctor in order to receive maximum benefits.

BlueCHiP, Coordinated Health Partners has a POS product which offers members the flexibility of obtaining services without a referral from their primary care doctor or from non-Plan providers. You will be subject to deductibles and coinsurance. For more information regarding this benefit, see page 42.

Your Rights

OPM requires all FEHB Plans to 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.

- Years in existence: 16 years
- Profit status: For profit

If you want more information about us, call 401/274-3500 , or write to 15 LaSalle Square, Providence, RI 02903 . You may also contact us by fax at 401-459-5089 or visit our website at www.bcbsri.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is the State of Rhode Island and the following cities and towns in the state of Massachusetts: Acushnet, Attleboro, Bellingham, Blackstone, Dartmouth, Dighton, Fall River, Fairhaven, Foxborough, Franklin, Mansfield, Medway, Mendon, Millville, New Bedford, North Attleboro, Norton, Plainville, Raynham, Rehoboth, Seekonk, Somerset, Swansea, Taunton, Uxbridge, Wesport and Wrentham.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care or Point of Service benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. BlueCHiP, Coordinated Health Partners, Inc. offers the HMO USA Guest Membership Program. To enroll in this program, please contact Customer Service at 401-274-3500 from within Rhode Island or toll –free at 1-800-564-0888 from outside of Rhode Island. 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.

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Section 2. How we change for 2003

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

Program-wide changes

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

Changes to this Plan

- Your share of the non-Postal premium will increase by 58.2% for Self Only or 47.0% for Self and Family.
- Office visits to the member's primary care physician will require a $15 copayment. Office visits to a specialist will require a $25 copayment. Previously, you paid a $10 copayment for office visits to your primary care physician or to a participating specialist with a referral from your primary care physician. (Section 5a)
- Inpatient admissions for acute care, maternity, mental health, substance abuse, transplants and hospice care will require a $500 per admission copayment, with a $1,000 individual/$2,000 family out-of-pocket maximum per calendar year. This will also apply to admissions that result as part of an emergency room visit. Previously, you paid nothing. (Section 5c)
- You will pay $7 per prescription unit or refill for generic drugs, $25 per prescription unit or refill for brand name drugs on the Plan's formulary and $40 per prescription unit or refill for brand name drugs not listed on the Plan's formulary. Prescriptions filled at a non-Plan pharmacy will be covered at 80% of the Plan's allowance less a $40 copayment. Previously, you paid $5 per prescription unit or refill for generic drugs, $15 per prescription unit or refill for brand name drugs on the Plan's formulary and $30 per prescription unit or refill for brand name drugs not listed on the Plan's formulary. Prescriptions filled at a non-Plan pharmacy were covered at 80% of the Plan's allowance less a $30 copayment. (Section 5f)
- Prescription drugs prescribed by a physician will be dispensed for up to a 30-day supply for non-maintenance drugs and maintenance drugs. Previously, prescription drugs prescribed by a physician were dispensed for up to a 34-day supply for non-maintenance drugs or the greater of a 34-day supply or 100 units for maintenance drugs. (Section 5f)
- Members utilizing the mail service prescription drug service will pay two copayments for a 90-day supply. For example, a generic drug available through the mail service program will cost $14 for a 90-day supply. Previously, you paid three copayments for a 90-day supply. (Section 5f)
- Fertility drugs purchased at the pharmacy require a 20% copayment. Previously, fertility drugs purchased at the pharmacy were covered with the applicable pharmacy copayment. (Section 5f)
- Infertility treatment, including artificial insemination, intrauterine insemination and assisted reproductive technology procedures require a 20% copayment.
- If you utilize the Point-of-Service benefit, the Plan will pay 70% of it's allowance after you meet the calendar year deductible of $500 per individual/$1,000 per family. You are protected by an out-of-pocket maximum of $5,000 per individual and $10,000 per family per calendar year. Previously, the Plan paid 80% of it's allowance after a $250 individual/$500 family deductible, with an out-of-pocket calendar year maximum of $3,000 per individual/$6,000 per family. (Section 5i)
- Members are now covered for up to twelve (12) chiropractic visits per calendar year. Previously, you were covered up to six (6) visits per year. (Section 5a)
- Emergency care as an outpatient at a hospital, including doctor's services will require a $50 copayment. If the emergency results in an admission to the hospital, the copayment is waived. Previously, you paid a $25 copayment for emergency room visits. (Section 5d)
- Emergency/urgent care at an urgent care center, including doctor's services, will require a $25 copayment. Previously, you paid a $20 copayment for urgent care center visits. (section 5d)

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 401-274-3500 from within the State of Rhode Island or 1-800-564-0888 from outside of Rhode Island.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims. If you use our point-of-service program, you can also get care from non-Plan providers, or from participating providers without a required referral, but it will cost you more.

- **Plan providers**

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

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

- **Plan facilities**

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

What you must do to get 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. You will select a primary care physician for you and each covered member of your family when you enroll by completing the primary care physician selection card provided by the Plan. If you want to change your primary care physician at any time, you must contact Customer Service at 401-274-3500 from within the State of Rhode Island and 1-800-564-0888 from outside of Rhode Island prior to receiving any services. The change will not be effective until the first day of the following month.

- **Primary care**

Your primary care physician can be a family practitioner, general practitioner, internist, or pediatrician. In addition, some OB/GYNs are also primary care physicians. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician has authorized a certain number of visits. 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 your OB-GYN for annual exams, go for your annual eye exam and receive up to twelve (12) chiropractic visits per year without a referral. In addition, you do not need a referral from your primary care doctor for mental health or substance abuse services, however, you must receive authorization for these services from the Plan's mental health administrator. Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will work with your specialist to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  – terminate our contract with your specialist for other than cause; or

  – drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  – reduce our service area and you enroll in another FEHB Plan,

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

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

• Hospital care

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

If you are in the hospital when your enrollment in our Plan begins, call our Customer Service Department immediately at 401-274-3500 from within Rhode Island or toll –free at 1-800-564-0888 from outside of Rhode Island. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

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

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

Circumstances beyond our control

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

Services Requiring Prior Medical Review

Your primary care physician has authority to refer you for most services. For certain services, however, it is recommended that your physician obtain prior 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 the Prospective Medical Review process. It is recommended that your physician obtain prior medical review for the following services to ensure that they will be covered: inpatient admissions, home health care/home IV therapy, home physical, speech and occupational therapy, speech therapy, durable medical equipment, inpatient and outpatient hospice care, skilled nursing care, inpatient rehabilitation, pulmonary rehabilitation, human growth hormone therapy and organ transplants. Mental health and substance abuse services require authorization from the Plan's Behavioral Care Administrator. You may be responsible for payment of these services if they are determined to not be medically necessary.

We continue to recommend that you obtain prior medical review for these same services when utilizing the POS benefit. When utilizing non-Plan participating providers, it is recommended that you advise your provider to contact the Plan for prior medical review in advance of such services to ensure they will be covered.

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 a provider, facility, pharmacy, etc., when you receive services. Example: When you see your primary care physician you pay a copayment of $15 per primary care office visit, $25 per specialist office visit and when you go in the hospital, you pay $500 per admission.
•**Deductible**	We do not have a deductible except as noted under the POS benefit.
•**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 infertility services and diabetic supplies. Coinsurance also applies when you use the POS benefit.
Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance and copayments	After your in-network inpatient copayments per admission reach $1000 per person or $2000 per family per calendar year, you do not have to pay any more for covered inpatient services for that year. There are no other out-of-pocket maximums except as noted under the POS benefit.

Section 5. Benefits – OVERVIEW

(See page 8 for how our benefits changed this year and page 55 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 401-274-3500 from within Rhode Island or toll –free at 1-800-564-0888 from outside of Rhode Island. or at our website at www.bcbsri.com

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 calendar year deductible for services received from Plan participating providers. Please see Section 5(i) regarding your Point-of-Service benefits.
- 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 After the calendar year deductible…
Diagnostic and treatment services	
Professional services of physicians • In physician's office • At home • Office medical consultations • Second surgical opinion	$15 per visit to your primary care physician $25 per visit to a specialist
Professional services of physicians • In an urgent care center	$25 per office visit
Professional services of physicians • During a hospital stay • In a skilled nursing facility	Nothing
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing

Preventive care, adult	You pay

Routine screenings, such as:
• Total Blood Cholesterol – once every three years
• Colorectal Cancer Screening, including:
  • Fecal occult blood test
  • Sigmoidoscopy, screening – every five years starting at age 50
• Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older
• Routine pap test
Note: The office visit copay applies if test is received on the same day; see *Diagnosis and Treatment*, above.
	Nothing.

Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar year	Nothing.
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* • *Weight reduction programs, including laboratory tests related to programs designed for the purposes or weight reduction All charges.*	*All charges.*
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza • Pneumococcal vaccine, age 65 and over	Nothing.
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 22)
• Examinations, such as:
  – Eye exams through age 17 to determine the need for vision correction.
  – Ear exams through age 17 to determine the need for hearing correction
  – Examinations done on the day of immunizations (through age 22)
	$15 per office visit

Not covered • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.* • *Weight reduction programs, including laboratory tests related to programs designed for the purposes or weight reduction* • *Examination, evaluations, or services performed solely for educational or developmental purposes.*	*All charges.:*

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 do not need to precertify your normal delivery; see page 31 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. In addition, coverage of injury or illness or sickness including necessary care and treatment of medically diagnosed congenital defects and birth abnormalities will be covered for the first 31 days of a newborn's life; all care after the first 31 days will be covered 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).	$15 for initial office visit at Member's PCP, otherwise, $25 for initial office visit Specialist; covered in full thereafter
Not covered: • *Routine sonograms to determine fetal age, size or sex*	*All charges.*
Family planning	
A range of voluntary family planning services, limited to: • Voluntary sterilization (See Surgical procedures Section 5(b)) • Surgically implanted contraceptives • Intrauterine devices (IUDs) • Diaphragms	Nothing.
• Injectable contraceptive drugs (such as Depo provera) NOTE: Pharmacy purchased contraceptives are covered under the prescription drug benefit with the applicable prescription drug copay.	20%
• Medically necessary genetic counseling	$25 per visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Treatment for infertility when the cause of infertility was a previous sterilization*	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: – *Intravaginal insemination (IVI)* – *Intracervical insemination (ICI)* – *Intrauterine insemination (IUI)* • *Assisted reproductive technology (ART) procedures, such as:* – *in vitro fertilization* – *embryo transfer, gamete GIFT and zygote ZIFT* *Zygote transfer* 20%	20%
• Fertility drugs Note: Fertility drugs purchased at the pharmacy also have a 20% copayment.	20%
Not covered: • *Freezing (i.e., cryo-preservation) and storage of gametes, sperm, embryos or other specimens for future use;* • *sperm bank (i.e., storage);* • *donor stipend;* • donor oocytes for non-infertile couples (e.g., member has genetic disorder, HIV+ status, etc.);	*All charges.*
Allergy care	
Testing and treatment • Allergy serum • Allergy injection	$25 per office visit 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 are limited to those transplants listed under Organ/Tissue Transplants on page 29. • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the medical benefit. Note: – We will only cover GHT when we preauthorize the treatment. Benefits for treatment will be continued as long as there has been a satisfactory response to growth hormone of at least 5 cm a year after the first year.	Nothing.

Physical and occupational therapies	
• Physical and occupational therapy for services by each of the following: – Qualified physical therapists and – Occupational therapists. admission 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. You must show significant improvement within sixty (60) days to receive authorization for additional treatment. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to eighteen (18) weeks or thirty six (36) visits, whichever comes first.	$25 per office visit $25 per outpatient visit Nothing per visit during covered inpatient
Not covered: • *long-term rehabilitative therapy* • *exercise programs* • *massage therapy* • *recreational therapy*	*All charges.*
Speech therapy	
Speech services by a speech therapist Note: You must show significant improvement within sixty (60) days to receive authorization for additional treatment. $25 per office visit	$25 per office visit $25 per outpatient visit Nothing per visit during covered inpatient admission
Hearing services (testing, treatment, and supplies)	**You pay**
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see *Preventive care, children*)	$25 per office visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	Nothing
• Annual eye refractions Note: See Preventive care, children for eye exams for children	 $25 per office visit
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*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.	$25 per office 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 other routine foot care*	*All charges.*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: We pay internal prosthetic devices as hospital benefits; see Section 5(c) for payment information. See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	$20 per item.
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges.*
Durable medical equipment (DME)	
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; (the type of wheelchair we allow will depend on your medical condition); • crutches; • walkers; • blood glucose monitors; and • insulin pumps.	$20 per item

Durable medical equipment (DME) *(Continued)*	**You pay**
Not covered: • *Motorized wheel chairs* • *Equipment that serves as a comfort or convenience item. Electrical or mechanical features which enhance basic equipment usually serve a convenience function. Determination of medical necessity should be made regarding the coverage of these features.* • *Equipment used for environmental control or to enhance the environmental setting or surroundings of an individual should not be considered durable medical equipment. Examples of these include air conditioners, air filters, portable jacuzzi pumps, humidifiers, etc.* • *Repairs to patient owned equipment*	*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 including oxygen therpay, intravenous therapy and medications	Nothing.
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	
• Manipulation of the spine and extremities up to twelve (12) self-referred visits per calendar year • One set of x-rays of the spine every three (3) years	$25 per office visit
Not covered: • *Other imaging studies or laboratory work ordered by a chiropractor*	*All charges*

Alternative treatments	You pay
No benefit.	All charges.
Educational classes and programs	
Coverage is limited to: • Smoking Cessation – Coverage is limited to primary care visits and individual counseling for smoking cessation. • Prescription nicotine substitutes, including transdermal patches, are covered under the prescription drug benefit up to a maximum of a three (3) month supply (see Section 5(f)). Member must submit proof of being smoke free for a one-year period for reimbursement.	$15 per office visit
• Diabetes self-management - Diabetes education, when medically necessary and prescribed by a physician, may be provided only by the physician or, upon his or her referral to, an appropriately licensed and State certified diabetes educator. Coverage is limited to five (5) individual sessions or seven (7) group sessions.	$15 per visit.
• Asthma self-management	Nothing

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 calendar year deductible for services received from Plan participating providers. Please see Section 5(i) regarding your Point-of-Service benefits.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- YOUR PHYSICIAN SHOULD GET PRIOR MEDICAL REVIEW OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
Surgical procedures	
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 amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity – a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information.	$25 per office visit; Nothing for surgery

Surgical procedures continued on next page.

Surgical procedures *(continued)*	**You pay**
• Voluntary sterilization (e.g., Tubal ligation, Vasectomy) • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$25 per office visit; Nothing for surgery
Not covered: • *Blood Storage* • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*
Reconstructive surgery	
• 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.	Nothing.
• 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 lymphedemas; – breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Nothing.
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	
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.	Nothing.
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 • Allogenetic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas. • Medications directly related to the transplant for a one-year period after the transplant. **All transplants must be performed at a Plan-designated center of excellence. Contact** 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
• Transportation/lodging when performed at a Plan-designated center of excellence	Up to $5,000
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 remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- We have no calendar year deductible for services received from Plan participating providers. Please see Section 5(i) regarding your Point-of-Service benefits.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
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.	$500 per admission $1000 individual/$2000 family out-of-pocket maximum for admission copays per calendar year.
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 • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.)	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes-schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care (unless medically necessary)*	*All charges*

Outpatient hospital or ambulatory surgical center	
• 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
Not covered: blood and blood derivatives not replaced by the member	*All charges.*
Extended care benefits/skilled nursing care facility benefits	**You pay**
Extended care/skilled nursing facility (SNF): • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by a skilled nursing facility when prescribed by a Plan doctor	Nothing
Not covered: custodial care All charges.	
Hospice care	
Supportive and palliative care for a terminally ill member is covered in the home or hospice facility.	
Inpatient care (limited to 21 days per calendar year)	$500 per admission
Family counseling	$1000 individual/$2000 family out-of-pocket maximum per calendar year
Hospice services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six (6) months or less.	
Outpatient care	Nothing
Not covered: • *independent nursing* • *homemaker services*	*All charges.*
Ambulance	
• Local professional ambulance service when medically appropriate	Nothing

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.
- 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 our service area:

Please call your primary care doctor. In extreme emergencies, if you are unable to contact your doctor, call 911 or go to the nearest emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or your family member should notify the Plan within 48 hours unless it is not reasonably possible to do so. It is your responsibility to ensure that the Plan has been notified timely.

If you need to be hospitalized in a non-Plan facility, the Plan must notified within forty-eight (48) hours or on the first working day following you admission , unless it is not reasonably possible to notify the Plan within that timeframe.

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

Emergencies outside our service area:

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

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

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

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$15 per PCP visit $25 per Specialist visit
• Emergency care at an urgent care center	$25 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 per hospital emergency room visit. If emergency results in an admission to the hospital, the copay is waived.
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
• Emergency care at a doctor's office	$25 per visit
• Emergency care at an urgent care center	$25 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 per hospital emergency. If emergency results in an admission to a hospital, the copay is waived.
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	
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	Nothing.

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.
- The inpatient copayment applies to inpatient hospital and some alternative care settings.
- 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 After the calendar year deductibe...
Mental health and substance abuse benefits	
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 • Services in approved alternative care settings residential treatment, full-day hospitalization, facility based intensive outpatient treatment	$25 per visit

Mental health and substance abuse benefits - continued on next page

Mental health and substance abuse benefits *(continued)*	**You pay**
• Medication management	$25 per visit
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility	$500 per admission
• Services in approved alternative care settings such as partial hospitalization	$1000 individual/$2000 family out-of-pocket maximum per admission per calendar year
• Services in approved alternative care settings such as facility based intensive outpatient treatment, residential treatment	$25 per visit
Not covered: • *Services not coordinated through our Administrator* • *Methodone treatment programs*	*All charges.*

Preauthorization

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

Treatment for mental health conditions and substance abuse may be obtained directly by contacting BlueCHiP's Mental Health Administrator at 1-800-544-5977 or 401-276-4052 prior to services being rendered. Our Administrator will determine and authorize the appropriate number of visits and determine the appropriate specialist. A referral from your PCP is not required.

Limitation We may limit your benefits if you do not obtain a 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.
- 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. Plan pharmacies include CVS and Brooks pharmacies as well as additional independent pharmacies. Prescriptions filled at non-Plan pharmacies will be covered at 80% of BlueCHiP, Coordinated Health Partners' allowance after a $40 copay. In addition, most prescription drugs are available through the participating mail order pharmacy. Contact Customer Service at 401-274-3500 from within Rhode Island and 1-800-564-0888 from outside of Rhode Island for more information or to obtain a mail services enrollment form directly logon to www.pharmacare.com.
- **We use a formulary.** BlueCHiP, Coordinated Health Partners uses a drug formulary, which is a listing of quality, cost effective medications that are covered under your prescription drug benefit for a lower copay. We cover non-formulary drugs prescribed by a physician; however, you will be responsible for a higher copay.
- **These are the dispensing limitations.** Prescription drugs prescribed by a physician will be dispensed for up to a 30-day supply for non-maintenance drugs and maintenance drugs. If there is no generic equivalent available, you will still have to pay the brand name copayment. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand or if you specifically ask and sign for a brand name medication.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name 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 brand-name product. 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 brand-name drugs.

  You can save money by using generic drugs. However, you and your physician have the option to request a name-brand if a generic option is available. Using the most cost-effective medication saves money.
- **When you have to file a claim.** You will be required to submit a claim for prescriptions purchased from a non-Plan pharmacy. You will be required to pay the non-Plan pharmacy directly and the Plan will reimburse you once you have submitted the receipt, your name, Plan identification number to Basic Claims Administration, 444 Westminster Street, Providence, RI 02903.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered*. • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (contact Customer Service for limitations) • Contraceptive drugs and devices purchased at the pharmacy • Injectible drugs purchased at the pharmacy • Prenatal vitamins **NOTE:** Fertility drugs purchased at the pharmacy require a 20% copayment.	\$7 per prescription unit or refill for generic drugs \$25 per prescription unit or refill for brand name drugs on the Plan's formulary \$40 per prescription unit or refill for brand name drugs not listed on the Plan's formulary Prescriptions filled at non-Plan pharmacy will be covered at 80% of the Plan's allowance less a \$40 copayment Mail order: \$14 for formulary generic; \$50 for formulary brand drugs; \$80 for non-formulary drugs for a 90-day supply. Note: If there is no generic equivalent available, you will still have to pay the brand name copay. In addition, if a brand name drug becomes available as a generic, you will be required to pay the highest copayment.
Not covered: • *Over-the-counter drugs (even if prescribed)* • *Drugs and supplies for cosmetic purposes* • *Drugs to enhance athletic performance* • *Compound medications not made up of at least one Legend drug* • *Prescription drugs prescribed or dispensed outside our guidelines* • *Drugs which have not been proven effective according to the Food and Drug Administration* • *Vitamins (excluding prenatal), nutrients and food supplements even if a physician prescribes or administers them* • *Drugs and supplies for the purpose of weight reduction*	*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	For the deaf or hearing impaired, please call our TDD Number. From outside Rhode Island dial 1-877-232-8432 and from within the State of Rhode Island dial (401) 459-5505.
Reciprocity benefit	When you or a covered member are traveling throughout the United States, and need urgent medical care before you return home, call 1-800-810-BLUE to locate a Blue Cross and Blue Shield traditional provider or log on to www.bcbs.com. In addition, you must contact Customer Service before or after you receive care (within 48 hours) to ensure that your claim is paid appropriately. Please remember to coordinate all follow-up care through your primary care physician.
High risk pregnancies	If you are pregnant, you will be part of our Little Steps prenatal program. Little Steps is designed to work with you and your physician to help you heave the healthiest baby possible. Little Steps includes free classes on parenting, newborn care and breast-feeding. The classes are held at participating hospitals throughout Rhode Island. For more information contact Customer Service.
Centers of excellence	To ensure you receive quality care, we selectively choose medical facilities that specialize in various transplants to participate in our network. The facilities are chosen based on the duration of their transplant program, volume of transplants performed each year, patient outcomes, and qualifications of their transplant program medical staff. Each facility is well known and respected throughout the country, and is designated a "Center of Excellence" for its commitment to quality care and positive patient outcomes. By utilizing one of our network facilities, you will receive quality care and can better manage your costs. For more information, contact Customer Service.

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.
- Plan dentists must provide or arrange your care.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists ehich makes hospitalization necessary to safeguard the health of the patient. See section 5© for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing • works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare

IMPORTANT

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 caused by an unexpected or unintentional means and must occur within seventy-two (72) hours of injury. Only the following services are covered: • Extraction of teeth needed to avoid infection of teeth damaged in the injury • Suturing and suture removal • Re-implanting and stabilization of dislodged teeth • Medication received from the provider	$50 per hospital emergency room visit $25 per office visit
Not covered: *Injuries incurred as a result of biting and/or chewing*	
Dental benefits	
We have no other dental benefits.	

Section 5 (i). Point of service benefits

Facts about this Plan's POS option

At your option, you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals whenever you need care, except for the benefits listed below under "What is not covered." Benefits not covered under Point of Service must either be received from or arranged by Plan doctors to be covered. When you obtain covered non-emergency medical treatment from a non-Plan doctor without a referral from a Plan doctor, you are subject to the deductibles, coinsurance and maximum benefit stated below.

What is covered

Under the point-of-service benefit, you are covered for medically necessary, covered health services when you self-refer to a non-Plan provider or to a BlueCHiP provider without a referral from your PCP. You may receive medically necessary covered health services listed in this brochure, except for the services listed under what is not covered. Once you use the point-of-service benefit, all services associated with the episode of care (i.e., lab, x-ray, hospitalization) will be paid according to your point-of-service benefit. If you choose to use the point-of-service benefit, you will receive a lower allowance than when the standard HMO benefit is utilized.

You are able to self-refer to a non-Plan provider either inside or outside of our service area. You must call BlueCHiP for authorization for hospitalization.

Plan Authorization

When utilizing the POS benefit, we continue to recommend that you obtain prior medical review for the same services that we recommend you do so under the Standard HMO benefit. When utilizing non-Plan participating providers, it is recommended that you advise your provider to contact the Plan for prior medical review in advance of such services to ensure they will be covered.

Deductible

When the point-of-service benefit is utilized, you pay a $500 deductible per member per calendar year or a $1000 deductible per family per calendar year for doctor's visits, other outpatient services, and hospital services. The deductible is not reimbursable by the Plan. If you decide to use non-Plan providers or self refer to a Plan provider, this deductible applies to all covered benefits. Copayments under the BlueCHiP, Coordinated Health Partners' point-of-service benefit cannot be used to meet your calendar year deductible.

Coinsurance

Members are able to self-refer to a provider either inside or outside the Service Area. If the self-referral is to a provider who does not participate with the BlueCHiP network, but who is part of the Blue Cross and Blue Shield national traditional network (Host Blue), you will only be responsible for your deductible and the 30% coinsurance. To check if the provider participates with this program, please call 1-800-810-BLUE or log on to www.bcbs.com. These providers will file the claim directly. This feature is referred to as the BlueCard program.

If you self-refer to a provider who is neither part of the BlueCHiP network, nor part of the BlueCard program, you will be responsible for any amount over our allowance, in addition to your deductible and coinsurance amount.

When you use the Flex Plan Rider to self-refer for services to a BlueCHiP participating provider, BlueCHiP will pay 70% of the BlueCHiP fee schedule based on existing contractual relationships with the provider. BlueCHiP providers cannot charge the member more than the contracted fee.

When you obtain health care services through the BlueCard program outside the BlueCHiP network, you will pay 30% of the amount for the covered services. The amount charged for a covered service is calculated on the lower of:

- The billed charges for your Covered Health Care Services, or
- The negotiated price that the on-site Blue Cross and/or Blue Shield Plan ("Host Blue") passes on to us.

Often, this "negotiated price" will consist of a simple discount, which reflects the actual price paid by the Host Blue. However, sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price will also be adjusted in the future to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price.

Statutes in a small number of states may require the Host Blue to use a basis for calculating your liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate your liability calculation methods that differ from the usual BlueCard method noted above in this section or require a surcharge, We would then calculate your liability for any Covered Health Care Services in accordance with the applicable state statute in effect at the time you received your care.

When you receive services from providers that are not contracted with BlueCHiP or a Host Blue Plan, we will pay 70% of the fee schedule, as determined by BlueCHiP. The member is responsible for the remaining balance of the non-network provider's charges if they are greater than the fee schedule. Payment for these services will be made directly to the member. The member is responsible to pay the provider directly for the services.

All payments made by BlueCHiP for services through the Point of Service benefit will be subject to a deductible as outlined above.

Out-of-Pocket Maximum

You are protected by an out-of-pocket maximum of $5,000 per person per calendar year and $10,000 per family per calendar year. This includes deductibles and copayments. Charges over the fee allowance cannot be applied to the out-of-pocket maximum.

Emergency Benefits

True, medically necessary emergency care (even if received from a non-participating provider) is always covered as a standard HMO benefit.

Prescription Drugs

You may have prescriptions filled when utilizing the point-of-service benefit. You will be covered at 80% of the BlueCHiP, Coordinated Health Partners after a $40 copay. The benefits and requirements are the same as those for the standard HMO Prescription Drug Benefit.

What is Not Covered

- Anesthesia consultations
- Chiropractic care
- Diagnostic procedures, such as laboratory tests and x-rays
- Durable Medical Equipment (DME) and medical supplies
- Emergency room visits
- Home health services
- Infertility services
- Mental conditions/substance abuse benefits
- Outpatient physical, speech and occupational therapies, cardiac rehabilitation
- Rehabilitation hospitalizations
- Skilled nursing facility care
- Transplant coverage
- Vision care benefits

How to Obtain Benefits

If you receive services from a non-participating provider, you may be required to pay up front and submit to us for reimbursement. Please call Customer Service at 401-274-3500 from within the State of Rhode Island or toll free at 1-800-564-0888 from outside of Rhode Island for a claim form. We will provide you with a form within 15 days of your request. Submit the claim to Basic Claims Administration, 444 Westminster Street, Providence, RI 02903 as soon as possible. You must submit a complete claim form by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

Section 5 (j). 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 a FEHB disputed claim about them.** Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

Medicare prepaid plan

Enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 46, annuitants and former spouses with FEHBP coverage and Medicare Part B may elect to drop their FEHBP coverage and enroll in a Medicare prepaid plan when one is available in their area. They may then later re-enroll in the FEHBP Program. Most federal annuitants have Medicare Part A. Those **without** Medicare Part A may join this Medicare pre-paid plan but will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHBP enrollment and changing to a Medicare prepaid plan. Contact us at 1-800-505-2583 for information on the Medicare prepaid plan and the cost of that enrollment.

If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 1-800-505-2583 for information on the benefits available under the Medicare HMO.

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

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *What Services Require Our Prior Approval* on page 11.**

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; or
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

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

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, hospital, and drug

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 401-274-3500 from within the State of Rhode Island or toll-free at 1-800-564-0888 from outside of Rhode Island.

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

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

Submit your claims to: **Basic Claims Administration**
444 Westminster Street
Providence, Rhode Island 02903

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:15 LaSalle Square, Providence, RI 02903; 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, if applicable, arrange for the health care provider to give you the care); or

(b) Write to you and maintain our denial — go to step 4; or

(c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.

3 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, Health Benefits Contracts Division 3, 1900 E Street, NW, Washington, DC 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 more than one claim, you must clearly identify which documents apply to which claim.
Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

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

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

If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied 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 401-274-3500 from within the State of Rhode Island or toll-free at 1-800-564-0888 from outside Rhode Island 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 expedited treatment too, or
- You may call OPM's Health Benefits Contracts Division 3 at 202/606-0755 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

• What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

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

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

• The Original Medicare Plan (Part A or Part B)

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

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care. *Your care must continue to be authorized by your Plan PCP, or precertified as required.*

Claims process when you have the Original Medicare Plan

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

- When we are the primary payer, we process the claim first.

- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will then provide secondary benefits for the covered charges. You will not need to do anything. To find out if you need to do something to file your claims, call us at 401-274-3500 from within Rhode Island or toll –free at 1-800-564-0888 from outside of Rhode Island.

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

(Primary payer chart begins on 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, or	✓	
b) The position is not excluded from FEHB		✓
(Ask your employing office which of these applies to you.)		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' compensation	
B. When you — or a covered family member — have Medicare based on end stage renal disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and…		
1) Are eligible for Medicare based on disability, and		
a) Are an annuitant, or	✓	
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 our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive cost-sharing for your FEHB coverage.

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. 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 enroll in Medicare Part A or Part B, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE and CHAMPVA

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

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the program.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our providers.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State Program.

When other Government agencies are responsible for your care

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

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 12.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

Covered services

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

Custodial care

Custodial care means non-medical care, including room and board, provided to you if you have a mental or physical condition and require assistance in your daily living or personal needs. Custodial care can be provided by persons without professional skills or training who can assist you with dressing, bathing, eating, taking medication and preparation for special diets. Care that exceeds 90 days may also be classified as Long term care.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.

Experimental or investigational services

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

Group Health Coverage

A plan maintained by an employer to provide medical care, directly or indirectly, to employees, ex-employees and their families

Medical necessity

Medical necessity means the health care service provided to treat your illness or injury. The services must: 1) be essential to the diagnosis, treatment, or care of your condition; 2) be commonly and customarily recognized in your provider's profession as appropriate for your diagnosis; 3) be performed in the most cost-effective manner or at a location providing a less intensive level of care; and 4) not be determined by us to be experimental or investigational.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:

(a) the amount the provider charges for the service or
(b) the maximum amount we pay any provider for that service

Us/We	Us and we refer to *BlueCHiP, Coordinated Health Partners, Inc.*
You	You refers to the enrollee and each covered family member.

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

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

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

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

Children's Equity Act

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

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

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (of 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 the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as temporary continuation of coverage (TCC).

When you lose benefits

•When FEHB coverage ends

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

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

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

• Spouse equity coverage

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

•Temporary Continuation of coverage

If you leave Federal service, or if you lose coverage because you no longer qualify as family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

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

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

•Converting to individual coverage

You may convert to a non-FEHB individual policy if:

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

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

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

•Getting a Certificate of Group Health Plan Coverage

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

Long Term Care Insurance Is Still Available!

Open Season for Long Term Care Insurance

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

FEHB Doesn't Cover It

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

You Can Also Apply Later, But…

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

You Must Act to Receive an Application

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

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

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

Summary of benefits for the BlueCHiP, Coordinated Health Partners, Inc. 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; $25 specialist	14
Services provided by a hospital: • Inpatient	$500 per admission copay	31
• Outpatient	Nothing	32
Emergency benefits: • In-area	$50 per emergency room visit; $25 for urgent care center visit; $15 for primary care office visit; $25 for specialist office visit	34
• Out-of-area	$50 per emergency room visit; $25 for urgent care center visit; $15 for primary care office visit; $25 for specialist office visit	34
Mental health and substance abuse treatment	Regular cost sharing.	36
Prescription drugs	$7 for formulary generic drugs; $25 for formulary brand drugs; $40 for non-formulary drugs at a participating pharmacy for each 30-day supply; $40 copay then 20% at a non-participating pharmacy. Mail Order: $14 for formulary generic; $50 for formulary brand drugs; $80 for non-formulary drugs for a 90-day supply.	38
Dental Care	No benefit.	41
Vision Care Annual Eye Exam Eyeglasses	 $25 per office visit Nothing for one pair of eyeglasses to correct impairment directly caused by intraocular surgery; No other benefit for eyeglasses.	21
Special features: *Reciprocity Benefit; High Risk Pregnancy*		40
Point of Service benefits — Yes		42
Protection against catastrophic costs (your catastrophic out-of-pocket maximum)	Nothing for in-network inpatient admissions after $1,000 per person/$2000 per family per calendar year	12

2003 Rate Information for
BlueCHiP, Coordinated Health Partners

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
Location Information							
High Option **Self Only**	**DA1**	**$109.30**	**$53.09**	**$236.82**	**$115.03**	**$129.03**	**$33.36**
High Option Self & Family	**DA2**	**$249.62**	**$166.16**	**$540.84**	**$360.02**	**$294.70**	**$121.08**