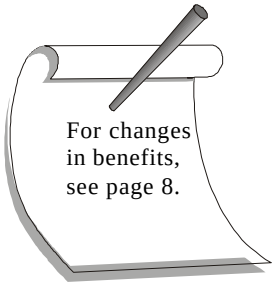
Blue Cross-HMO 2003

http:// www.bluecrossca.com

A Health Maintenance Organization



Serving: Most of California

Enrollment in this Plan is limited. You must live or work in our geographic area to enroll. See page 7 for requirements.

Enrollment Code:
M51 Self Only
M52 Self and Family

This Plan has a commendable rating from the NCQA. See the 2003 *Guide* for more information on accreditation.

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 73-517

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

OFFICE OF THE DIRECTOR

Dear Federal Employees Health Benefits Program Participant:

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

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

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

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

Sincerely,

Kay Coles James
Director

Notice of the Office of Personnel Management's

Privacy Practices

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table of Contents

Introduction

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

This brochure describes the benefits of the Blue Cross – HMO under our contract (CS 2514) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. 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 Blue Cross.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

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

Stop Health Care Fraud

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

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

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 records or recommend services.
- Avoid using health care providers who say that an item 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 services.
- 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 800-235-8631and explain the situation.
    - If we do not resolve the issue:

CALL: THE HEALTH CARE FRAUD HOTLINE
202/418-3300

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

- Do not maintain as a family member on your policy:
    - your former spouse after a divorce decree or annulment is final (even if a court 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 of 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. Blue Cross is solely responsible for the selection of these providers in your area. Contact Blue Cross for a copy of our 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 and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

Who provides my health care?

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

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

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

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

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

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

How we pay providers

Your medical group is paid a set amount for each member per month. Your medical group may also get added money for some types of special care or for overall efficiency, and for managing services and referrals. Hospitals and other health care facilities are paid a set amount for the kind of service they provide to you or an amount based on a negotiated discount from their standard rates. If you want more information, please call us at 800-235-8631, or you may call your medical group.

You do not have to pay any Blue Cross HMO provider for what we owe them, even if we don't pay them. But you may have to pay a non-Plan provider any amounts not paid to them by us.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about your health plan, its networks, providers, and facilities. You can also find out about care management, which includes medical practice guidelines, disease management programs and how we determine if procedures are experimental or investigational. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you.

If you want specific information about us, call 800-235-8631, or write to P.O. Box 4089, Woodland Hills, CA 91365. You may also contact us by fax at 818-234-6401, or visit our website at www.bluecrossca.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:

Northern California

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

Southern California

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

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

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

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

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

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency or urgent care services. 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 you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 2003

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

Program-wide changes

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

Changes to this Plan

- Your share of the non-Postal premium will increase by 26.7% for Self Only or 35% for Self and Family.
- Coverage will be provided for certain routine patient care costs for a member who has been accepted into an approved clinical trial for cancer and whose personal physician has obtained prior authorization from the plan.
- Coverage will be provided for hospice care when a member's terminal illness has a prognosis of life of one year, if the disease follows its normal course.
- The brochure has been clarified to show that coverage is not provided for scalp/hair prosthesis or any form of hair replacement.

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 participating 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 800/235-8631 or write to us at Blue Cross of California, P.O. Box 4089, Woodland Hills, Ca. 91365. You may also request replacement cards through our website at www.bluecrossca.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance, and you will not have to file claims. For treatment of a mental health or substance abuse condition you may request an authorized referral to a non-Plan provider. See Mental Health and Substance Abuse Benefits (Section 5e) for details.

- **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. Your primary care physician will be the first doctor you see for all your health care needs. If you need special kinds of care, this doctor will refer you to other kinds of health care providers. This decision is important since your primary care physician provides or arranges for most of your health care. Your primary care physician will be part of a Blue Cross HMO contracting medical group. There are two types of Blue Cross HMO medical groups:

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

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

- You must live or work within 30 miles of the medical group.
- You and your family members do not have to enroll in the same medical group.

- **Primary care**

Your primary care physician can be a general or family practitioner, internist or pediatrician. Certain specialists we may approve may also be designated primary care physician. 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 doctor may refer you to another physician if you need special care. Your primary care physician must approve all the care you get except when you have an emergency or need urgent care.

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

- You will need to make the appointment at the other doctor's office.
- Your primary care physician will give you a referral form to take with you to your appointment. This form gives you the approval to get this care. If you don't get this form, ask for it or talk to your Blue Cross HMO coordinator.
- You may have to pay a copayment. You shouldn't get a bill, unless it is for a copayment, for this service. If you do, send it to your Blue Cross HMO coordinator at your primary medical group right away. The medical group will see that the bill is paid. If you need additional help you can call our customer service department.

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

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

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

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

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

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

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

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

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

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

Ready Access. There are two ways you may get special care without getting an approval from you medical group. These two ways are the "Direct Access" and "Speedy Referral" programs. Not all medical groups take part in the Ready Access program. See your Blue Cross HMO Directory for those that do.

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

- Allergy
- Dermatology
- Ear/Nose/Throat

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

Speedy Referral. If you need special care, your primary care physician may be able to refer you for it without getting an approval from your medical group first. The types of special care you can get through Speedy Referral depend on your medical group.

If You Are A Woman

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

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

When You Want a Second Opinion

Your medical group is responsible for arranging second opinions and specialty care with health care providers who are part of or who are affiliated with your Blue Cross HMO medical group. Working with your medical group supports and improves the coordination and quality of your medical care.

If your primary care physician referred you to a specialist (called a "group" specialist) and you want a second opinion, you have the right to a second opinion by an appropriately qualified health care professional who is part of the Blue Cross HMO provider network. If there is no appropriately qualified health care professional in the network, we will authorize a second opinion by another appropriately qualified health care professional, taking into account your ability to travel.

Reasons for asking for a second opinion include, but are not limited to:

- Questions about whether recommended surgical procedures are reasonable or necessary.

- Questions about the diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to a serious chronic condition.
- The clinical indications are not clear or are complex and confusing.
- A diagnosis is in doubt because of test results that do not agree.
- The first doctor is unable to diagnose the condition.
- The treatment plan in progress is not improving your medical condition within an appropriate period of time.
- You have tried to follow the treatment plan or you have talked with the specialist about serious concerns you have about your diagnosis or plan of care.

To ask for a second opinion about recommendations by your primary care physician, call your primary care physician or your Blue Cross HMO coordinator at your medical group.

To ask for a second opinion from a specialist outside your medical group, please call us at 800/235-8631. The customer service representative will verify your Blue Cross HMO membership, get preliminary information, and give your request to an RN case manager.

A decision is made within five business days from when we get the information necessary to make a decision. Decisions on urgent requests are made within a time frame appropriate to your medical condition and no later than the next business day.

When approved, your case manager helps you with selecting a Blue Cross HMO specialist within a reasonable travel distance and makes arrangements for your appointment at a time convenient for you and appropriate to your medical condition. If your medical condition is serious, your appointment will be scheduled within no more than seventy-two (72) hours. Your case manager will work with you and your medical group to make sure the specialist has your medical records before your appointment. Except for your usual co-payment, we cover the specialist's fee.

An approval letter is sent to you and the specialist. The letter includes the services approved and the date of your scheduled appointment. It also includes a toll free number to call your case manager if you have questions or need additional help. Approval is for the second opinion consultation only. It does not include any other services such as lab, x-ray, or treatment by the specialist. You and your primary care physician will get a copy of the specialist's report, which includes any recommended diagnostic testing or procedures. When you get the report, you and your primary care physician or group specialist should work together to determine your treatment options and develop a treatment plan. Your medical group must authorize all follow-up care.

Only our Medical Director may decide when we will not cover the fees for a specialist you choose. This may happen when you choose a specialist who is not part of the Blue Cross HMO network and the same kind of specialist is available in the network. If your request is not approved, the letter we send you will include the names of the specialists that can be approved.

You may appeal a disapproval decision by following our complaint process. Procedures for filing a complaint are described later in this booklet under Section 8 and in your denial letter.

If you have questions or need more information about this program, please contact your Blue Cross HMO coordinator at your medical group or call us at 800/235-8631.

Here are other things you should know about specialty care:

- 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.

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**

There may be a time when your primary care physician says you need to go to the hospital. If it is not an emergency, the medical group will look into whether or not it is medically necessary. If the medical group approves your hospital stay, you will need to go to a hospital that works with your medical group. The same is true for admissions 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 800/235-8631. 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.

Section 4. Your costs for covered services

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

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

  Example: When you see your primary care physician you pay a copayment of $10 per office visit.

- **Deductible** — This Plan does not have a deductible.

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

  Example: In our Plan, you pay 50% of our allowance for infertility services.

Your catastrophic protection out-of-pocket maximum

After your copayments total $1,000 for one family member or $3,000 for three or more family members in any calendar year, you do not have to pay any more for covered services. However, copayments or coinsurance for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments or coinsurance for these services:

- *Prescription drug benefits*
- *Infertility services*

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

Section 5. Benefits – OVERVIEW

(See page 8 for how our benefits changed this year and page 63 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 800/235-8631 or at our website at www.bluecrossca.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.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office……	$10 per office visit
Professional services of physicians • In an urgent care center…… • During a hospital stay…….. • In a skilled nursing facility……... • Office medical consultations…… • Second surgical opinion……...	Nothing Nothing Nothing $10 per office visit $10 per office visit
Professional services of physicians • At home	$10 per visit
Lab, X-ray and other diagnostic tests	**You pay**
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
• Full physical exams and periodic check-ups ordered by your primary care physician……	$10 per office visit
• Eye exams to determine the need for vision correction. Vision exams include a vision check by your primary care physician to see if it is medically necessary for you to have a complete vision exam by a vision specialist. If approved by your primary care physician, this may include an exam with diagnosis, a treatment program and refractions……	Nothing
• Ear exams to determine the need for hearing correction. Hearing exams include tests to diagnose and correct hearing……	Nothing
• Health screenings as prescribed by your primary care physician, such as mammograms, Pap tests and any cervical cancer screening tests approved by the U.S. Food and Drug Administration, prostate cancer screenings, sigmoidoscopies, colonoscopies and all other medically accepted cancer screening tests……..	Nothing
• Immunizations prescribed by your primary care physician……..	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*

Preventive care, (all enrolled children regardless of age)	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Well-child care for routine examinations and care, such as:	
-- Full physical exams and periodic check-ups ordered by your primary care physician ……	Nothing
-- Eye exams to determine the need for vision correction. Vision exams include a vision check by your primary care physician to see if it is medically necessary for you to have a complete vision exam by a vision specialist. If approved by your primary care physician, this may include an exam with diagnosis, a treatment program and refractions……	Nothing
-- Ear exams to determine the need for hearing correction. Hearing exams include tests to diagnose and correct hearing……	Nothing

Maternity care	You pay
Complete maternity (obstetrical) care, such as:	
• Prenatal care…….	$10 per office visit
• Delivery……	Nothing
• Postnatal care……...	$10 per office visit
Note: Here are some things to keep in mind:	
• You do not need to precertify your normal delivery.	
• You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary.	
• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Newborn circumcision is covered under Surgery benefits (See 5b).	
• We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	

Family planning	You pay
A broad range of voluntary family planning services, such as:	
• Voluntary sterilization for females (tubal ligation)……..	$150
• Voluntary sterilization for males (vasectomy)…….	$50
• Family planning visits …….	$10 per office visit
• Shots and implants for birth control (such as Depo provera)……	Nothing
• Intrauterine contraceptive devices (IUDs) and diaphragms, dispensed by a doctor……...	Nothing
• Doctor's services to prescribe, fit and insert an IUD or diaphragm……..……	$10 per office visit
• Genetic testing, when medically necessary……..	Nothing
NOTE: Oral contraceptives are covered under the prescription drug benefit.	
Not covered: Reversal of voluntary surgical 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)* Note: We cover fertility drugs under the prescription drug benefit.	50% for all care
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* *--in vitro fertilization* *--embryo transfer, gamete GIFT and zygote ZIFT* *--Zygote transfer* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*

Allergy care	You pay
Testing and treatment…….	$10 per office visit
Allergy serum……	Nothing

Treatment therapies	You pay
• Chemotherapy and radiation therapy……	Nothing
• Respiratory and inhalation therapy……	Nothing
• Dialysis – Hemodialysis and peritoneal dialysis……	Nothing
• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy…….	Nothing
• Growth hormone therapy when approved by your primary care physician……..	Nothing

Physical and occupational therapies and cardiac rehabilitation	You pay
• Visits for rehabilitation, such as physical therapy and occupational therapy when prescribed by your physician for the services of each of the following: --qualified licensed physical therapists; and --licensed occupational therapists.	Nothing
• Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 60 days.	Nothing
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*

Speech therapy	You pay
• Visits to a licensed speech therapist when prescribed by your physician.	Nothing

Hearing services (testing, treatment, and supplies)	You pay
• Hearing testing which includes screenings to diagnose and correct hearing	Nothing
Not covered: • Hearing aids or services for fitting or making a hearing aid	*All charges*

Vision services (testing, treatment, and supplies)	You pay
• Vision screening includes a vision check by your primary care physician to see if it is medically necessary for you to have a complete vision exam by a vision specialist. If approved by your primary care physician, this may include an exam with diagnosis, a treatment program and refractions.	Nothing
Not covered: • *Eyeglasses or contact lenses* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive laser surgeries*	*All charges*

Foot care	You pay
We cover medically necessary care for the diagnosis and treatment of conditions of the foot, when prescribed by your physician. See durable medical equipment for information on podiatric shoe inserts.	$10 per office visit
Not covered: • *Routine foot care*	*All charges*

Orthopedic and prosthetic devices	You pay
• Surgical implants	Nothing
• Artificial limbs or eyes	Nothing
• The first pair of contact lenses or eye glasses when needed after a covered and medically necessary eye surgery	Nothing
• Breast prostheses following a mastectomy	Nothing
• Prosthetic devices to restore a method of speaking when required as a result of a laryngectomy	Nothing
• Colostomy supplies	Nothing
• Supplies needed to take care of these devices	Nothing
Not covered: • *Orthopedic shoes (except when joined to braces) or shoe inserts (except custom molded orthotics). This does not apply to shoes and inserts designed to prevent or treat foot complications due to diabetes.* • *Scalp hair prosthesis including wigs and any other form of hair replacement.*	*All charges*

Durable medical equipment (DME)	You pay
• You can rent or buy up to **$2,000 (a calendar year)** of long-lasting medical equipment (called durable medical equipment) and supplies if they are: --Ordered by your Plan physician. --Used only for the health problem. --Used only by the person who needs the equipment or supplies. --Made only for medical use. We cover items such as: • Hospital beds • Wheelchairs • Insulin pumps • Surgical bras **Note:** Covered medical supplies include therapeutic shoes and inserts designed to prevent foot complications due to diabetes.	Nothing
Durable Medical Equipment is Not covered if: --It is needed only for your comfort or hygiene. --It is for exercise. --It is needed for making the room or home comfortable, such as air conditioning or air filters.	*All charges*

Home health services	You pay
You can get the following home health care, furnished by a home health agency (HHA): • Care from a registered nurse • Physical therapy, occupational therapy, speech therapy, or respiratory therapy • Visits with a medical social service worker • Care from of a health aide who works under a registered nurse with the HHA. • Services include oxygen therapy, intravenous therapy and medications	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charge*
Chiropractic Care	**You pay**
Covered up to 20 visits in a year when you see a chiropractor in the American Specialty Health Plans (ASHP) network. Also up to $50 per calendar year in rental or purchase charges are covered for medical equipment and supplies ordered by an ASHP chiropractor, and approved as medically necessary by ASHP. Such medical equipment includes: (1) elbow, back, thoracic, lumbar, rib or wrist supports; (2) cervical collars or pillows; (3) ankle, knee, lumbar, or wrist braces; (4) heel lifts; (5) hot or cold packs; (6) lumbar cushions; (7) orthotics; and (8) home traction units for treatment of the cervical or lumbar regions. **Note:** The *ASHP* chiropractor is responsible for obtaining the necessary approval from the Plan.	$10 per office visit
Not covered: • *Any services provided by ASHP that are not approved by us, except for the first visit;* • *The services of a non-ASHP chiropractor.*	*All charges*
Alternative treatments	**You pay**
Acupuncture – Medically necessary acupuncture if referred by your primary care physician and approved by the medical group, for the treatment of chronic pain.	$10 per office visit
Not covered: • Acupressure, or massage to help pain, treat illness or promote health by putting pressure to one or more areas of the body	*All charges*

Educational classes and programs	You pay
Coverage is limited to: • Diabetes self-management programs supervised by a doctor to teach you and your family members about the disease and how to take care of it. This includes training, education and nutrition therapy to enable you to use the equipment, supplies and medicines needed to manage the disease. • Other health education programs given by your primary care physician or the medical group. Ask about our many programs to: --Educate you about living a healthy life --Get a health screening --Learn about your health problem	Usually Nothing- Separate copayments may apply to some programs. Call us for more information.

Cancer Clinical Trials	You pay

Routine patient care costs, as defined below, for phase I, phase II, phase III and phase IV cancer clinical trials
 	
All of the following conditions must be met:
 	
• The treatment you get in a clinical trial must either:
  • Involve a drug that is exempt under federal regulations from a new drug application, or
  • Be approved by (i) one of the National Institutes of Health, (ii) the U.S. Food and Drug Administration in the form of an investigational new drug application, (iii) the United States Department of Defense, or (iv) the United States Veteran's Administration.
• You must have cancer to be able to participate in these clinical trials.
• Participation in these clinical trials must be recommended by your primary care physician after deciding it will help you.
• For the purpose of this provision, a clinical trial must have a therapeutic intent. Clinical trials to just test toxicity are not included in this coverage.
 	
Routine patient care costs are the costs associated with the services provided, including drugs, items, devices and services which would otherwise be covered under the Plan, including health care services which are:
 	
• Typically provided absent a clinical trial.
• Required solely to provide the investigational drug, item, device or service.
• Clinically appropriate monitoring of the investigational item or service.
• Prevention of complications arising from the provision of the investigational drug, item, device, or service.
• Reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or care of the complications.
	$10 per office visit
	
	Nothing for all other services

Not covered: • Drugs or devices not approved by the U.S. Food and Drug Administration that are part of the clinical trial. • Services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses that you may need because of the treatment you get for the purposes of the clinical trial. • Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient. • Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the Plan. • Health care services usually provided by the research sponsors free of charge to members enrolled in the trial.	*All charges*

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.
- 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. Any costs associated with the facility charge (i.e. hospital, surgical center, etc.) are covered in Section 5 (c).

IMPORTANT

Benefit Description	You pay
Surgical procedures	
A comprehensive range of services, such as: • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Any medically necessary eye surgery • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Treatment of burns • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity as determined by your medical group, when the treatment is approved in advance • Insertion of internal prostethic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information. **Note:** Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits or a pacemaker and Surgery benefits for insertion of the pacemaker.	Nothing
• Voluntary sterilization for female (tubal ligation)……. • Voluntary sterilization for male (vasectomy)……	$150 $50
Not covered: • *Reversal of voluntary sterilization;* • *Radial keratotomy and other refractive laser surgeries.*	*All charges*

Reconstructive surgery	You pay
• Reconstructive surgery performed to correct deformities caused by congenital or developmental abnormalities, illness, or injury for the purpose of improving bodily function, reducing symptoms or creating a normal appearance.	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 this 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. This does not apply to surgery you might need to:* *-- give you back the use of a body part* *-- have a breast reconstruction after a mastectomy* *-- Correct or repair a deformity caused by birth defects, abnormal development, injury or illness in order to improve function, symptomatology or create a normal appearance.* *Cosmetic surgery does not become reconstructive because of psychological or psychiatric reasons.* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	**You pay**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Splint therapy or surgical treatment for disorders of the joints linking the jawbones and the skull (the temporomandibular joints); including the complex of muscles, nerves and other tissues related to those joints; 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 • Kidney • Liver • Lung: Single –Double • Pancreas • Allogenic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-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, when approved by the Plan medical director • Autologous tandem transplants for testicular and other 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 Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *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
Dental Care– General anesthesia and facility services when dental care must be provided in a hospital or ambulatory surgery center when you are: • Less than seven years old; • Developmentally disabled; or • Your health is compromised and general anesthesia is medically necessary. **Note**: No benefits are provided for the dental procedure itself or for the professional services of a dentist to do the dental procedure.	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.
- 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).

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.	Nothing

Inpatient hospital continued on next page.

Inpatient hospital *(Continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood transfusions. This includes the cost of blood, blood products or blood processing • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services **Note**: Inpatient hospital services are covered for dental care only when the stay is: --Needed for dental care because of other medical problems you may have; --Ordered by a doctor (M.D.) or a dentist (D.D.S.); and --Approved by the medical group.	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, convalescent care facilities, schools, etc.* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	**You pay**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service	Nothing
Dental Care– Facility services when dental care must be provided in a hospital or ambulatory surgery center when you are: • Less than seven years old; • Developmentally disabled; or • Your health is compromised and general anesthesia is medically necessary. **Note**: No benefits are provided for the dental procedure itself or for the professional services of a dentist to do the dental procedure.	Nothing

Skilled nursing care facility benefits	You pay
We cover the following care in a skilled nursing facility for up to **100 days in a calendar year**. • A room with two or more beds • Special treatment rooms • Regular nursing services • Laboratory tests • Physical therapy, occupational therapy, speech therapy, or respiratory therapy • *Drugs* and medicines given during your *stay*. This includes oxygen. • Blood transfusions • Needed medical supplies and appliances	Nothing
Not covered: custodial care	*All charges*

Hospice care	You pay
We cover the following hospice care if you have an illness that may lead to death within one year. Your primary care physician will work with the hospice and help develop your care plan. The hospice must send a written care plan to your medical group every 30 days. • Interdisciplinary team care to develop and maintain a plan of care • Short-term inpatient hospital care in periods of crisis or as respite care. Respite care is provided on an occasional basis for up to five consecutive days per admission • Physical therapy, occupational therapy, speech therapy and respiratory therapy • Social services and counseling services • Skilled nursing services given by or under the supervision of a registered nurse • Certified home health aide services and homemaker services given under the supervision of a registered nurse • Diet and nutrition advice; nutrition help such as intravenous feeding or hyperalimentation • Volunteer services given by trained hospice volunteers directed by a hospice staff member • Drugs and medicines prescribed by a doctor • Medical supplies, oxygen and respiratory therapy supplies • Care which controls pain and relieves symptoms • Bereavement services, including assessing the needs of the bereaved family and developing a care plan to meet those needs, both before and after death. Bereavement services are available to covered members of the immediate family (spouse, children, step-children, parents, brothers and sisters) for up to one year after the employee's or covered family member's death	Nothing
Not covered: Independent nursing, homemaker services	*All charges*

Ambulance	You pay
You can get these services from a licensed ambulance in an emergency or when ordered by your primary care physician. (We will provide benefits for these services if you receive them as a result of a 9-1-1 emergency response system call for help if you think you have an emergency.) Air ambulance is also covered, but, only if ground ambulance service can't provide the service needed. Air ambulance service, if medically necessary, is provided only to the nearest hospital that can give you the care you need. • Base charge and mileage • Disposable supplies • Monitoring, EKG's or ECG's, cardiac defibrillation, CPR, oxygen, and IV Solutions IN SOME AREAS, THERE IS A 9-1-1 EMERGENCY RESPONSE SYSTEM. THIS SYSTEM IS TO BE USED ONLY WHEN THERE IS AN EMERGENCY.	Nothing

Section 5 (d). Emergency services

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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 is urgent care?

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

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

What to do in case of emergency:

If you need emergency services, get the medical care you need right away. In some areas, there is a 9-1-1 emergency response system that you may call for emergency services (this system is to be used only when there is an emergency that requires an emergency response).

Once you are stabilized, your primary care physician must approve any care you need after that.

- Ask the hospital or emergency room doctor to call your primary care physician.
- Your primary care physician will approve any other medically necessary care or will take over your care.

You may need to pay a copayment for emergency room services. We cover the rest.

If You Are In-Area. You are in-area if you are 20 miles or less from your medical group (or 20 miles or less from your medical group's hospital, if your medical group is an independent practice association).

If you need emergency services, get the medical care you need right away. If you want, you may also call your primary care physician and follow his or her instructions.

Your primary care physician or medical group may:

- Ask you to come into their office;
- Give you the name of a hospital or emergency room and tell you to go there;
- Order an ambulance for you;
- Give you the name of another doctor or medical group and tell you to go there; or
- Tell you to call the 9-1-1 emergency response system.

If You're Out of Area. You can still get emergency services if you are more than 20 miles away from your medical group.

If you need emergency services, get the medical care you need right away (follow the instructions above for What to do in case of emergency). In some areas, there is a 9-1-1 emergency response system that you may call for emergency services (this system is to be used only when there is an emergency that requires an emergency response). You must call us within 48 hours if you are admitted to a hospital.

Remember:

- We won't cover services that do not fit the description of medical emergency on page 32.
- Your primary care physician must approve care you get once you are stabilized, unless Blue Cross HMO approves it.
- Once your medical group or Blue Cross HMO gives an approval for emergency services, they cannot withdraw it.

Benefit Description	You pay
Emergency inside or outside of our service area	
• Emergency care at a doctor's office ……	$10 per office visit
• Emergency care at an urgent care center……	$25 per visit
• Emergency care on an outpatient basis at a hospital (if care results in admission to a hospital, the copayment will not apply)……	$25 per visit
• Emergency care at a hospital on an inpatient basis……	Nothing
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*

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

IMPORTANT

Cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- 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 can get care for outpatient professional treatment of mental health and substance abuse conditions by a Plan provider without getting prior approval from your medical group. In order for care to be covered, you must go to a Plan provider. You can get a directory of Plan providers from us by calling 800/235-8631. You must get prior approval for all inpatient facility based care and any visits to a non-Plan provider. Please see Medical Management Programs on page 35 for more information.**

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
We will cover services for the treatment of mental health and substance abuse conditions provided by a Plan provider. We will also cover services of a non-Plan provider if an authorized referral is obtained.	Cost sharing and limitations for benefits that we cover (for example, visit/day limits, coinsurance, copayments, and catastrophic protection out-of-pocket maximums) for mental health and substance abuse are based on the cost sharing and limits for similar benefits under our network medical, hospital, prescription drug, diagnostic testing, and surgical benefits.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers……...	$10 per office visit
• Medication management…..……..	$10 per office visit
• Diagnostic laboratory or x-ray tests…….……	Nothing
• Facility-based care (care provided in a hospital, psychiatric health facility, or residential treatment center)……. *Note: If facility based care is not approved by us before you get care, we **will not provide benefits.** Please see Medical Management Programs on page 35 for more information.*	Nothing
Not covered: • Services we have not approved. ***Note:** OPM's review of disputes about network treatment plans will be based on the treatment plan's clinical appropriateness. OPM will generally not order one clinically appropriate treatment plan in favor of another.*	*All charges*

Medical Management Programs for Mental Health and Substance Abuse Conditions

Medical Management Programs apply only to the treatment of mental health and substance abuse conditions for the following services:

- facility based care (facility based care is care provided in a hospital, psychiatric health facility, or residential treatment center) and
- authorized referrals to non-Plan providers.

The medical management programs are set up to work together with you and your physician to be sure that you get appropriate medical care and avoid costs you weren't expecting.

You don't have to get a referral from your primary care physician when you go to a Plan provider for professional services, such as counseling, for the treatment of mental health and substance abuse conditions. You can get a directory of Plan providers who specialize in the treatment of mental health and substance abuse conditions from us by calling 800/235-8631.

Your primary care physician must provide or coordinate all other care and your medical group must approve it.

We have two medical management programs for treatment of mental health and substance abuse conditions:

- The Utilization Review Program applies to facility-based care for the treatment of mental health and substance abuse conditions.
- The Authorization Program applies to referrals to non-Plan providers.

We will pay benefits only if you are covered at the time you get services, and our payment will follow the terms and requirements of this Plan.

Utilization Review Program

The utilization review program looks at whether care is medically necessary and appropriate, and the setting in which care is provided. We will let you and your physician know if we have determined that services can be safely provided in an outpatient setting, or if we recommend an inpatient stay. We certify and monitor services so that you know when it is no longer medically necessary and appropriate to continue those services.

You need to make sure that your physician contacts us before scheduling you for any service that requires utilization review. If you get any such service without following the directions under "How to Get Utilization Reviews," no benefits will be provided for that service.

Utilization review has three parts:

- **Pre-service review.** We look at non-emergency facility-based care for the treatment of mental health and substance abuse conditions and decide if the proposed facility-based care is medically necessary and appropriate.
- **Concurrent review.** We look at and decide whether services are medically necessary and appropriate when pre-service review is not required or we are notified while service is being provided, such as with an emergency admission to a hospital.
- **Retrospective review.** We look at services that have already been provided:
  - When a pre-authorization, pre-service or concurrent review was not completed; or
  - To examine and audit medical information after services were provided.

Retrospective review may also be done for services that continued longer than originally certified.

Effect on Benefits

- When you don't get the required pre-service review before you get facility-based care for the treatment of mental health and substance abuse conditions, we **will not provide benefits** for those services.
- Facility-based care for the treatment of mental health and substance abuse conditions will be provided only when the type and level of care requested is medically necessary and appropriate for your condition. If you go ahead with any services that have been determined to be not medically necessary and appropriate at any stage of the utilization review process, we **will not provide benefits** for those services.
- When services are not reviewed before or during the time you receive the services, we will review those services when we receive the bill for benefit payment. If that review determines that part or all of the services were not medically necessary and appropriate, we **will not provide benefits** for those services.

How to Get Utilization Reviews

Remember, you must make sure that the review has been done.

Pre-Service Reviews

No benefits will be provided if you do not get pre-service review before receiving scheduled (non-emergency) services, as follows:

- You must tell your physician that this Plan requires pre-service review. Physicians who are Plan providers will ask for the review for you. The toll-free number to call for pre-service review is 800/274-7767.
- For all scheduled services that require utilization review, you or your physician must ask for the pre-service review at least three working days before you are to get services.
- We will certify services that are medically necessary and appropriate. For facility-based care for the treatment of mental health and substance abuse conditions we will, if appropriate, certify the type and level of services, as well as a specific length of stay. You, your physician and the provider of the service will get a written notice showing this information.
- If you do not get the certified service within 60 days of the certification, or if the type of the service changes, you must get a new pre-service review.

Concurrent Reviews

- If pre-service review was not done, you, your physician or the provider of the service must contact us for concurrent review. If you have an emergency admission or procedure, you need to let us know within one working day of the admission or procedure, unless your condition prevented you from telling us or a member of your family was not available to tell us for you within that time period.
- When you tell Plan providers that you must have utilization review, they will call us for you. You may ask a non-Plan provider to call the toll free number on your Member ID card or you may call directly.
- When we decide that the service is medically necessary and appropriate, we will, depending upon the type of treatment or procedure, certify the service for a period of time that is medically appropriate. We will also decide on the medically appropriate setting.
- If we decide that the service is not medically necessary and appropriate, we will tell your physician by telephone no later than 24 hours after the decision. You and your physician will receive written notice no later than one business day after the decision.

Retrospective Reviews

- We will do a retrospective review:
  - If we were not told of the service you received, and were not able to do the appropriate review before your discharge from the hospital or residential treatment center.
  - If pre-service or concurrent review was done, but services continued longer than originally certified.
  - For the evaluation and audit of medical documentation after you got the services, whether or not pre-service or concurrent review was performed.
- If such services are determined to not have been medically necessary and appropriate, we will deny certification.

Authorization Program

The authorization program provides prior approval for medical care or service by a non-Plan provider. The service you receive must be a covered benefit of this Plan.

You must get approval before you get any non-emergency or non-urgent service from a non-Plan provider for the treatment of mental health and substance abuse conditions. The toll-free number to call for prior approval is on your member ID card.

If you get any such service, and do not follow the procedures set forth in this section, no benefits will be provided for that service.

Authorized Referrals. In order for the benefits of this Plan to be provided, you must get approval **before** you get services from non-Plan providers. When you get proper approvals, these services are called authorized referral services.

Effect on Benefits. If you receive authorized referral services from a non-Plan provider, the Plan provider copayment will apply. When you do not get a referral, **no benefits are provided** for services received from a non-Plan provider.

How to Get an Authorized Referral. You or your physician must call the toll-free telephone number on your member ID card **before** scheduling an admission to, or before you get the services of, a non-Plan provider.

When an Authorized Referral Will be Provided. Referrals to non-Plan providers will be approved only when all of the following conditions are met:

- There is no Plan provider who practices the specialty you need, provides the required services or has the necessary facilities within 50-miles of your home; AND
- You are referred to the non-Plan provider by a physician who is a Plan provider; AND
- The services are authorized as medically necessary before you get the services.

Disagreements with Medical Management Program Decisions

- If you or your physician don't agree with a Medical Management Program decision, or question how it was reached, either of you may ask for a review of the decision. To request a review, call the number or write to the address included on your written notice of determination. If you send a written request it must include medical information to support that services are medically necessary.
- If you, your representative, or your physician acting for you, are still not satisfied with the reviewed decision, a written appeal may be sent to us.
- If you are not satisfied with the appeal decision, you may follow the procedures under Section 8: The disputed claims process.

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 on page 40.
- 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.** Drugs must be prescribed by a health care provider licensed to prescribe such medication, and must be given to you within one year of being prescribed.
- **Where you can obtain them.** You may fill the prescription at any licensed retail pharmacy or by our mail service program.
- **Using Participating Pharmacies.** To get medicine your physician has prescribed:
  --Go to a participating pharmacy.
  --For help finding a participating pharmacy, call us at 1-800-700-2541.
  --Show your Member ID card.
  --Pay your copayment when you get the medicine. You must also pay for any medicine or supplies that are not covered under the Plan.
  --When your prescription is for a brand name drug, the pharmacist will substitute it with a generic drug unless your physician writes "dispense as written".
- **Using Non-Participating Pharmacies. It will cost you more if you go to a non-participating Pharmacy**:
  --Take a claim form with you to the non-participating pharmacy. If you need a claim form or if you have questions, call 1-800-700-2541.
  --Have the pharmacist fill out the form and sign it.
  --Then send the claim form (within 90 days) to:

  Prescription Drug Program
  P.O. Box 4165
  Woodland Hills, CA 91365-4165

  When we first get your claim, we take out:
  --Costs for medicine or supplies not covered under the Plan,
  --Then any cost more than the limited fee schedule we use for non-participating pharmacies, and
  --Then your copayment.
  The rest of the cost is covered.
- **If you are out of state,** and you need medicine,
  --Call **1-800-700-2541** to find out where there is a participating pharmacy.
  --If there is no participating pharmacy, pay for the drug and send us a claim form.

Prescription drug benefits – CONTINUED

- **Getting your medicine through the mail.** When you order medicines through the mail, here's what to do:
  --Get your prescription from your health care provider. He or she should be sure to sign it. It must have the drug name, how much and how often to take it, how to use it, the provider's name and address and telephone number along with your name and address.
  --Fill out the order form. The first time you use the mail service program, you must also send a filled out Patient Profile questionnaire about yourself**.** Call 1-866-274-6825for order forms and the Patient Profile questionnaire.
  --Be sure to send the copayment along with the prescription and the order form and the Patient Profile. You can pay by check, money order, or credit card.
  --Send your order to:

  Blue Cross Prescription Drug Program - Mail Service
  P.O. Box 961025
  Fort Worth, TX 76161-9863
  1-866-274-6825

  --There may be some medicines you cannot order through this program. Call 1-866-274-6825 to find out if you can order your medicine through the mail service program.

- **We use a formulary.** A preferred drug list, sometimes called a formulary, is used to help your physician make prescribing decisions. This list of drugs is updated quarterly by a committee of doctors and pharmacists so that the list includes drugs that are safe and effective in the treatment of disease. If you are prescribed a non-preferred drug without "dispense as written", you will have to pay the higher copayment listed on the next page.

  You can get drugs not listed as preferred drugs for the lower copayment if the physician writes "do not substitute" or "dispense as written" on the prescription. Some drugs need to be approved - the physician or pharmacy will know which drugs they are.

  If you have questions about whether a drug is on the preferred drug list or needs to be approved, please call us at 1-800-700-2541.

  If we don't approve a request for a drug that is not part of our preferred drug list, you or your physician can appeal the decision by calling us at 1-800-700-2541. If you are not satisfied with the result, please see Section 8: The disputed claims process.

- **These are the dispensing limitations.** You can get a 30-day or 100 unit supply, whichever is less, if you get the drug at a retail pharmacy. You can get a 60-day supply of drugs at a retail pharmacy for treating attention deficit disorder if they:
  --Are FDA approved for treating attention deficit disorder;
  --Are federally classified as Schedule II drugs; and
  --Require a triplicate prescription form.
  If the physician prescribes a 60-day supply for the treatment of attention deficit disorders, you have to pay double the amount of copay for retail pharmacy. If you get the drugs through our mail service program, the copay will be the same as for any other drug.

  You can get a 90-day supply if you get the drug from our mail service program.

  Drugs for the treatment of impotence and/or sexual dysfunction are:
  --Limited to six tablets (or treatments) for a 30-day period; and
  --Available at retail pharmacies only. You must give us proof that a medical condition has caused the problem.

- **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.

Prescription drug benefits begin on the next page.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a retail pharmacy or through our mail order program: • Outpatient Drugs and medicines which require a prescription by law. Formulas prescribed by a physician for the treatment of phenylketonuria. These formulas are subject to the brand name copayment. • Oral and injectable contraceptive drugs • Prescribed contraceptive drugs and devices which are approved by the U.S. Food and Drug Administration. • Insulin, with a copayment charge applied to each vial • Diabetic supplies including insulin syringes, needles, glucose test tablets and test tape. Benedict's solution or equivalent and acetone test tablets. • Disposable needles and syringes needed for injecting covered prescribed medication • Drugs used primarily for the purpose of treating infertility • Smoking cessation drugs and medications, only if a prescription is required by law • Drugs that have FDA labeling to be injected under the skin by you or a family member • Drugs for sexual dysfunction (see limits on page 39) Here are some things to keep in mind about our prescription drug program: • At participating pharmacies, a generic equivalent will be dispensed if it is available, unless your physician specifically requires a brand name drug. • If you receive brand name drugs when there is no generic equivalent, you will still have to pay the brand name drug copayment.	**For Blue Cross Participating Pharmacies:** Preferred generic drugs: **$5 copay** per prescription or refill Brand name drugs and generic, non-preferred drugs if the physician writes "dispense as written": **$10 copay** per prescription or refill All non-preferred drugs if the physician DOES NOT write "dispense as written": **50%** of the cost of the prescription or refill **For Non-participating Pharmacies:** Generic drugs: **$5 plus 50%** of the drug limited fee schedule Brand name drugs: **$10 plus 50%** of the drug limited fee schedule **For drugs through the Mail Service Program:** Preferred generic drugs: **$5 copay** per prescription or refill Brand name drugs and generic, non-preferred drugs if the physician writes "dispense as written": **$20 copay** per prescription or refill All non-preferred drugs if the physician DOES NOT write "dispense as written": **50%** of the cost of the prescription or refill

Covered medications and supplies *(continued)*	**You pay**
Not covered: • *Immunizing agents, biological sera, blood, blood products or blood plasma.* • *Drugs and medicines you can get without a physician's prescription, except insulin or niacin for cholesterol lowering.* • *Drugs labeled "Caution, Limited by Federal Law to Investigational Use," experimental drugs. Drugs and medicines prescribed for experimental indications.* • *Any cost for a drug or medicine that is higher than what we cover.* • *Cosmetics, health and beauty aids.* • *Drugs used mainly for cosmetic purposes.* • *Drugs for losing weight, except when needed to treat morbid obesity (for example, diet pills and appetite suppressants).* • *Drugs you get outside the United States.* • *Infusion drugs, except drugs you inject under the skin yourself.* • *Herbal, nutritional and diet supplements.* • *Drugs to enhance athletic performance.*	*All charges*

Section 5 (g). Special features

Feature	Description
MedCall (24-hour nurse assessment service)	Your Plan includes MedCall, a 24-hour nurse assessment service to help you make decisions about your medical care. When you call MedCall toll free at **800-977-0037**, be prepared to provide your name, the patient's name (if you're not calling for yourself), the employee's social security number, and the patient's phone number. The nurse will ask you some questions to help determine your health care needs. Based on the information you provide, the advice may be: • Home self-care. A follow-up phone call may be made to determine how well home self-care is working. • Schedule a routine appointment within the next two weeks, or an appointment at the earliest time available (within 64 hours), with your primary care physician. • Call your primary care physician for further discussion and assessment. • To go to an urgent care center used by your primary care physician. • To go to an emergency room used by your primary care physician. • Instructions to immediately call 911. In addition to providing a nurse to help you make decisions about your health care, MedCall gives you free unlimited access to its Audio Health Library featuring recorded information on more than 100 health care topics. To access the Audio Health Library, call toll free 800-977-0037 and follow the instructions given. We have made arrangements with an independent company to make MedCall available to you as a special service. It may be discontinued without notice. **Note: MedCall is an optional service. Remember, the best place to go for medical care is your primary care physician.**

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.
- Your medical group must provide or arrange for your care.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below. See Hospital benefits (Section 5c).
- 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

We cover restorative services and supplies necessary for the initial repair (but not replacement) of sound natural teeth. The need for these services must result from an accidental injury. **You pay nothing.** Care is not covered if you damage or injure your teeth while chewing or biting.

Dental benefits

We have no other dental benefits.

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

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

Optional Dental Benefits – These are separate benefit packages that require additional premiums.

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

Dental SelectHMO & Dental Net - Dental Maintenance Organization Options: These are plans that offer members broad ranges of dental coverage at a lower cost. Under either plan, members choose their own dentist from a network of providers, and may change their dentist at any time. Once you have enrolled in Dental SelectHMO or Dental Net, your provider will perform preventive and diagnostic services and other dental services free of charge or at a greatly reduced rate.

Key Dental SelectHMO & Dental Net Advantages

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

Eyewear Savings Program for Blue Cross-HMO Members at no extra premium

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

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

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

Blue Cross Senior Secure features all of the health coverage services offered by Medicare plus some extra services Medicare does not offer. Contact Customer Service, toll free 1-888-230-7338 to obtain detailed benefits and a list of providers in your area. As indicated on page 53, you may remain enrolled in FEHBP when you enroll in a Medicare Prepaid Plan.

Benefits on this page are not part of the FEHB contract

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 we determine it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition.**

We do not cover the following:

- 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 provided by non-Plan providers unless you receive a referral or the services are for emergency or urgent care.
- Services, drugs, or supplies you receive without charge while in active military service.

Section 7. Filing a claim for covered services

How to claim benefits

You normally won't have to submit claims to us unless you receive emergency or urgent case services from a provider who doesn't contract with us. If you file a claim, please send us all of the documents for your claim as soon as possible. To obtain claim forms or other claims filing advice or answers about our benefits, contact us at 800-235-8631, or at our website at www.bluecrossca.com.

Deadline for filing your claim

Most claims will be submitted for you. However, there is a deadline for filing claims yourself. You must submit claims by December 31 of the year after the year you received the service. OPM can extend this deadline if you show that circumstances beyond your control prevented you from filing on time.

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	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: Blue Cross of California, P.O. Box 4089, Woodland Hills, Ca. 91365; 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. For additional review information regarding Review of Denials of Experimental or Investigative Treatment - go to page 49. Blue Cross will only initiate this additional review if you have not proceeded to step 4 below.
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, Insurance Contracts Division 2, 1900 E Street, NW, Washington, DC 20415-3620.

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 prior approval, then call us at 800/235-8671 and we will expedite our review; or

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

-- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or

-- You may call OPM's Insurance Contracts Division 2 at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

ADDITIONAL COMPLAINT INFORMATION

Review of Denials of Experimental or Investigative Treatment. If coverage for a proposed treatment is denied because we or your medical group determine that the treatment is experimental or investigative, you may ask that the denial be reviewed by an external independent medical review organization which has a contract with the California Department of Managed Health Care. To request this review, please call us at the telephone number listed on your identification card or write to us at Blue Cross of California, 21555 Oxnard Street, Woodland Hills, CA 91367. To qualify for this review, all of the following conditions must be met:

- You have a life threatening or seriously debilitating condition. The condition meets either or both of the following descriptions:
  - A life threatening condition or a disease is one where the likelihood of death is high unless the course of the disease is interrupted. A life threatening condition or disease can also be one with a potentially fatal outcome where the end point of clinical intervention is the patient's survival.
  - A seriously debilitating condition or disease is one that causes major irreversible morbidity.
- The proposed treatment must be recommended by either (a) a Plan provider or (b) a board certified or board eligible physician qualified to treat you who certifies in writing that the proposed treatment is more likely to be beneficial than standard treatment. This certification must include a statement of the evidence relied upon.
- If this review is requested either by you or by a qualified provider, other than a Blue Cross HMO provider, as described above, the requester must supply two items of acceptable medical and scientific evidence. This evidence consists of the following sources:
  - Peer-reviewed scientific studies published in medical journals with nationally recognized standards;
  - Medical literature meeting the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline, and MEDLARS database Health Services Technology Assessment Research;
  - Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act;
  - The American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
  - Findings, studies or research conducted by or under the auspices of federal governmental agencies and nationally recognized federal research institutes; and
  - Peer reviewed abstracts accepted for presentation at major medical association meetings.

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

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

When we are the secondary payer, we will determine what the reasonable charge for the benefit should be. After the first plan pays, we will pay either what is left of the reasonable charge or our regular benefit, whichever is less. We will not pay more than the reasonable charge. If we are the secondary payer, we may be entitled to receive payment from your primary plan.

We will always provide you with the benefits described in this brochure. Remember: even if you do not file a claim with your other plan, you must still tell us that you have double coverage.

•What is Medicare

Medicare is a health insurance program for:

- People 65 years of age or 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 Managed Care Plan is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

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

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and 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.

Tell us if you or a family member is enrolled in Original Medicare. When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

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

- 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 pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 800/235-8531.
- We will not waive any copayments or coinsurance when you have both our Plan and Medicare.

Section 9. Coordinating benefits with other coverage - CONTINUED

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…		
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		✓

Section 9. Coordinating benefits with other coverage - CONTINUED

•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).

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 any of our copayments or coinsurance 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, but we will not waive any of our copayments or coinsurance. 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 you 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 service area.

•Private contract

A physician may ask you to sign a private contract agreeing that you can be billed directly for service ordinarily covered by Original Medicare. Should you sign an agreement, Medicare will not pay any portion of the charges, and we will not increase our payment. We will still limit our payment to the amount we would have paid after Original Medicare's payment.

•If you do not enroll in Medicare Part A or Part B

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

Section 9. Coordinating benefits with other coverage - CONTINUED

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 Plan 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 or party, you must reimburse us for any services we paid for. 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

Blue Cross HMO Coordinator

Blue Cross HMO coordinator is the person at your medical group who can help you with understanding your benefits and getting the care you need.

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. You may also be responsible for additional amounts. See Section 4 - page 14.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See Section 4 – page 14.

Covered services

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

Custodial care

Custodial care is care for your personal needs. This includes help in walking, bathing or dressing. It also includes preparing food or special diets, feeding, giving medicine which you usually do yourself or any other care for which the services of a professional health care provider are not needed.

Experimental or investigational services

Experimental procedures are those that are mainly limited to laboratory and/or animal research. Investigative procedures or medications are those that have progressed to limited use on humans, but which are not generally accepted as proven and effective within the organized medical community. Any experimental or investigative procedures or medications are not covered under this Plan. Your medical group or we will determine whether a service is considered experimental or investigative. Please see page 49 for more information.

Medical necessity

Medically necessary procedures, services, supplies or equipment are those that Blue Cross decides are:

- Appropriate and necessary for the diagnosis or treatment of the medical condition;
- Provided for the diagnosis or direct care and treatment of the medical condition;
- Within standards of good medical practice within the organized medical community;
- Not primarily for your convenience, or for the convenience of your physician or another provider; and

- The most appropriate procedure, supply, equipment or service which can safely be provided. The most appropriate procedure, supply, equipment or service must satisfy the following requirements:

  There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, equipment, service or supply are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for you with the particular medical condition being treated than other possible alternatives; and

  Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and

  For hospital stays, acute care as an inpatient is necessary due to the kind of services you are receiving or the severity of your condition, and safe and adequate care cannot be received by you as an outpatient or in a less intensified medical setting.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. In most cases, our Plan allowance is equal to a rate we negotiate with providers. This rate is normally lower than what they usually charge and any savings are passed on to you.

Us/We

Us and we refer to Blue Cross of California.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

Children's Equity Act

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

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits for you 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 your children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot make any changes after retirement. Contact your employing office for further information.

When benefits and premium start

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

When you retire

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

When you lose benefits

•When FEHB coverage ends

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

-- Your enrollment ends, unless you cancel your enrollment, or

-- You are a family member no longer eligible for coverage.

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

- **Spouse equity coverage**

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

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn age 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 question. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Still Available

Open Season for Long Term Care Insurance

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

FEHB Doesn't Cover It

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

You Can Also Apply Later, But…

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

You Must Act to Receive an Application

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

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

Index

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

Summary of benefits for the Blue Cross- HMO - 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, unless you receive an authorized referral or the services are for emergency or urgent care.

Benefits	**You Pay**	**Page**
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office.....	$10 office visit copay	16
Services provided by a hospital:		
• Inpatient.....	Nothing	28
• Outpatient (other than emergency room care).....	Nothing	29
Emergency visits to a hospital emergency room or urgent care center:		
• In-area.....	$25 per visit	33
• Out-of-area.....	$25 per visit	33
Mental health and substance abuse treatment.....	Regular cost sharing	34
Prescription drugs	*Network pharmacy: $5 per preferred generic; $10 per brand name drug; 50% for non-preferred drugs.* *Non-Network pharmacy: $5 plus 50% of drug limited fee per generic; $10 plus 50% of drug limited fee per brand name drug.* *Mail Order Program: $5 per preferred generic; $20 per brand name drug; 50% for non-preferred drugs.*	40
Dental Care.....	Restorative services for accidental injury: you pay nothing. No other dental benefits.	43
Vision Care.....	Annual eye refraction; you pay nothing.	20
Special features: MedCall, a 24-hour nurse assessment service.		42
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum).....	Nothing after $1,000/Self Only or $3,000/Family enrollment per year Some costs do not count toward this protection	14

2003 Rate Information for
Blue Cross- HMO

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
Most of California							
High Option Self Only	M51	$100.04	$33.34	$216.74	$72.25	$118.37	$15.01
High Option Self and Family	M52	$249.62	$90.67	$540.84	$196.46	$294.70	$45.59