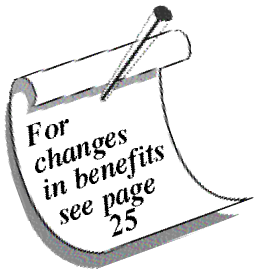
Blue Cross of Idaho
Coordinated Care Services 1998

A Health Maintenance Organization with a Point of Service product



Serving: Southwestern, Eastern and Northern Idaho

You must live or work in the service area to enroll in this Plan.

Enrollment code:
GM1 Self only
GM2 Self and family

Service area: Services from Plan providers are available only in the area described on page 9.

Special Notice: Enrollment codes ZL and ZK have been consolidated into enrollment code GM for 1998. Subscribers enrolled in codes ZL and ZK will be automatically transferred to code GM unless they enroll in another health benefits plan during the 1997 Open Season.

Authorized for Distribution by the:

United States Office of Personnel Management

Federal Employees Health Benefits Program

RI 73-426

Blue Cross of Idaho Coordinated Care Services

Blue Cross of Idaho Health Services, Inc., d.b.a. Blue Cross of Idaho Coordinated Care Services, using the brand name HMO*Blue*® (hereinafter referred to collectively as "HMO*Blue*"), 1501 Federal Way, Boise, Idaho 83705-2550, has entered into a contract (CS 2368) with the Office of Personnel Management (OPM) as authorized by the Federal Employees Health Benefits (FEHB) law, to provide a comprehensive medical plan herein called HMO*Blue* or the Plan.

This brochure is based on text included in the contract between OPM and this Plan and is intended to be a complete statement of benefits available to FEHB members. A person enrolled in the Plan is entitled to the benefits stated in this brochure. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control. If enrolled for Self and Family, each eligible family member is also entitled to these benefits.

Premiums are negotiated with each plan annually. Benefit changes are effective January 1, 1998, and are shown on the inside back cover of this brochure.

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Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD. This could result in CRIMINAL PENALTIES. Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital or pharmacy, etc., charged your plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider and ask for an explanation – sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your plan at 1-800-627-6654 and explain the situation.
- If the matter is not resolved after speaking to your plan (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E. Street, N.W., Room 6400
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain services for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

General Information

Confidentiality

Medical and other information provided to the Plan, including claim files, is kept confidential and will be used only: 1) by the Plan and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal action; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education.

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Plan. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider or Plan facility as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Plan.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system. As a member of this Plan, once your enrollment is effective, you will be covered only for services provided or arranged by a Plan doctor except in the case of emergency as described on page 15, or when you self-refer for point of service, or POS, benefits as described on page 19. If you are confined in a hospital on the effective date, you must notify the Plan so that it may arrange for the transfer of your care to Plan providers. See *"If you are hospitalized"* on page 4.

FEHB plans may not refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option, unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day or your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about: when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan; if you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period; both parent and child are covered only for care received from Plan providers, except for emergency or POS benefits.
- You will not be informed by your employing office (or your retirement system) or your Plan when a family member loses eligibility.
- You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Plan does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.
- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Plan promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. Before you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

You may also remain enrolled in this Plan when you join a Medicare prepaid plan.

Contact your local Social Security Administration (SSA) office for information on local Medical prepaid plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.

- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she generally will be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children and former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administration charge. TCC for former family members continues for up to 36 months after the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36 month period noted above.

Notification and election requirements

Separating employees - Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

Children - You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

Former spouses - You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices are available – or chosen – when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Facts about this Plan

This plan is a comprehensive medical plan, sometimes called a Health Maintenance Organization (HMO) that offers a point of service, or POS, product. Whenever you need services, you may choose to obtain them from your personal care doctor within the Plan's provider network or go outside the network for treatment. Within the Plan's network you are required to select a personal care doctor who will provide or arrange for your care and you will pay minimal amounts for comprehensive benefits. There are no claim forms when Plan doctors are used. When you choose a non-Plan doctor or other non-Plan provider under the POS option, you will pay a substantial portion of the charges and the benefits available may be less comprehensive. See page 19 for more information.

Your decision to join an HMO should be based on your preference for the plan's benefits and delivery system, not because a particular provider is in the plan's network. You cannot change plans because a provider leaves the HMO.

Because the Plan provides or arranges your care and pays the cost, it seeks efficient and effective delivery of health services. By controlling unnecessary or inappropriate care, it can afford to offer a comprehensive range of benefits. In addition to providing comprehensive health services and benefits for accidents, illness and injury, the Plan emphasizes preventative benefits such as office visits, physicals, immunizations and well-baby care. You are encouraged to get medical attention at the first sign of illness.

Who provides care to Plan members?

HMO*Blue* is a group model Health Maintenance Organization (HMO). As an HMO, HMO*Blue* is a prepaid health plan providing an extensive range of comprehensive health services for a fixed payment. The Plan coordinates multi-specialty services with convenient support services (i.e., Laboratory, Pharmacy, Physical Therapy, Radiology and X-Ray) and area hospitals.

Each new member is asked to select a primary care doctor from the available primary care physicians. If help is needed in selecting the right physician for anyone in the family, call the Plan affiliated medical center or HMO*Blue*. Once the physician is selected, all of your health care will be coordinated by him/her so that you need only call day or night for any medical problem. If the problem requires a physician of a different specialty, the primary care doctor will see that you are appropriately referred. If your primary care doctor is away because of vacation, meeting or illness, there will always be a specific physician of the same specialty taking his or her calls.

Role of a primary care doctor

The first and most important decision each member must make is the selection of a primary care doctor. The decision is important since it is through this doctor that all other health services, particularly those of specialists, are obtained. It is the responsibility of your primary care doctor to obtain any necessary authorizations from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other Plan providers are covered only when you have been referred by your primary care doctor or when you use POS benefits.

Choosing your doctor

The Plan's provider directory lists (generally family practitioners, pediatricians, and internists), with their locations and phone numbers, and notes whether or not the doctor is accepting new patients. Directories are updated on a regular basis and are available at the time of enrollment or upon request by calling the Customer Services Department at 800-627-6654. You can also find out if your doctor participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: **When you enroll in this plan, services (except for emergency benefits or POS benefits) are provided through the Plan's delivery system; the continued availability and/or participation of any one doctor, hospital, or other provider, cannot be guaranteed.**

If you enroll, you will be asked to let the Plan know which primary doctor(s) you have selected for you and each member of your family by sending a selection form to the Plan. If you need help choosing a doctor, call the Plan. Members may change their selection by notifying the Plan 30 days in advance.

If you are receiving services from a doctor who leaves the Plan, the plan will pay for covered services until the Plan can arrange for you to be seen by another participating doctor.

Referrals for specialty care

Except in a medical emergency, or when a primary care doctor has designated another doctor to see his or her patients, or when you choose to use the Plan's POS benefits, you must receive a referral from your primary care doctor before seeing any other doctor or obtaining special services. Referral to a participating specialist is given at the primary care doctor's discretion; if non-Plan specialists or consultants are required, the primary care doctor will arrange appropriate referrals.

When you receive a referral from your primary care doctor, you must return to the primary care doctor after the consultation unless your doctor authorizes additional visits. All follow-up care must be provided or authorized by the primary care doctor. Do not go to the specialist for a second visit unless your primary care doctor has arranged for, and the Plan has issued an authorization for, the referral in advance.

Except for out-of-area emergency services, covered services performed without approval or referral from a member's primary care doctor are subject to the terms of this brochure; therefore, a referral for service does not necessarily guarantee that those services are covered services. If a member receives services or schedules visits to a referred provider over and above the limits described in the referral by the primary care doctor, those services are eligible under the point of service benefits.

Authorizations

The Plan will provide benefits for covered services only when the services are medically necessary to prevent, diagnose or treat your illness or condition. Your Plan doctor must obtain the Plan's determination of medical necessity before you may be hospitalized, referred for specialty care or obtain follow-up care from a specialist.

Precertifications

Preadmission Review or Emergency Admission Review is required for all inpatient services. The primary care doctor or member must contact HMO*Blue*'s Preadmission Review Team in advance of a hospital admission or notify the Preadmission Review Team within 48 hours after an emergency admission (includes maternity and unscheduled cesarean section delivery). In the event either Preadmission Review or Emergency Admission Review is required but the primary care doctor or member fails to notify HMO*Blue*, the eligible expenses will be reduced by 50% or the copayment will be increased by $500 per admission, whichever is less.

For new members

If you are already under the care of a specialist who is a Plan participant, you must still obtain a referral from a Plan primary care doctor for the care to be covered by the Plan. If the doctor who originally referred you to this specialist is now your Plan primary care doctor, you need only call to explain that you are now a Plan member and ask that you be referred for your next appointment.

If you are selecting a new primary care doctor and want to continue with this specialist, you must schedule an appointment so that the primary care doctor can decide whether to treat the condition directly or refer you back to the specialist.

Hospital care

If you require hospitalization, your primary care doctor or authorized specialist will make the necessary arrangements and continue to supervise your care.

Out-of-pocket maximum

Copayments are required for a few benefits. However, copayments will not be required for the remainder of the calendar year after your out-of-pocket expenses for services provided or arranged by the Plan reach $1,000 per Self Only enrollment or $2,500 per Self and Family enrollment. This copayment maximum does not include charges for prescription drugs and inpatient mental health services. There is no out-of-pocket maximum for the charges you pay when you use POS benefits, as described on page 19.

You should maintain accurate records of the copayments made, as it is your responsibility to determine when the copayment maximum is reached. You are assured a predictable maximum in out-of-pocket costs for covered health and medical needs. Copayments are due when service is rendered, except for emergency care.

Facts about this Plan *continued*

Deductible carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible will be covered by your old plan if they are for care you got in January before the effective date of coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.

Submit claims promptly

When you are required to submit a claim to this Plan for covered expenses, submit your claim promptly. The Plan will not pay benefits for claims submitted later than December 31 of the calendar year following the year in which the expense was incurred, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Other considerations

Plan providers will follow generally accepted medical practice in prescribing any course of treatment. Before you enroll in this Plan, you should determine whether you will be able to accept treatment or procedures that may be recommended by Plan providers.

The Plan's service area

The service area for this Plan, where Plan providers and facilities are located, is described on the front cover of this brochure and on this page. You must live or work in the service area to enroll in this Plan.

In Southwestern Idaho, the Idaho counties of Ada, Boise, Canyon and Payette, and portions of Owyhee County as defined by the following zip codes: 83628, 83639 and 83650.

In Eastern Idaho, the Idaho counties of Bannock, Bingham, Bonneville, Franklin, Gooding, Jefferson, Jerome, Lincoln, Minidoka, Oneida, Power and Twin Falls.

In Northern Idaho, the Idaho counties of Benewah, Bonner, Boundary, Kootenai, Latah and Shoshone.

Benefits for care outside the service area are limited to emergency services, as described on page 15, and to services covered under Point of Service Benefits, as described on page 19.

If you or a covered family member move outside the service area, you may enroll in another approved plan. It is not necessary to wait until you move or for the open season to make such a change; contact your employing office or retirement system for information if you are anticipating a move.

General Limitations

Important notice

Although a specific service may be listed as a benefit, it will be covered for you only if, in the judgment of your Plan doctor, it is medically necessary for the prevention, diagnosis, or treatment of your illness or condition. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under this Plan or be used in the prosecution or defense of a claim under this plan.** This brochure is based on text included in the contract between OPM and this Plan and is intended to be a complete statement of benefits available to FEHB members. You should use this brochure to determine your entitlement to benefits. However, if conflicts are discovered between the language of this brochure and the contract, the contract will control.

Circumstances beyond Plan control

In the event of major disaster, epidemic, war, riot, civil insurrection, disability of a significant number of Plan providers, complete or partial destruction of facilities, or other circumstances beyond the Plan's control, the Plan will make a good faith effort to provide or arrange for covered services. However, the Plan will not be responsible for any delay or failure in providing service due to lack of available facilities or personnel.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Plan and all necessary documents and authorizations as requested by the Plan.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, benefits will be coordinated with Medicare according to Medicare's determination of which coverage is primary. Generally, you do not need to take any action after informing the Plan of your or your family member's eligibility for Medicare. Your Plan will provide you with further instructions if a Medicare claim needs to be filed.

Group health insurance and automobile insurance

This coordination of benefits (double coverage) provision applies when a person covered by this plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Plan.

When there is double coverage for covered benefits, other than emergency services from non-Plan providers, this Plan will continue to provide its benefits in full, but is entitled to receive payment for the services and supplies provided, to the extent that they are covered by the other coverage, no-fault or other automobile insurance or any other primary plan.

One plan normally pays its benefits in full as the primary payer, and the other plan pays a reduced benefit as the secondary payer. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount which, when added to the benefits payable by the other coverage, will not exceed reasonable charges. The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners. When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have. This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Plan to obtain information about benefits of services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first. As a member of a prepaid plan, special limitations on your CHAMPUS coverage apply; your primary provider must authorize all care unless you use a non-Plan provider for POS benefits as described on page 19. See your CHAMPUS Health Benefits Advisor if you have questions about CHAMPUS coverage.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers'compensation (under section 8103 of title 5, U.S.C) or by similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers'compensation or similar laws. If medical benefits provided under such laws are exhausted, this Plan will be financially responsible for services or supplies that are otherwise covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for services it provided that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other Government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

General Limitations *continued*

Liability insurance and third party actions

If a covered person is sick or injured as a result of the act or omission of another person or party, the Plan requires that it be reimbursed for the benefits provided in an amount not to exceed the amount of the recovery, or that it be subrogated to the person's rights to the extent of the benefits received under this Plan, including the right to bring suit in the person's name. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

General Exclusions

All benefits are subject to the limitations and exclusions in this brochure. **Although a specific service may be listed as a benefit, it will not be covered for you unless your Plan doctor determines it is medically necessary to prevent, diagnose or treat your illness or condition as discussed underAuthorizations on page 8.** The following are excluded:

- Care by non-Plan doctors or hospitals except for authorized referrals or emergencies (see Emergency Benefits) or eligible self-referred services obtained under Point of Service Benefits;
- Expenses incurred while not covered by this Plan;
- Services furnished or billed by a provider or facility barred from the FEHB Program;
- Services not required according to accepted standards of medical, dental, or psychiatric practice;
- Procedures, treatments, drugs or devices that are experimental or investigational;
- Procedures, services, drugs and supplies related to sex transformations; and
- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.

Medical and Surgical Benefits

What is covered

A comprehensive range of preventive, diagnostic and treatment services is provided by Plan doctors and other Plan providers. This includes all necessary office visits; **you pay** a $10 office visit copay, but no additional copay for laboratory tests and X-rays. Within the service area, house calls will be provided if, in the judgment of the Plan doctor, such care is necessary and appropriate; **you pay** a $10 copay for a doctor's house call, nothing for home visits by nurses and health aides.

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

- Preventive care, including well-baby care and periodic check-ups
- Mammograms are covered as follows: for women age 35 through age 39, one mammogram during these five years; for women ages 40 through 49, one mammogram every one or two years; for women age 50 through 64, one mammogram every year; and for women age 65 and above, one mammogram every two years. In addition to routine screening, mammograms are covered when prescribed by the doctor or when medically necessary to diagnose or treat your illness.
- Routine immunizations and boosters (copay is waived when immunizations and boosters are the only medical service received on a visit to the doctor's office)
- Consultations by specialists

- Outpatient surgery performed in an ambulatory surgical unit. **You pay** a $100 copay per visit
- Diagnostic procedures, such as laboratory tests and X-rays
- Complete obstetrical (maternity) care for all covered females, including prenatal, delivery and postnatal care by a Plan doctor. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. Inpatient stays will be extended if medically necessary. If enrollment in the Plan is terminated during pregnancy, benefits will not be provided after coverage under the Plan has ended. Ordinary nursery care of the newborn child during the covered portion of the mother's hospital confinement for maternity will be covered under either a Self Only or Self and Family enrollment; other care of an infant who requires definitive treatment will be covered only if the infant is covered under a Self and Family enrollment.
- Voluntary sterilization and family planning services. **You pay** a $100 copayment per facility charge when these services are provided in an ambulatory surgical unit.
- Diagnosis and treatment of diseases of the eye
- Allergy testing and treatment, including test and treatment materials (such as allergy serum)
- The insertion of internal prosthetic devices, such as pacemakers and artificial joints.
- Cornea, heart, heart/lung, lung (single and double), kidney, kidney/pancreas and liver transplants; allogeneic (donor) bone marrow transplants; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic 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. Treatment for multiple myeloma and epithelial ovarian cancer may be provided as part of a non-randomized clinical trial and if pre-authorized by the Medical Director. Related medical and hospital expenses of the donor are covered. Related donor costs (e.g. registry and testing) and travel expenses are excluded from coverage. **You pay** inpatient copayments (see page 14).
- Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.
- Dialysis
- Chemotherapy, radiation therapy, and inhalation therapy
- Surgical treatment of morbid obesity
- Blood and blood derivatives
- Chiropractic care
- Home health services of nurses and health aides, when prescribed by your Plan doctor, who will periodically review the program for continuing appropriateness and need
- All necessary medical or surgical care in a hospital or extended care facility from Plan doctors and other Plan providers, at no additional cost to you.

Limited benefits

Oral and maxillofacial surgery is provided for nondental surgical and hospitalization procedures for congenital defects, such as cleft lip and cleft palate, and for medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses including, but not limited to, treatment of fractures and excision of tumors and cysts. All other procedures involving the teeth or intra-oral areas surrounding the teeth are not covered, including any dental care involved in treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.

Reconstructive surgery will be provided to correct a condition resulting from a functional defect or from an injury or surgery that has produced a major effect on the member's appearance and if the condition can reasonably be expected to be corrected by such surgery.

Long Term inpatient rehabilitative therapy is covered; **you pay** $100 per admission. The admission must occur within 120 days from an acute care hospitalization discharge. Benefits are limited up to $150,000 lifetime maximum.

Short-term rehabilitative therapy (physical, speech and occupational) is provided on an inpatient or outpatient basis for up to two months per condition if significant improvement can be expected within two months; **you pay** $100 per admission; **you pay** a $10 copay per outpatient session. Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.

Diagnosis and treatment of infertility is covered; **you pay** $10 doctor's office visit copay. The following types of artificial insemination are covered: intravaginal insemination (IVI); intracervical insemination (ICI) and intrauterine insemination (IUI); **you pay** a $10 copay per visit. Cost of donor sperm is not covered. Fertility drugs are not covered. Other assisted reproductive technology (ART) procedures such as in vitro fertilization and embryo transfer are not covered.

Durable medical equipment, such as wheelchairs or hospital beds and oxygen for home use, including equipment, are covered; **you pay** 20% copayment when purchased from a contracting supplier. Preauthorization is required on durable medical equipment that costs $300 or more and benefits are not available for replacement when used by member for less than five years. Equipment purchased from a non-contracting supplier is not covered.

Prosthetic appliances, including first contact lens and/or eyeglasses purchased within 90 days following cataract surgery, are covered; **you pay** 20% copayment when purchased from contracting supplier; **you pay** 50% copayment when purchased from a non-contracting supplier. Synthesized or artificial speech or communication output device or system or any similar device are not covered, except for voice boxes used to replace all or part of a surgically removed larynx.

Orthopedic Devices, such as braces, are covered; **you pay** 20% copayment when purchased from a contracting supplier; **you pay** 50% copayment when purchased from a non-contracting supplier. Preauthorization is required for orthopedic devices which cost $300 or more. Foot orthotics are not covered.

What is not covered

- Physical examinations that are not necessary for medical reasons, such as those required for obtaining or continuing employment or insurance, attending school or camp, or travel
- Reversal of voluntary, surgically-induced sterility
- Plastic surgery primarily for cosmetic purposes
- Transplants not listed as covered
- Hearing aids
- Homemaker services
- Cardiac rehabilitation
- Vision care

Hospital/Extended Care Benefits

What is covered

Hospital care

The Plan provides a comprehensive range of benefits with no dollar or day limit when you are hospitalized under the care of a Plan doctor. **You pay** a $100 copay per inpatient admission for non-surgical health services and an additional $100 copay for surgical or maternity health services per admission. Inpatient admission copayments are limited to a maximum of $200 per admission. **All necessary services are covered,** including:

- Semiprivate room accommodations; when a Plan doctor determines it is medically necessary, the doctor may prescribe private accommodations or private duty nursing care
- Specialized care units, such as intensive care or cardiac care units

Extended care

The Plan provides a comprehensive range of benefits with no dollar or day limit when full time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by a Plan doctor and approved by the Plan. **You pay** nothing. **All necessary services are covered,** including:

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

Hospice care

Supportive and palliative care for a terminally ill member is covered in the home or hospice facility. Services include inpatient and outpatient care, and family counseling; these services are provided under the direction of a Plan doctor who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.

Ambulance Service

Benefits are provided for ambulance transportation ordered or authorized by a Plan doctor; **you pay** a $50 copay per trip.

Limited benefits

Inpatient dental procedures

Hospitalization for certain dental procedures is covered when a Plan doctor determines there is a need for hospitalization for reasons totally unrelated to the dental procedure; the Plan will cover the hospitalization, but not the cost of the professional dental services. Conditions for which hospitalization would be covered include hemophilia and heart disease; the need for anesthesia, by itself, is not such a condition.

Acute inpatient detoxification

Hospitalization for medical treatment of substance abuse is limited to emergency care, diagnosis, treatment of medical conditions, and medical management of withdrawal symptoms (acute detoxification) if the Plan doctor determines that outpatient management is not medically appropriate. See page 16 for nonmedical substance abuse benefits.

What is not covered

- Personal comfort items, such as telephone and television
- Custodial care, rest cures, domiciliary or convalescent care

Emergency Benefits

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that the Plan may determine are medical emergencies – what they all have in common is the need for quick action.

Emergencies within the Service Area

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

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible. Ambulance charges are subject to a $50 copayment per trip.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan Providers except as covered under the POS benefit.

Plan pays...

Reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

You pay...

$50 per hospital emergency room visit or $10 per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copay is waived.

Emergencies outside the Service Area

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

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

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

Plan pays...

Reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers.

You pay...

$50 per hospital emergency room visit or $10 per urgent care center visit for emergency services that are covered benefits of this Plan. If the emergency results in admission to a hospital, the emergency care copay is waived.

What is covered

- Emergency care at a doctor's office or an urgent care center
- Emergency care as an outpatient or inpatient at a hospital, including doctors'services
- Ambulance service approved by the Plan

Emergency Benefits *continued*

What is not covered

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

Filing claims for non-Plan providers

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure described on page 21.

Mental Conditions/Substance Abuse Benefits

Mental Conditions

What is covered

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

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

Outpatient care

All necessary outpatient visits to Plan doctors, consultants or other psychiatric personnel each calendar year; **you pay** a $25 copay per visit.

Inpatient care

Up to 30 days of hospitalization each calendar year; **you pay** nothing for the first day, a $25 copay per day for days 2 through 30 – all charges thereafter.

What is not covered

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

Substance Abuse

What is covered

This Plan provides medical and hospital services such as acute detoxification services for the medical, non-psychiatric aspects of substance abuse, including alcoholism and drug addiction, the same as for any other illness or condition. Services for the psychiatric aspects are provided in conjunction with the mental conditions benefit shown above. Outpatient visits to the Plan mental health providers for crisis intervention are covered as well as inpatient services necessary for diagnosis and treatment of the psychiatric aspects of substance abuse. The mental conditions benefit visits/day limitations and copayments apply to the above covered services for substance abuse care.

Mental Conditions/Substance Abuse Benefits *continued*

Residential treatment program

Residential treatment services for substance abuse are provided if a Plan provider determines that outpatient management is not medically appropriate; **you pay** nothing for the first day, $25 per day for days 2 through 21. This benefit is limited to 21 days per confinement, two confinements per lifetime.

What is not covered

Treatment that is not authorized by a Plan doctor

Prescription Drug Benefits

What is covered

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 34-day supply or 100 unit supply, whichever is greater; **you pay** a $5 copay per prescription unit or refill for generic drugs or a $12 copay per prescription drug or refill for brand name drugs. When generic substitution is permissible (i.e., a generic drug is available and the presiding doctor does not require the use of a name brand drug), but you request the name brand drug, **you pay** the price difference between the generic and name brand drugs as well as the $12 copay per prescription unit or refill.

Drugs are prescribed by Plan doctors and dispensed in accordance with the Plan's drug formulary. Non-formulary drugs will be covered when prescribed by a Plan doctor.

Drugs obtained at a non-Plan pharmacy are covered up to the Plan's usual, customary and reasonable (UCR) amount. **You pay** the applicable copay shown above plus the difference between the Plan's UCR amount and the cost of the drug.

Covered medications and accessories include:

- Drugs for which a prescription is required by law
- Oral and injectable contraceptive drugs
- Insulin, with a copay charge applied to each vial
- Disposable needles and syringes needed for injecting covered prescribed medication
- Intravenous fluids and medication for home use, and some injectable drugs are covered under Medical and Surgical Benefits.

What is not covered

- Drugs available without a prescription or for which there is a nonprescription available
- Diabetic supplies except needles and syringes
- Vitamins and nutritional substances that can be purchased without a prescription
- Medical supplies such as dressings and antiseptics
- Contraceptive devices
- Drugs for cosmetic purposes
- Drugs to enhance athletic performance
- Smoking cessation drugs and medication, including nicotine patches
- Implanted time-released medications, such as Norplant
- Fertility drugs

Other Benefits

Dental care

Accidental injury benefit

Emergency dental services required as a result of an accident are covered; **you pay nothing.** The need for these services must result from an accidental injury. Preauthorization must be obtained from HMO*Blue* Medical Utilization Review Department before further dental services are rendered, following the emergency treatment.

Point of Service (POS) Benefits

Facts about HMO*Blue's* POS option

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

What is covered

Members may choose to opt-out of the Plan network and receive services within or outside the service area, without a referral and receive a lesser benefit than from participating Plan doctors. Only services covered under the HMO are covered under the POS benefit, except for those benefits listed as not covered.

Deductibles

A deductible of $500 per member must be satisfied before benefits are paid.

Coinsurance

Once the deductible is satisfied, the Plan will pay 70% of the preestablished customary allowance. **You pay** 30% of the customary allowance and all charges in excess of the customary allowance.

The member's out-of-pocket expenses under the POS benefit do not apply to the out-of-pocket maximum under the HMO benefits. There is no maximum out-of-pocket coinsurance limitation under the POS. The deductible and charges in excess of the preestablished customary allowance are not included in your maximum out-of-pocket costs.

Precertification

The purpose of precertification is to ensure that benefits are provided for medically necessary care. Preadmission review is required for all inpatient admissions to hospitals or other medical facilities. Call HMO*Blue* as soon as you know that you or your eligible dependent will be admitted to a hospital. Call within 24 hours, or by the end of the first working day, after you or your eligible dependent has an unplanned admission for an emergency medical condition or maternity delivery services. For preadmission review or admissions certification call 1-800-627-1187 or 208-345-2576.

If precertification is not obtained, benefits will be reduced to 50% (you pay 50% of the customary allowance) not to exceed a Plan maximum of $500. The penalty does not apply to your out-of-pocket costs.

Emergency Benefit

True emergency care is payable as an HMO benefit. Non-emergency care without a referral is covered under the POS benefit.

Other Benefits

Maternity

Members are responsible for a $400 copayment for maternity care including prenatal care, delivery and postnatal care.

Prescription Drugs

Prescription drugs prescribed by a Plan or referral doctor and obtained at a Plan pharmacy will be dispensed for up to a 34-day supply or 100 unit supply, whichever is greater. **You pay** a $5 copayment for generic drugs and $12 copayment for brand name drugs per prescription unit or refill when generic substitution is permissible or when the prescribing doctor requires the name brand drug; **you pay** the brand name copay plus the difference in cost between the generic and brand name drugs when a generic substitution is permissible and you request the brand name drug. For prescriptions obtained out of the service area, please call 1-800-776-9820 for the nearest network pharmacy.

Maximum benefit

The aggregate benefit maximum limit payable per member is $1,000,000 per lifetime. When a member has reached his or her benefit maximum, no further benefits shall be owed and paid to the member under this contract or any other agreement, certificate or contract with Blue Cross of Idaho Coordinated Care Services.

How to Obtain Benefits

If you receive services from non-Plan providers or hospitals, you are responsible for an annual deductible, coinsurance, lifetime maximum and precertification requirements. The provider may request that you pay for the services in advance and file a claim form for reimbursement. Claim forms should be sent to the following address: HMO*Blue*, P.O. Box 7408, Boise, Idaho 83707.

What is not covered

Out of network benefits are not provided for the following services:

- Immunizations
- Well-baby and well-child care
- Routine periodic health evaluations
- Mental Health or substance abuse services
- Diagnosis and treatment for infertility and fertilization procedures
- Drugs listed as non-covered under the HMO benefits
- All services listed as not covered under the HMO benefits

How to Obtain Benefits

Questions

If you have a question concerning Plan benefits or how to arrange for care, contact the Plan's Customer Services Department at 1-800-627-6654. Or you may write to the Plan at 1501 Federal Way, P.O. Box 7408, Boise, Idaho 83707.

Disputed claims review

Plan Reconsideration

If a claim for payment or services is denied by the Plan, you must ask the Plan, in writing and within six months of the date of the denial, to reconsider its denial before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Plan an opportunity to reconsider your claim. Your written request to the Plan must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided.

Within 30 days after receipt of your request for reconsideration, the Plan must affirm the denial in writing to you, pay the claim, provide the service, or request additional information reasonably necessary to make a determination. If the Plan asks a provider for information it will send you a copy of this request at the same time. The Plan has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Plan will base its decision on the information it has on hand.

OPM review

If the Plan affirms its denial, you have the right to request a review by OPM to determine whether the Plan's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Plan's letter affirming its initial denial.

You may also ask OPM for a review if the Plan fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Plan. In this case, OPM must receive a request for review within 120 days of your request to the Plan for reconsideration or of the date you were notified that the Plan needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment or service should have been paid or provided. If the Plan has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned to OPM:

- A copy of your letter to the Plan requesting reconsideration;
- A copy of the Plan's reconsideration decision (if the Plan failed to respond, provide instead (a) date of your request to the Plan or (b) the dates the Plan requested and you provided additional information to the Plan);
- Copies of documents that support your claim, such as doctor's letters, operative reports, bills, medical records, and explanation of benefit (EOB) forms; and
- Your daytime phone number.

Medical documentation received from you or the Plan during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, P.O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by the Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Plan's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Plan's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement - If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C. , to use the information collected from you and the Plan to determine if the Plan has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Plan in support of OPM's decision on the disputed claim.

Notes

Notes

How HMO*Blue* Changes January 1998

Do not rely on this page; it is not an official statement of benefits.

Program-wide Changes

- This year, the Office of Personnel Management (OPM) instituted minimum benefit levels in all plans for normal deliveries (48 hours of inpatient care), cesarean sections (96 hours of inpatient care) and mastectomies (48 hours of inpatient care). See page 12 for this Plan's benefits.
- OPM also requires each prepaid plan to list the specific artificial insemination procedures that it covers. See page 13 for this Plan's benefits.
- The mammogram screening schedule is shown on page 11.

Changes to this Plan

- A Point-of-Service (POS) option has been added. Previously, only standard HMO benefits were offered. See page 19-20.
- The $10 office visit copay is now waived for immunizations. You will pay nothing for immunizations when received under the HMO benefit. Immunizations are not covered under the POS benefit. See page 11.
- Primary care doctors or members must contact HMO*Blue*'s Preadmission Review Team prior to a planned hospital admission. In the event of an emergency admission (including maternity and unscheduled cesarean section deliveries), the primary care doctor or member must contact the Plan within 48 hours of the admission. Failure to precertify will result in a benefit reduction of 50% of eligible charges or the copayment will be increased by $500 per admission, whichever is less. See page 8.

Summary of Benefits for Blue Cross of Idaho Coordinated Care Services – 1998

Do not rely on this chart alone. All benefits are provided in full unless otherwise indicated subject to the limitations and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). **ALL SERVICES COVERED UNDER THIS PLAN, WITH THE EXCEPTION OF EMERGENCY CARE AND SERVICES AVAILABLE AS POS BENEFITS, ARE COVERED ONLY WHEN PROVIDED OR ARRANGED BY PLAN DOCTORS.**

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	Comprehensive range of medical and surgical services without dollar or day limit. Includes in-hospital doctor care, room and board, general nursing care, private room and private nursing care if medically necessary, diagnostic tests, drugs and medical supplies, use of operating room, intensive care and complete maternity care. **You pay** a $100 copay per inpatient admission for non-surgical health services and an additional $100 copay for surgical or maternity health services per admission	14
	Extended Care	All necessary services, no dollar limit or day limit. **You pay** nothing	14
	Mental Conditions	Diagnosis and treatment of acute psychiatric conditions for up to 30 days of inpatient care per year. **You pay** nothing for the first day, $25 per day for days 2-30	16
	Substance Abuse	Residential treatment for chemical dependency is covered. See benefit description for details	16
Outpatient care		Comprehensive range of services such as diagnostic and treatment of illness or injury, including specialist's care; preventive care, including well-baby care, periodic routine check-ups and immunizations; laboratory tests and X-rays; complete maternity care. **You pay** a $10 copay per office visit; $10 per house call by a doctor; $100 per outpatient surgical visit to an ambulatory surgical unit	11, 12
	Home Health care	All necessary visits by nurses and health aides. **You pay** nothing	11, 12
	Mental Conditions	Outpatient visits for evaluation, diagnosis and crisis intervention. **You pay** $25 per visit	16
	Substance Abuse	Covered under mental conditions benefit	16, 17
Emergency care		Reasonable charges for services and supplies required because of a medical emergency. You pay a $50 copay to the hospital for each emergency room visit and any charges for services that are not covered by this Plan	15
Prescription drugs		Drugs prescribed by a Plan doctor and obtained at a Plan pharmacy. **You pay** a $5 per prescription unit or refill for generic drugs; **you pay** $12 per prescription unit or refill for name brand drugs	17
Dental care		Accidental injury benefit; **you pay** nothing	18
Vision care		No current benefit	
Out-of-pocket maximum		Copayments are required for a few benefits; however, after your out-of-pocket expenses reach a maximum of $1,000 per Self Only or $2,500 per Self and Family enrollment per calendar year, covered benefits will be provided at 100%. This copay maximum does not include charges for: prescription drugs and inpatient mental health services. There is no out-of-pocket maximum for the charges you pay when you use POS benefits	8

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United States Office of Personnel Management

Federal Employees Health Benefits Program

1998 Rate Information for

Blue Cross of Idaho Coordinated Care Services

FEHB Benefits of this Plan are described in brochure 73-426

The 1998 rate for this Plan follow. **Non-Postal** rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to an FEHB Guide or contact the agency that maintains your health benefits enrollment. **Postal rates** apply to all USPS career employees and do not apply to non-career Postal employees, Postal retirees or associate members of any Postal employees organization.

		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
Self Only	GM1	65.96	33.04	142.91	71.59	78.06	20.94
Self and Family	GM2	142.27	97.28	308.25	210.78	168.36	71.19