

**Attach
Your
Logo**

HMO name (32 pt)
<http://www.planAddress.org> (14 pt)

2001

**A Health Maintenance Organization
with a point of service product**

Serving: *{insert general service area }*

Enrollment in this Plan is limited; see page 5 for requirements.

Artwork:

For changes
in benefits,
see page xx.

*Add NCQA logo if applicable and say
below it:*

*This Plan has _____ accreditation from
the NCQA. See the 2001 Guide for more
information on NCQA.*

*{{Add logo for
any MBHO or
other
accreditation}}*

Enrollment codes for this Plan:

001 Self Only
002 Self and Family

Special notice: This Plan is offered for the first time under the Federal Employees Health Benefits Program during the 2000 Open Season.

Authorized for distribution by the:

OPM
Logo

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



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Introduction

Sample Benefit Plan
Address
City...

This brochure describes the benefits of (*insert Plan name*) under our contract (CS xxxx) 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.

A person enrolled in this Plan is entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2001, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page xx. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means [*insert plan name*].

The plain language team reorganized the brochure and the way we describe our benefits. When you compare this Plan with other FEHB plans, you will find that the brochures have the same format and similar information to make comparisons easier.

If you have comments or suggestions about how to improve this brochure, let us know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail us at fehwebcomments@opm.gov or write to OPM at Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

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.

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

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

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

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

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance. *[[if you are fulfilling your patient's bill of rights requirement here, this paragraph must be more detailed]]*

Patients' Bill of Rights

{Plan -- you can insert the paragraph that is called "Who provides my health care" from the 2000 brochure; please check for plain language}

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, which allows you to get information about your health plan, its networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

{Insert here the PBR information that you wish to include in the brochure, such as:}

- *{explain compliance and licensing requirements}*
- Years in existence
- Profit status

If you want more information about us, call xxx/xxx-xxxx, or write to xxx. You may also contact us by fax at xxx/xxx-xxxx or visit our website at xxx.

Service Area

*{Pick up text from Section 3 “What is this Plan’s service area?” in your 2000 brochure.} To enroll in this Plan, you must live in or work in our Service Area. **{Rule – show “live in” or “live in or work in” or, if you allow more flexibility to this rule, say what the requirements are.}***

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our *{HMOs insert "plan network", and FFS insert "our PPO network"}* will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed *{insert "higher patient cost sharing" or "shorter day or visit limitations"}* on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Patient safety *{text to follow}*
-

Changes to this Plan

-

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at xxx.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance, {←Plan specific} and you will not have to file claims. {POS, if any, make plan specific:} If you use our point-of-service program, you can also get care from non-Plan providers, or from participating providers without a required referral, but it will cost you more.

• Plan providers

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards. {Plan specific to modify entire paragraph, and add primary/specialist/etc}

We list Plan providers in the provider directory, which we update periodically. The list is also on our website. {Plan specific to modify entire paragraph, and add primary/specialist/etc}

• 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. {Plan specific - list optional}

What you must do

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. {insert information here about how to select the physician.}

• Primary care

Your primary care physician can be a {insert types, i.e. – family practitioner, internist or pediatrician}. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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

• Specialty care

Your primary care physician will refer you to a specialist for needed care. However, you may see {insert types/circumstances} without a referral. {text/list from 2000 brochure}

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician

will *{plans be sure to describe accurately – i.e. PCP works with specialist, works with plan, etc., to...}* develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause; or
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
 - reduce our service area and you enroll in another FEHB Plan,you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us.

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

• Hospital care

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

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

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

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

These provisions apply only to the hospital benefit of the hospitalized person; we cover your other non-hospital care.

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process.....*{plan specific, for example, "We call this review and approval process precertification.}* Your physician must obtain *.* for the following services: *{Insert your list – use "such as" or "limited to" – list does not have to be exhaustive}*

{Describe process. Description must explain these points: Description; Penalty – if any; What to do to get it or extend it; what happens if it doesn't; any exceptions to the rule... {THIS IS THE FORMER PRECERT language}

{If you have POS, show precert if any...}

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 when you receive services.

Example: When you see your primary care physician you pay a copayment of \$10 *{plan specific}* per office visit and when you go in the hospital, you pay \$100 per admission.

• Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for those services. Copayments do not count toward any deductible. *{Plan specific}* – OR – We do not have a deductible *{and delete remaining paragraphs}*.

- The calendar year deductible is \$xxx per person under High Option and \$xxx per person under Standard Option. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach \$xxx under High Option and \$xxx under Standard Option. *{delete if not apply}*
- We also have separate deductibles for: *{if you have other deductibles, bullet list and explain them here. A hospital deductible is not a deductible -- it is a copayment.}*

NOTE: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan.

And, if you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to any deductible of your new option. If you change plans during the year, you must begin a new deductible under your new plan.

• Coinsurance

Coinsurance is the percentage of our negotiated fee that you must pay for your care. Coinsurance doesn't begin until you meet your deductible. *{Plan specific}* - OR - We do not have coinsurance. *{If the later is the case, delete the next paragraph}*

Example: In our Plan, you pay 50% of our allowance for infertility services and durable medical equipment. *{List Plan-specific amounts}*

Your out-of-pocket maximum

{HMO; circumstance 1} After your copayments *{and/or coinsurance, and deductibles-- whatever--to be plan specific}* total \$_____ per person or \$_____ per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments *{or whatever}* for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments *{or whatever}* for these services:

- *{list}*

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

Your out-of-pocket maximum

{HMO; circumstance 2} We do not have an out-of-pocket maximum. *{Use this paragraph instead, when you have no out-of-pocket maximum}*