BlueAdvantage HMO on the Pathway HMO Network

www.anthem.com

Anthem

833-611-6919

2021

A Health Maintenance Organization

This plan's health coverage qualifies as minimum essential coverage and meets the minimum value standard for the benefits it provides. See page 8 for details. This plan is accredited. See page 13.

Serving: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, Jefferson, El Paso (Colorado Springs Region) and Larimer (Fort Collins Region) counties.

Enrollment in this Plan is limited. You must live or work in our geographic service area to enroll. See page 14 for requirements.

Enrollment codes for this Plan:

WW1 High Option Self Only
WW3 High Option Self Plus One
WW2 High Option Self and Family

IMPORTANT

- Rates: Back Cover
- Changes for 2021: Page 15
- Summary of Benefits: Page 78

FEHB
Federal Employees Health Benefits Program

Authorized for distribution by the:

United States
Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

RI 73-897

Important Notice from BlueAdvantage HMO on the Pathway HMO Network About

Our Prescription Drug Coverage and Medicare

The Office of Personnel Management has determined that the BlueAdvantage HMO on the Pathway HMO Network prescription drug coverage is, on average, expected to pay out as much as the standard Medicare prescription drug coverage will pay for all plan participants and is considered Creditable Coverage. This means you do not need to enroll in Medicare Part D and pay extra for prescription drug coverage. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and your FEHB plan will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly Medicare Part D premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next Annual Coordinated Election Period (October 15 through December 7) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 800-772-1213 TTY: 800-325-0778.

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 800 MEDICARE (1-800-633-4227), (TTY: 877-486-2048).

Table of Contents

Introduction

This brochure describes the benefits of the BlueAdvantage HMO on the Pathway HMO Network Plan under HMO Colorado, Inc. d/b/a HMO Colorado contract (CS 2955) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. Customer service may be reached at 833-611-6919 or through our website: www.anthem.com. The address for BlueAdvantage HMO on the Pathway HMO Networks' administrative offices is:

Anthem BlueAdvantage HMO on the Pathway HMO Network
P.O. Box 5747
Denver, CO 80217-5747

This brochure is the official statement of benefits. No verbal 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 Plus One or 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, 2020, unless those benefits are also shown in this brochure. Rates are shown at the end of this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2020, and changes are summarized on page 15. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples:

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee and each covered family member, “we” means BlueAdvantage HMO on the Pathway HMO Network.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean.
- Our brochure and other FEHB Plans’ brochures have the same format and similar descriptions to help you compare plans.

Stop Health Care Fraud!

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

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

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

- Do not give your plan identification (ID) number over the phone or to people you do not know, except for your health care providers, authorized health benefits plan, or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Periodically review your claim history for accuracy to ensure we have not been billed for services you did not receive.
- Do not ask your physician to make false entries on certificates, bills, or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
  - Call the provider and ask for an explanation. There may be an error.
  - If the provider does not resolve the matter, call us at 833-611-6919 and explain the situation.
  - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

877-499-7295

Or go to www.opm.gov/our-inspector-general/hotline-to-report-fraud-waste-or-abuse/complaint-form/

The online reporting form is the desired method of reporting fraud in order to ensure accuracy, and a quicker response time.

You can also write to:

United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street NW Room 6400
Washington, DC20415-1100

- Do not maintain as a family member on your policy:
- Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise)
- Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26).

A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage (TCC).
- Fraud or intentional misrepresentation of material fact is prohibited under the Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include falsifying a claim to obtain FEHB benefits, trying to or obtaining service or coverage for yourself or for someone else who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly by your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Discrimination is Against the Law

The BlueAdvantage HMO on the Pathway HMO Network complies with all applicable Federal civil rights laws, to include both Title VII of the Civil Rights Act of 1964.

You can also file a civil rights compliant with the Office of Personnel Management by mail at: Office of Personnel Management Healthcare and Insurance Federal Employee Insurance Operations, Attention: Assistant Director FEIO, 1900 E Street NW, Suite 3400 S, Washington, DC 20415-3610.

Preventing Medical Mistakes

Medical mistakes continue to be a significant cause of preventable deaths within the United States. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. Medical mistakes and their consequences also add significantly to the overall cost of healthcare. Hospitals and healthcare providers are being held accountable for the quality of care and reduction in medical mistakes by their accrediting bodies. You can also improve the quality and safety of your own health care and that of your family members by learning more about and understanding your risks. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a physician with whom you feel comfortable talking.
- Take a relative or friend with you to help you take notes, ask questions and understand answers.

2. Keep and bring a list of all the medications you take.

- Bring the actual medications or give your physician and pharmacist a list of all the medications and dosage that you take, including non-prescription (over-the-counter) medications and nutritional supplements.
- Tell your physician and pharmacist about any drug, food and other allergies you have, such as to latex.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medication is what the doctor ordered. Ask your pharmacist about the medication if it looks different than you expected.
- Read the label and patient package insert when you get your medications, including all warnings and instructions.
- Know how to use your medication. Especially note the times and conditions when your medication should and should not be taken.
- Contact your doctor or pharmacist if you have any questions.
- Understand both the generic and brand names of your medication. This helps ensure you do not receive double dosing from taking both a generic and a brand. It also helps prevent you from taking a medication to which you are allergic.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures. Will it be in person, by phone, mail, through the Plan or Provider's portal?
- Don't assume the results are fine if you do not get them when expected. Contact your healthcare provider and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital or clinic is best for your health needs.

- Ask your doctor about which hospital or clinic has the best care and results for your condition if you have more than one hospital or clinic to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital or clinic.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery?"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications or nutritional supplements you are taking.

Patient Safety Links

For more information on patient safety, please visit:

- www.jointcommission.org/speakup.aspx. The Joint Commission's Speak Up™ patient safety program.
- www.jointcommission.org/topics/patient_safety.aspx. The Joint Commission helps health care organizations to improve the quality and safety of the care they deliver.
- www.ahrq.gov/patients-consumers/. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.bemedwise.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medications.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Preventable Healthcare Acquired Conditions ("Never Events")

When you enter the hospital for treatment of one medical problem, you do not expect to leave with additional injuries, infections, or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, patients do suffer from injuries or illnesses that could have been prevented if doctors or the hospital had taken proper precautions. Errors in medical care that are clearly identifiable, preventable and serious in their consequences for patients, can indicate a significant problem in the safety and credibility of a health care facility. These conditions and errors are sometimes called "Never Events" or "Serious Reportable Events."

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores, and fractures, and to reduce medical errors that should never happen. When such an event occurs, neither you nor your FEHB plan will incur costs to correct the medical error. Should an event occur and you were required to make payments to the provider you will be reimbursed for your out-of-pocket costs. The list of Never Events or Hospital Acquired Conditions is as follows:

- Surgery performed on the wrong body part
- Surgery performed on the wrong patient
- Wrong surgical procedure performed on a patient
- Unintended retention of a foreign object in a patient after surgery or other procedure
- Air embolism
- Blood Incompatibility
- Surgical site infection following bariatric surgery for obesity (laparoscopic gastric bypass, gastroenterostomy, laparoscopic gastric restrictive surgery)

- Surgical site infection, mediastinitis, following coronary artery bypass graft
- Surgical site infection following certain orthopedic procedures (spine, neck, shoulder, elbow)
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures (total knee replacement, hip replacement)
- Catheter associated urinary tract infection
- Manifestations of poor glycemic control (diabetic ketoacidosis, nonketotic hyperosmolar coma, hypoglycemic coma, secondary diabetes with ketoacidosis, secondary diabetes with hyperosmolarity)
- Vascular catheter associated infection
- Falls and trauma (fracture, dislocation, intracranial injury, crushing injury, burn, electric shock)
- Pressure ulcers, stages III and IV

FEHB Facts

Coverage Information

- **No pre-existing condition limitation**

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

- **Minimum essential coverage (MEC)**

  Coverage under this plan qualifies as minimum essential coverage. Please visit the Internal Revenue Service (IRS) website at www.irs.gov/uac/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision for more information on the individual requirement for MEC.

- **Minimum value standard**

  Our health coverage meets the minimum value standard of 60% established by the ACA. This means that we provide benefits to cover at least 60% of the total allowed costs of essential health benefits. The 60% standard is an actuarial value; your specific out-of-pocket costs are determined as explained in this brochure.

- **Where you can get information about enrolling in the FEHB Program**

  See www.opm.gov/healthcare-insurance for enrollment information as well as:

  - Information on the FEHB Program and plans available to you
  - A health plan comparison tool
  - A list of agencies that participate in Employee Express
  - A link to Employee Express
  - Information on and links to other electronic enrollment systems

  Also, your employing or retirement office can answer your questions, and give you 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
  - What happens when your enrollment ends
  - 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. For information on your premium deductions, you must also contact your employing or retirement office.

- **Types of coverage available for you and your family**

  Self Only coverage is for you alone. Self Plus One coverage is for you and one eligible family member. Self and Family coverage is for you, and one eligible family member, or your spouse, and your dependent children under age 26, including any foster children authorized for coverage by your employing agency or retirement office. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self Plus One or 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 Plus One or 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 Plus One or 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 are married. A Carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of any changes in family member status, including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, you or they cannot be enrolled in or covered as a family member by another enrollee in another FEHB plan.

If you have a qualifying life event (QLE) - such as marriage, divorce, or the birth of a child - outside of the Federal Benefits Open Season, you may be eligible to enroll in the FEHB Program, change your enrollment, or cancel coverage. For a complete list of QLEs, visit the FEHB website at www.opm.gov/healthcare-insurance/life-events. If you need assistance, please contact your employing agency, Tribal Benefits Officer, personnel/payroll office, or retirement office.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below. A Self Plus One enrollment covers you and your spouse, or one other eligible family member as described in the chart below.

Children	Coverage
Natural children, adopted children, and stepchildren	Natural, adopted children and stepchildren are covered until their 26th birthday.
Foster children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certification stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children incapable of self-support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married children	Married children (but **NOT** their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

Newborns of covered children are insured only for routine nursery care during the covered portion of the mother's maternity stay.

You can find additional information at www.opm.gov/healthcare-insurance.

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

- If you have no FEHB coverage, your employing office will enroll you for Self Plus One or Self and Family coverage, as appropriate, in the lowest-cost nationwide plan option as determined by OPM;
- 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 Plus One or Self and Family, as appropriate, 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 Plus One or Self and Family, as appropriate, in the lowest-cost nationwide plan option as determined by OPM.

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 does not serve the area in which your children live, unless you provide documentation that you have other coverage for the children.

If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that does not serve the area in which your children live as long as the court/administrative order is in effect. Similarly, you cannot change to Self Plus One if the court/administrative order identifies more than one child. Contact your employing office for further information.

When benefits and premiums start

The benefits in this brochure are effective 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. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be processed according to the 2021 benefits of your prior plan or option.** If you have met (or pay cost-sharing that results in your meeting) the out-of-pocket maximum under the prior plan or option, you will not pay cost-sharing for services covered between January 1 and the effective date of coverage under your new plan or option. However, if your prior plan left the FEHB Program at the end of the year, you are covered under that plan's 2020 benefits until the effective date of your coverage with your new plan. 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.

If your enrollment continues after you are no longer eligible for coverage, (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

When you retire

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

When you lose benefits

- **When FEHB coverage ends**

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

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

  Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

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

- **Upon divorce**

  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 provide health coverage for you. However, you may be eligible for your own FEHB coverage under either 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 additional information about your coverage choices. You can also visit OPM's website at www.opm.gov/healthcare-insurance/healthcare/plan-information/. A carrier may request that an enrollee verify the eligibility of any or all family members listed as covered under the enrollee's FEHB enrollment.

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

  If you leave Federal service, Tribal employment, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). The Affordable Care Act (ACA) did not eliminate TCC or change the TCC rules. For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal or Tribal job, if you are a covered dependent child and you turn 26, etc.

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

  Enrolling in TCC. Get the RI 79-27, which describes TCC, from your employing or retirement office or from www.opm.gov/healthcare-insurance. It explains what you have to do to enroll.

  Alternatively, you can buy coverage through the Health Insurance Marketplace where, depending on your income, you could be eligible for a new kind of tax credit that lowers your monthly premiums. Visit www.HealthCare.gov to compare plans and see what your premium, deductible, and out-of-pocket costs would be before you make a decision to enroll. Finally, if you qualify for coverage under another group health plan (such as your spouse's plan), you may be able to enroll in that plan, as long as you apply within 30 days of losing FEHBP coverage.

- **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 or Tribal service, your employing office will notify you of your right to convert**.** You must contact us in writing 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 contact us in writing 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, a waiting period will not be imposed and your coverage will not be limited due to pre-existing conditions. When you contact us, we will assist you in obtaining information about health benefits coverage inside or outside the Affordable Care Act's Health Insurance Marketplace in your state. For assistance in finding coverage, please contact us at 833-611-6919 or visit our website at www.anthem.com.

- **Health Insurance Marketplace**

If you would like to purchase health insurance through the ACA's Health Insurance Marketplace, please visit www.HealthCare.gov. This is a website provided by the U.S. Department of Health and Human Services that provides up-to-date information on the Marketplace.

Section 1. How This Plan Works

General features of our HMO

This Plan is a health maintenance organization (HMO). OPM requires that FEHB plans be accredited to validate that plan operations and/or care management meet nationally recognized standards. BlueAdvantage HMO on the Pathway HMO Network holds the following accreditations: Accredited status with the National Committee for Quality Assurance (NCQA). To learn more about this plan's accreditation(s), please visit the following websites: National Committee for Quality Assurance (www.ncqa.org).

We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. We are solely responsible for the selection of these providers in your area. Contact us 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 pay only 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.

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 cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies). If you want more information, please call us at 833-611-6919, or you may call your provider.

Preventive care services

Preventive care services are generally covered with no cost-sharing and are not subject to copayments, deductibles or annual limits when received from a network provider.

Catastrophic protection

We protect you against catastrophic out-of-pocket expenses for covered services. The IRS limits annual out-of-pocket expenses for covered services, including deductibles and copayments, to no more than $7,000 for Self Only enrollment, and $14,000 for a Self Plus One or Self and Family. The out-of-pocket limit for this Plan may differ from the IRS limit, but cannot exceed that amount.

Your Rights and Responsibilities

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and our providers. 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.

- Anthem BlueCross BlueShield has been serving the health insurance needs of Colorado residents since 1938.
- Profit status - Anthem BlueCross BlueShield of Colorado is a for-profit Colorado corporation.

You are also entitled to a wide range of consumer protections and have specific responsibilities as a member of this Plan. You can view the complete list of these rights and responsibilities by visiting our website, BlueAdvantage HMO on the Pathway HMO Network at www.anthem.com. You can also contact us to request that we mail a copy to you.

If you want information about us, call 833-611-6919, or write to BlueAdvantage HMO on the Pathway HMO Network, P.O Box 5747 Denver, CO. 80217-5747. You may also visit our website at www.anthem.com/federal-employees/health-plans-co/.

By law, you have the right to access your protected health information (PHI). For more information regarding access to PHI, visit our website for BlueAdvantage HMO on the Pathway HMO Network at www.anthem.com to obtain our Notice of Privacy Practices. You can also contact us to request that we mail you a copy of that Notice.

Your medical and claims records are confidential

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

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:

Colorado Counties: Adams, Arapahoe, Boulder, Broomfield, Denver, Douglas, El Paso (Colorado Springs Region) , Jefferson and Larimer (Fort Collins Region).

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 your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas or refer to Section 5(h) Wellness and Other Special Features on page 59 for details regarding our reciprocity benefits. 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. Changes for 2021

Please familiarize yourself with the benefits and limitations of the Plan.

- Office and outpatient physical, occupational, and speech therapy will require prior authorization.
- The Plan will no longer cover Vitamin D and iron supplements as preventive care services under the Prescription Drug benefits.
- We will now offer a Medicare Advantage plan. See Section 9 for more information.

Section 3. How You Get Care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as 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 833-611-6919 or write to us at BlueAdvantage HMO on the Pathway HMO Network, P.O. Box 5747, Denver, CO 80217-5747. You may also request replacement cards through our website at www.anthem.com.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only be responsible for your cost-sharing (copayments, coinsurance, deductibles, and non-covered services and supplies).

- **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 covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care**

Your primary care physician can be a general or 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**

You do not need a referral from your primary care physician. You may self-refer within the network for medically necessary care.

Here are some other things you should know about specialty care:

- If you have a chronic and disabling condition and lose access to your specialist because we:
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program plan; or
  - reduce our service area and you enroll in another FEHB plan;

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

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

- **Hospital care**

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

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our plan begins, call our customer service department immediately at 833-611-6919. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

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;
- 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. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM 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.

You need prior plan approval for certain services

Since your primary care physician arranges most referrals to specialists and inpatient hospitalization, the pre-service claim approval only applies to care shown under *Other services*.

- **Gender reassignment services**

Prior Plan approval must be obtained in advance in order for gender reassignment services for the treatment of gender dysphoria to be covered.

Certain providers have been designated to provide gender reassignment services. If a Plan provider is not available you will need to obtain an authorized referral in order for services to be covered. See Section 3. How to request precertification for an admission or get prior authorization for Other services. See page 38 for non-covered services.

For individuals undergoing any combination of the following; hysterectomy, salpingo-oophorectomy, ovariectomy, or orchiectomy, it is considered **medically necessary** when *all* of the following criteria are met:

1. The individual is at least 18 years of age; **and**
2. The individual has capacity to make fully informed decisions and consent for treatment; **and**
3. The individual has been diagnosed with gender dysphoria, and exhibits all of the following:
   - The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; **and**
   - The transsexual identity has been present persistently for at least two years; **and**
   - The disorder is not a symptom of another mental disorder; **and**
   - The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; **and**
4. For individuals without a medical contraindication, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician; **and**
5. If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (for example, psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; **and**

6. Two referrals from qualified mental health professionals* who have independently assessed the individual. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (for example, if practicing within the same clinic) are required. The letter(s) must have been signed within 12 months of the request submission.

For individuals undergoing surgery, consisting of any combination of the following, metoidioplasty, phalloplasty, vaginoplasty, penectomy, clitoroplasty, labiaplasty, vaginectomy, scrotoplasty, urethroplasty, or placement of testicular prostheses, it is considered **medically necessary** when *all* of the following criteria are met:

1. The individual is at least 18 years of age; **and**
2. The individual has capacity to make fully informed decisions and consent for treatment; **and**
3. The individual has been diagnosed with gender dysphoria and exhibits all of the following:
   - The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; **and**
   - The transsexual identity has been present persistently for at least two years; **and**
   - The disorder is not a symptom of another mental disorder; **and**
   - The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; **and**
4. For individuals without a medical contraindication, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician; **and**
5. Documentation** that the individual has completed a minimum of 12 months of successful continuous full time real-life experience in their new gender, across a wide range of life experiences and events that may occur throughout the year (for example, family events, holidays, vacations, season-specific work or school experiences). This includes coming out to partners, family, friends, and community members (for example, at school, work, and other settings); **and**
6. Regular participation in psychotherapy throughout the real-life experience when recommended by a treating medical or behavioral health practitioner; **and**
7. If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (for example, psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; **and**
8. Two referrals from qualified mental health professionals* who have independently assessed the individual. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (for example, if practicing within the same clinic) are required. The letter(s) must have been signed within 12 months of the request submission.

Note:

- At least one of the professionals submitting a letter must have a doctoral degree (for example, Ph.D., M.D., Ed.D., D.Sc., D.S.W., or Psy.D) or a master's level degree in a clinical behavioral science field (for example, M.S.W., L.C.S.W., Nurse Practitioner [N.P.], Advanced Practice Nurse [A.P.R.N.], Licensed Professional Counselor [L.P.C.], and Marriage and Family Therapist [M.F.T.]) and be capable of adequately evaluating co-morbid psychiatric conditions. One letter is sufficient if signed by two providers, one of whom has met the specifications set forth above.
- The medical documentation should include the start date of living full time in the new gender. Verification via communication with individuals who have related to the individual in an identity-congruent gender role, or requesting documentation of a legal name change, may be reasonable in some cases.

For individuals undergoing gender reassignment surgery, bilateral mastectomy is considered **medically necessary** when ALL of the following criteria have been met:

1. The individual is at least 18 years of age; **and**
2. The individual has capacity to make fully informed decisions and consent for treatment; **and**
3. The individual has been diagnosed with gender dysphoria and exhibits all of the following:
   - The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; **and**
   - The transsexual identity has been present persistently for at least two years; **and**
   - The disorder is not a symptom of another mental disorder; **and**
   - The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; **and**
4. If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (for example, psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; **and**
5. The individual is a female desiring gender transition.

Nipple reconstruction, including tattooing, following a mastectomy that meets the medically necessary criteria above is considered **medically necessary.**

The use of hair removal procedures to treat tissue donor sites for a planned phalloplasty or vaginoplasty procedure is considered **medically necessary.**

Gender reassignment surgery is considered **not medically necessary** when one or more of the criteria above have not been met.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. The following includes, but is not limited to, services that require prior plan approval:

- All inpatient admissions (except for a normal delivery)
- Office and outpatient physical, occupational and speech therapy.
- Bariatric Surgery and other treatments for Clinically Severe Obesity

- Behavioral Health and Substance Abuse Services for Intensive Outpatient programs (IOP), Partial Hospitalization Programs (PHP), Transcranial Magnetic Stimulation for Depression, and Residential Treatment
- Certain Cardiovascular services such as, but not limited to: Cardiac Catheterization with Coronary Angiography, Echocardiograms, Arterial Ultrasound and Percutaneous Coronary Intervention (PCI)
- Certain Radiation Therapy services such as, but not limited to: Intensity Modulated Radiation therapy (IMRT), Proton Beam radiation Therapy, Brachytherapy, Image Guided Radiation Therapy (IGRT) in association with External Beam Radiation Therapy
- Diagnostic Imaging such as, but not limited to: Computed Tomography (CT), Computed Tomographic Angiography (CTA), Magnetic Resonance Angiography (MRA), Magnetic Resonance Imaging (MRI), Nuclear Cardiology and Positron Emission Tomography (PET)
- Gender reassignment services
- Newborn stays that go beyond the discharge of the mother
- Outpatient Sleep Testing and Therapy services
- Powered Devices such as, but not limited to: mobility devices or robotic lower body exoskeleton devices
- Prosthetic Devices
- Reconstructive surgery
- Transplants (Human Organ and Bone Marrow/Stem Cell)
- Treatment of temporomandibular (TMJ) disease

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call the toll-free telephone number on the back of your member ID card before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of days requested for hospital stay.

Non-urgent care claims

For non-urgent care claims, we will tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

Urgent care claims

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether or not it is an urgent care claim by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to let you know what information we need to complete our review of the claim. You will then have up to 48 hours to provide the required information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

You may request that your urgent care claim on appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review of your urgent care claim by OPM either in writing at the time you appeal our initial decision, or by calling us at 833-611-6919. You may also call OPM's FEHB2 at 202-606-3818 between 8 a.m. and 5 p.m. Eastern Time to ask for the simultaneous review. We will cooperate with OPM so they can quickly review your claim on appeal. In addition, if you did not indicate that your claim was a claim for urgent care, call us at 833-611-6919. If it is determined that your claim is an urgent care claim, we will expedite our review (if we have not yet responded to your claim).

Concurrent care claims

A concurrent care claim involves care provided over a period of time or over a number of treatments. We will treat any reduction or termination of our pre-approved course of treatment before the end of the approved period of time or number of treatments as an appealable decision. This does not include reduction or termination due to benefit changes or if your enrollment ends. If we believe a reduction or termination is warranted, we will allow you sufficient time to appeal and obtain a decision from us before the reduction or termination takes effect.

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

The Federal Flexible Spending Account Program – *FSAFEDS*

Health Care FSA (HCFSA)– Reimburses you for eligible out-of-pocket health care expenses (such as copayments, deductibles, physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn 26).

FSAFEDS offers paperless reimbursement for your HCFSA through a number of FEHB and FEDVIP plans. This means that when you or your provider files claims with your FEHB or FEDVIP plan, FSAFEDS will automatically reimburse your eligible out-of-pocket expenses based on the claim information it receives from your plan.

Emergency inpatient admission

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.

If your treatment needs to be extended

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, we will make a decision within 24 hours after we receive the claim.

What happens when you do not follow the precertification rules when using non-Plan providers

Since precertification is part of the prior approval process you would need approval to use a non-network facility. If you use a non-network facility without prior approval or precertification you may be financially responsible for the charges. You should always make sure that we have been contacted to perform precertification for non-network services.

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.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must follow the entire disputed claims process detailed in Section 8.

To reconsider a non-urgent care claim

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.

   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.

2. Write to you and maintain our denial.

To reconsider an urgent care claim

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

To file an appeal with OPM

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your Costs for Covered Services

This is what you will pay out-of-pocket for covered care:

Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, if any, coinsurance, and copayments) for the covered care you receive.
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 $20 per office visit.
Deductible	This Plan does not have a deductible.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. Example: In our Plan, you pay 20% of our allowance for Durable Medical Equipment.
Your catastrophic protection out-of-pocket maximum	After your copayments total $5,000 for Self Only or $5,000 per person for Self Plus One, or $10,000 for Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. Be sure to keep accurate records of your copayments and coinsurance since you are responsible for informing us when you reach the maximum.
Carryover	If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your prior plan if they are for care you received in January before your effective date of coverage in this Plan. If you have already met your prior plan's catastrophic protection benefit level in full, it will continue to apply until the effective date of your coverage in this Plan. If you have not met this expense level in full, your prior plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date of your coverage in this Plan. Your prior plan will pay these covered expenses according to this year's benefits; benefit changes are effective January 1.
When Government facilities bill us	Facilities of the Department of Veterans Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. Benefits

See page 15 for how our benefits changed this year. Page 79 is a benefits summary of our High Option. Make sure that you review the benefits that are available under the option in which you are enrolled.

Section 5. Benefits Overview

The benefit package is described in Section 5. Make sure that you carefully review the benefits that are available.

Section 5 is divided into subsections. Please read *Important things you should keep in mind* at the beginning of the subsections. Also read the general exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 833-611-6919 or on our website at www.anthem.com/federal-employees/health-plans-co/.

When you seek care from within our network, we offer the following unique features:

- No deductibles
- No office visit copay for covered preventive care services
- $20 non-preventive primary care office visit copay
- $20 telehealth visit with LiveHealth Online
- $200 emergency room copay
- $400 per day copay up to a maximum of 3 days per covered inpatient hospital admission
- $300 outpatient facility copay for surgery

Section 5(a). Medical Services and Supplies Provided by Physicians and Other Health Care Professionals

Important things you should 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.
- A facility copay applies to services that appear in this section but are performed in an ambulatory surgical center or the outpatient department of a hospital.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage.
- This plan has no calendar year deductible.

Benefit Description	You pay
Diagnostic and treatment services	**High**
Professional services of physicians • In physician's office • Home visits • Office medical consultations • Second surgical opinion	$20 per Primary Care Physician $30 per Specialist visit
• During a hospital stay • In a skilled nursing facility	Nothing
• In an urgent care center	$30 per visit
• Retail Health Clinic	$20 per visit
• Injectable or infused medications given by a physician in the office This does not include immunizations prescribed by your primary care physician nor allergy serum	$20 PCP / $30 Specialist per visit plus 20% of Plan allowance
Telehealth services	**High**
Telehealth online visits through LiveHealth Online Note: To get started visit the website at www.livehealthonline.com.	$20 per visit
Lab, X-ray and other diagnostic tests	**High**
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Ultrasound • Electrocardiogram and EEG	Nothing

Lab, X-ray and other diagnostic tests - continued on next page

Benefit Description	You pay
Lab, X-ray and other diagnostic tests (cont.)	**High**
• Genetic testing when medically necessary	Nothing
For the following services: • Advanced Imaging Procedures Note: Advanced Imaging Procedures are imaging procedures, including, but not limited to: Magnetic Resonance Imaging (MRI), Computerized Tomography (CT scans), Positron Emission Tomography (PET scan), Magnetic Resonance Spectroscopy (MRS scan), Magnetic Resonance Angiogram (MRA scan), Echocardiography, and nuclear cardiac imaging.	20% of Plan Allowance
Preventive care, adult	**High**
Routine physical every year. The following preventive services are covered at the time interval recommended at each of the links below : • Immunizations such as Pneumococcal, influenza, shingles, tetanus/ DTaP, and human papillomavirus (HPV). For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/ • Screenings such as cancer, osteoporosis, depression, diabetes, high blood pressure, total blood cholesterol, HIV, and colorectal cancer screening. For a complete list of screenings go to the U.S. Preventive Services Task Force (USPSTF) website at https://www.uspreventiveservicestaskforce.org • Individual counseling on prevention and reducing health risks • Well woman care such as Pap smears, gonorrhea prophylactic medication to protect newborns, annual counseling for sexually transmitted infections, contraceptive methods, and screening for interpersonal and domestic violence. For a complete list of Well Women preventive care services please visit the Health and Human Services (HHS) website at https://www.healthcare.gov/preventive-care-women/	Nothing
Routine mammogram - covered for women.	Nothing
Adult immunizations endorsed by the Centers for Disease Control and Prevention (CDC) based on the Advisory Committee on Immunization Practices (ACIP) schedule.	Nothing
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	
Not covered: • *Immunizations needed to travel outside the USA or work-related exposure.* • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, athletic exams, or travel.*	*All charges*

Benefit Description	You pay
Preventive care, children	**High**
• Well-child visits, examinations, and other preventive services as described in the Bright Future Guidelines provided by the American Academy of Pediatrics. For a complete list of the American Academy of Pediatrics Bright Futures Guidelines go to https://brightfutures.aap.org • Immunizations such as DTaP, Polio, Measles, Mumps, and Rubella (MMR), and Varicella. For a complete list of immunizations go to the Centers for Disease Control (CDC) website at https://www.cdc.gov/vaccines/schedules/index.html • You can also find a complete list of preventive care services recommended under the U.S. Preventive Services Task Force (USPSTF) online at https://www.uspreventiveservicestaskforce.org	Nothing
Note: Any procedure, injection, diagnostic service, laboratory, or X-ray service done in conjunction with a routine examination and is not included in the preventive recommended listing of services will be subject to the applicable member copayments, coinsurance, and deductible.	
Not covered: • *Immunizations needed to travel outside the USA or work-related exposure.* • *Routine physical or psychological exams or tests asked for by a job or other group, such as a school, camp, athletic exams, or sports program.*	*All charges*
Maternity care	**High**
Complete maternity (obstetrical) care, such as: • Prenatal care and Postnatal care • Screening for gestational diabetes for pregnant women • Delivery	$20 for initial provider visit. (office copay applies to the first prenatal visit). Note: You owe a hospital admission copay for inpatient hospital services related to delivery: See Section 5 (c)
Breastfeeding support, supplies and counseling for each birth	Nothing
Note: Here are some things to keep in mind: • You do not need to preauthorize your vaginal delivery • You may remain in the hospital up to 48 hours after a vaginal 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 Plus One or Self and Family enrollment. Newborn circumcision is covered under Surgery benefits (see Section 5(b)). • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. • Hospital services are covered under Section 5(c) and Surgical benefits Section 5(b).	

Maternity care - continued on next page

Benefit Description	You pay
Maternity care (cont.)	**High**
Note: When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.	
Not covered: • *For any services or supplies provided to a person not covered under the plan in connection with a surrogate pregnancy (including, but not limited to, the bearing of a child by another woman for an infertile couple).*	*All charges*
Family planning	**High**
Contraceptive counseling	Nothing
A range of voluntary family planning services, such as: • Voluntary sterilization (Limited to tubal ligation or vasectomy) See surgical procedures Section 5(b) • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo Provera) • Intrauterine devices (IUDs) • Diaphragm Note: We cover oral contraceptives under Section 5(f) prescription drug benefits.	$20 per Primary Care Physician $30 per Specialist visit
Not covered: • *Reversal of voluntary surgical sterilization* • *Voluntary abortions and related care*	*All Charges*
Infertility services	**High**
Diagnosis and treatment of infertility such as: • Artificial insemination (AI): - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI)	$20 per Primary Care Physician $30 per Specialist visit
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* - *in vitro fertilization (IVF)* - *embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs*	*All charges*

Benefit Description	You pay
Allergy care	**High**
• Testing and treatment	$20 PCP / $30 Specialist per visit plus 20% of Plan allowance.
• Allergy injections including serum Note: You pay nothing for injections or serum.	$20 per Primary Care Physician $30 per Specialist visit
Treatment therapies	**High**
• Chemotherapy	$20 PCP / $30 Specialist per visit plus 20% of Plan allowance for therapy services
• Radiation therapy	$20 PCP / $30 Specialist per visit plus 20% of Plan allowance for therapy services
• Cardiac rehabilitation following qualifying event/condition is provided for up to 36 sessions.	$20 PCP / $30 Specialist per visit or $30 per outpatient facility visit.
• Hemodialysis including treatment at home	$20 PCP / $30 Specialist per visit or $30 per outpatient facility visit.
• Intravenous (IV)/Infusion Therapy performed in a physician's office	$20 PCP / $30 Specialist per visit plus 20% of Plan allowance for IV and Infusion therapy services.
• Applied Behavior Analysis (ABA) – Children with autism spectrum disorder	$20 per Primary Care Physician $30 per Specialist visit
• Pulmonary Rehabilitation	$20 PCP / $30 Specialist per visit or $30 per outpatient facility visit.
• Respiratory and Inhalation therapy	$20 PCP / $30 Specialist per visit or $30 per outpatient facility visit.
• Growth hormone therapy Note: We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. As us to authorize GHT before you begin treatment. We will only cover GHT and relates services and supplies that we determine are medically necessary. See *Other services under You need prior Plan approval for certain services on pages 19-20.*	$20 PCP / $30 Specialist per visit plus 20% of Plan allowance for therapy services
Physical, occupational and speech therapies	**High**
20 visits each for rehabilitative and habilitative physical, occupational and speech therapy per calendar year by: • Occupational therapists • Physical therapists • Speech therapists Note: We only cover therapy when a physician: • orders the care • identifies the specific professional skills the patient requires and the medical necessity for skilled services; and • indicates the length of time the services are needed.	$20 PCP / $30 Specialist per visit or $30 per outpatient facility visit.

Physical, occupational and speech therapies - continued on next page

Benefit Description	You pay
Physical, occupational and speech therapies (cont.)	**High**
See Section 3, *Other services* for prior authorization requirements	$20 PCP / $30 Specialist per visit or $30 per outpatient facility visit.
Not covered: • *Treatment of frequent recurrences of pain, over a long period of time, that is not related to an active medical condition currently being treated.* • *Health club memberships, exercise equipment, charges from a physical fitness instructor or personal trainer, or any other charges for activities, equipment, or facilities used for developing or maintaining physical fitness, even if ordered by a physician. This exclusion also applies to health spas.* • *Programs to help you change how you live, like fitness clubs, or dieting programs. This does not apply to cardiac rehabilitation programs approved by your physician.*	*All charges*
Hearing services (testing, treatment, and supplies)	**High**
• Routine hearing screening • Newborn hearing screenings, re-screenings, audiology assessment and follow-up.	$20 per Primary Care Physician $30 per Specialist visit
• Hearing aids (monaural or binaural) including ear mold(s), the hearing aid instrument, batteries, cords and other ancillary equipment for children under 18. We cover auditory training when it is offered using approved professional standards. Initial and replacement hearing aids will be supplied every 5 years, a new hearing aid will be a covered service when alterations to your existing hearing aid cannot adequately meet your needs or be repaired; and • Visits for fitting, counseling, adjustments and repairs after receiving the covered hearing aid.	$20 PCP / $30 Specialist per visit plus 20% of Plan allowance for hearing aid services
Vision services (testing, treatment, and supplies)	**High**
• Medical and surgical treatment of injuries and/or diseases affecting the eye. • One routine eye-exam with refraction per year	$20 per Primary Care Physician $30 per Specialist visit
• The first pair of eyeglasses, including frames, or contact lenses are covered when they replace the function of the human lens for conditions caused by cataract surgery or injury. Note: Contact lenses or glasses are often prescribed following intraocular lens implantation for the treatment of cataracts. See Orthopedic and prosthetic devices for internal device insertion benefits.	$20 PCP / $30 Specialist per visit plus 20% of Plan allowance for first pair of lenses
Not Covered: • *Radial keratotomy and other refractive surgery* • *Eyeglasses, contact lenses or their fitting, vision therapy or routine vision exams, unless otherwise stated in this brochure.*	*All charges*

Benefit Description	You pay
Foot care	**High**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See Orthopedic and prosthetic devices for information on podiatric shoe inserts.	$20 per Primary Care Physician $30 per Specialist visit
Not covered: • *Routine foot care when not under treatment for vascular conditions, such as diabetes.* • *For foot care to improve comfort or appearance. This includes, but not limited to, care for flat feet, subluxations, corns, bunions, (except capsular and bone Surgery), calluses and toenails.*	*All charges*
Orthopedic and prosthetic devices	**High**
• Artificial limbs and eyes • Prosthetic Sleeve or Sock • Externally worn breast prostheses and surgical bras, including two replacements each calendar year following a mastectomy • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy • The first wig after cancer treatment • Either one set of standard prescription glasses or one set of contact lenses (whichever is right for the health problem) when needed to replace human lenses absent at birth or lost through intraocular surgery, ocular injury or for the treatment of keratoconus or aphakia • Purchase, fitting, needed changes, repairs, and replacements of Orthopedic Appliances and supplies Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. Note: For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services	$20 PCP / $30 Specialist per visit plus 20% of Plan allowance for orthopedic or prosthetic devices
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.* • *Foot Orthotics, orthopedic shoes and arch supports (except if you are diagnosed with diabetes).*	*All charges*

Benefit Description	You pay
Durable medical equipment (DME)	**High**
We cover rental or purchase of medical supplies and durable medical equipment including repair and adjustment. The rental cost must not be more than the price to buy the equipment. This equipment must serve only a health care purpose and be able to withstand repeated use. Medical and surgical supplies such as, but not limited to: • Syringes • Needles • Oxygen • Surgical dressings and splints • Diabetic supplies	$20 PCP / $30 Specialist per visit plus 20% of Plan allowance for DME
Not covered: • *Durable Medical Equipment purchased for your comfort or hygiene.* • *For air conditioners, humidifiers, dehumidifiers, special lighting or other environmental modifiers, wristlets, augmentative communication devices, surgical supports, and corsets or other articles of clothing, unless otherwise stated in this brochure.* • *Health club memberships, exercise equipment, charges from a fitness or personal trainer, or any other charges for physical fitness, even if ordered by a Physician. This also applies to health spas.*	*All charges*
Home health services	**High**
Up to 100 visits per calendar year for home health services when performed by a Home Health Care Agency or other Provider in your home. Services must be given on a part-time visiting basis for your course of treatment. Covered services include but are not limited to: • Professional nursing services you get from a registered nurse (R.N.) or a licensed practical nurse (L.P.N); • Health care/social services; • Diagnostic services; • Nutritional guidance; • Certified nurse aide services under the supervision of an R.N. or a therapist skilled in professional nursing services; • Therapy Services like physical, occupational, respiratory, inhalation, speech and hearing therapy. Therapy services are not subject to therapy limits; • Social work practice services from a social worker; • Medical and surgical supplies; • Durable medical equipment; and • Prescription Drugs but only if provided and billed by a Home Health Care Agency	Nothing
Home IV Therapy	20% of Plan allowance

Home health services - continued on next page

Benefit Description	You pay
Home health services (cont.)	**High**
Home IV therapy includes a mixture of nursing care, durable medical equipment and IV pharmaceutical services. These are delivered and/or given intravenously in the home. Home IV therapy includes services and supplies such as for Total Parenteral Nutrition (TPN), antibiotic therapy, pain management and chemotherapy. TPN received in the home is a covered benefit for the first 21 days after a Hospital discharge when it is medically necessary. More days may be given up to a maximum of 42 days per Benefit Period when preauthorized by Us. Aside from the limits above, home IV therapy services are not subject to the home health care limits listed above.	20% of Plan allowance
Chiropractic	**High**
Covered up to 20 visits per calendar year including: • Examinations • Office visits with manual adjustment of the spine • X-Ray of the spine and conjunctive physiotherapy.	$20 per Primary Care Physician $30 per Specialist visit
Alternative treatments	**High**
Combined total of 20 visits per calendar year for the following services: • **Massage therapy** for injury or illness for which massage has a therapeutic result. Coverage is provided for up to a 60 minute session per visit. Covered Services include acupressure and deep tissue massage, or other approved services. • **Acupuncture/ Nerve Pathway therapy** is limited to the treatment of neuromusculoskeletal pain, through the use of needles inserted along specific nerve pathways to ease pain resulting from an injury or illness.	$20 per Primary Care Physician $30 per Specialist visit
Not covered: • *Massage therapy any manipulative techniques or procedures which are not generally accepted in a majority of states' massage therapy licensing boards. Massage therapy supplies including but not limited to lotions* • *Acupuncture/nerve pathway therapy mainly for the purpose of weight control, related to menstrual cramps and addiction including smoking cessation*	*All charges*
Educational classes and programs	**High**
• Diabetes	$20 per Primary Care Physician $30 per Specialist visit
• Nutritional counseling for the treatment of obesity	Nothing
Tobacco cessation program includes: • Individual, group, and telephone counseling. • Coverage for physician-prescribed over-the-counter (OTC) and prescription drugs approved by the FDA to treat tobacco dependence.	Nothing

Educational classes and programs - continued on next page

Benefit Description	You pay
Educational classes and programs (cont.)	**High**
Note: See Section 5(f) Prescription benefits for information on physician prescribed OTC and prescription drugs approved by the FDA to treat tobacco dependence. See Section 5(e) for information on individual and group psychotherapy.	Nothing
Not covered: • *Services or supplies mainly for educational, vocational, or training purposes, unless otherwise stated.*	*All charges*

Section 5(b). Surgical and Anesthesia Services Provided by Physicians and Other Health Care Professionals

Important things you should 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 Coordinating benefits with Medicare and other coverage.
- The services listed below are for the charges billed by a physician or other health care professional for your surgical care. See Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR SOME SURGICAL PROCEDURES**. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.
- This plan has no calendar year deductible.

Benefit Description	You pay
Surgical procedures	**High**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery) • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information • Voluntary sterilization (limited to tubal ligation, vasectomy) • Treatment of burns **Note:** Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay hospital benefits for a pacemaker and surgery benefits for insertion of the pacemaker.	Nothing
Medically necessary gender reassignment surgical services to treat gender dysphoria will be covered as follows (See Section 3 for medical necessity criteria): • Reassignment surgeries, consisting of any combination of the following; hysterectomy, salpingo-oophorectomy; ovariectomy , or orchiectomy are considered medically necessary when all of the medical necessity criteria are met; or	Nothing

Surgical procedures - continued on next page

Benefit Description	You pay
Surgical procedures (cont.)	**High**
• Reassignment surgeries, consisting of any combination of the following; metoidioplasty, phalloplasty, vaginoplasty, penectomy, clitoroplasty, labiaplasty, vaginectomy, scrotoplasty, urethroplasty, or placement of testicular prostheses are considered medically necessary when all of the medical necessity criteria are met.	Nothing
Surgical treatment of morbid obesity (bariatric surgery) as determined by your Plan physician, when the treatment is approved in advance. In order for your physician to consider you for this surgery, you must: • Have a Body Mass Index of 40 or greater, or Body Mass Index of 35 or greater with co-morbid conditions including, but not limited to, life threatening cardio-pulmonary problems (severe sleep apnea, Pickwickian syndrome and obesity related cardiomyopathy), severe diabetes mellitus, cardiovascular disease or hypertension; and • Have actively participated in non-surgical methods of weight reduction; and • Have a psychiatric profile that will allow you to understand, tolerate and comply with all phases of care and are committed to long-term follow-up requirements. Note: Before the bariatric surgery can be approved, your physician must address post-operative expectations and give you a thorough explanation of the risks and benefits of the procedure.	Nothing
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care* • *Enhancements related to gender reassignment, including: abdominoplasty, blepharoplasty, breast augmentation, brow lift, calf implants, electrolysis, face lift, facial bone reconstruction, facial implants, gluteal augmentation, jaw reduction (jaw contouring), lip reduction/enhancement, lipofilling/collagen injections, liposuction, nose implants, pectoral implants, rhinoplasty, thyroid cartilage reduction (chondroplasty), voice modification surgery, or voice therapy*	*All charges*
Reconstructive surgery	**High**
Reconstructive surgery includes procedures that are meant to address a major change from normal in relation to accidental injury, disease, trauma, treatment of a disease or Congenital Defect. Note: If you are getting benefits for a covered mastectomy or for follow-up care for a covered mastectomy, and you decide to have breast reconstruction, you will also get coverage for: • Reconstruction of the breast on which the mastectomy has been performed; • Surgery and reconstruction of the other breast to give a balanced look; and	Nothing

Reconstructive surgery - continued on next page

Benefit Description	You pay
Reconstructive surgery (cont.)	**High**
• Prostheses and for physical problems caused by any stage of the mastectomy, including lymphedemas. Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure	Nothing
Not covered: • *Treatment of varicose veins or telangiectatic dermal veins (spider veins) by any method (including sclerotherapy or other surgeries) when services are rendered for cosmetic purposes.* • *For any procedures, services, equipment or supplies provided in connection with Cosmetic Services. Cosmetic Services have the intent to preserve, change or improve your appearance. There is no coverage for Surgery or treatments to change the texture or appearance of your skin. There is no coverage to change the size, shape or appearance of facial or body features (such as your nose, eyes, ears, cheeks, chin, chest or breasts) except where specifically required by law*	*All charges*
Oral and maxillofacial surgery	**High**
Oral surgical procedures, limited to: • Oral and maxillofacial surgery • Reduction of fractures of the jaws or facial bones. • Orthognathic surgery for a physical abnormality that prevents normal function of the upper and/or lower jaw and is medically necessary to attain functional capacity of the affected part. • Oral/surgical correction of accidental injuries. • Treatment of non-dental lesions, such as removal of tumors and biopsies. • Incision and drainage of infection of soft tissue not including odontogenic cysts or abscesses. • Surgical correction of anatomical abnormalities for treatment of temporomandibular (TMJ) disease when approved in advance by the Plan • 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*

Benefit Description	You pay
Organ/tissue transplants	**High**
These **solid organ transplants** are covered. These solid organ transplants are subject to medical necessity and experimental/ investigational review by the Plan. See Other services under You need prior Plan approval for certain services on page 19-20. Solid organ transplants are limited to: • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis • Cornea • Heart • Heart-lung • Intestinal transplants - Isolated small intestine - Small intestine with the liver - Small intestine with multiple organs such as the liver, stomach, and pancreas • Kidney • Kidney-pancreas • Liver • Lung - single/bilateral/lobar • Pancreas	Nothing
Tandem transplants for covered transplants: subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. Autologous tandem transplants: • AL Amyloidosis • Multiple myeloma (de novo and treated) • Recurrent germ cell tumors (including testicular cancer)	Nothing
Blood or Marrow Stem Cell Transplants: The Plan extends coverage for the diagnoses as indicated below. Allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Acute myeloid leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed) • Advanced Myeloproliferative Disorders (MPDs) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/ SLL) • Hemoglobinopathy • Infantile malignant osteopetrosis	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High**
• Kostmann's syndrome • Leukocyte adhesion deficiencies • Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) • Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) • Myelodysplasia/Myelodysplastic Syndromes • Paroxysmal Nocturnal Hemoglobinuria • Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Sickle Cell disease • X-linked lymphoproliferative syndrome Autologous transplant for: • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma recurrence - relapsed or refractory • Advanced Non-Hodgkin's lymphoma recurrence - relapsed or refractory • Amyloidosis • Breast Cancer • Ependymoblastoma • Epithelial ovarian cancer • Ewing's sarcoma • Multiple myeloma • Medulloblastoma • Neuroblastoma • Pineoblastoma • Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors	Nothing
Mini-transplants performed in a Clinical Trial Setting (non-myeloablative, reduced intensity conditioning with a diagnosis listed under Section II): Subject to medical necessity review by the Plan. Refer to Other services in Section 3 for prior authorization procedures. Allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Acute myeloid leukemia • Advanced Hodgkin's lymphoma with recurrence (relapsed)	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High**
• Advanced Myeloproliferative Disorders (MPDs) • Advanced non-Hodgkin's lymphoma with recurrence (relapsed) • Amyloidosis • Chronic lymphocytic leukemia/small lymphocytic leukemia (CLL/SLL) • Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) relapsed/refractory disease • Hemoglobinopathy • Marrow failure and related disorders (i.e., Fanconi's, Paroxysmal Nocturnal Hemoglobinuria, Pure Red Cell Aplasia) • Myelodysplasia/Myelodysplastic Syndromes • Paroxysmal Nocturnal Hemoglobinuria • Severe combined immunodeficiency • Severe or very severe aplastic anemia Autologous transplant for: • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma recurrence - relapsed or refractory • Advanced Non-Hodgkin's lymphoma recurrence - relapsed or refractory • Amyloidosis • Neuroblastoma	Nothing
These blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of health **approved clinical trial** and offered through a Plan-designated center of excellence and if approved by the Plan in accordance with the Plan's protocols. If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patient's condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial. Refer to Other services in Section 3 for prior authorization procedures. Allogeneic transplants for: • Beta Thalassemia Major • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Mutiple myeloma (after a previous autologous stem cell transplant or due to primary graft failure, failure to engraft or rejection) • Multiple sclerosis* • Sickle cell anemia	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High**
Procedure requires review for medical necessity and benefit determination by an external medical director. Non-myeloablative allogeneic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma • Advanced Non-Hodgkin's lymphoma - relapsed or refractory • Chronic lymphocytic leukemia • Chronic lymphocytic lymphoma/small lymphoma (CLL/SLL) (after allogeneic transplant) • Chronic myelogenous leukemia (after allogeneic transplant) • Early stage (indolent or non-advanced) small cell lymphocytic lymphoma (after allogeneic transplant) • Multiple myeloma (after a previous autologous stem cell transplant or due to primary graft failure, failure to engraft or rejection) • Multiple sclerosis • Myeloproliferative disorders (MDDs) • Myeloproliferative/Myelodysplastic syndromes • Sickle Cell disease *Procedure requires review for medical necessity and benefit determination by an external medical director. Autologous transplants for the following autoimmune diseases*: • Advanced childhood kidney cancers • Advanced Ewing sarcoma • Aggressive non-Hodgkin's lymphomas (Mantle Cell lymphoma, adult T-cell leukemia/lymphoma, peripheral T-cell lymphomas and aggressive Dendritic Cell neoplasms) • Breast cancer • Childhood rhabdomyosarcoma • Epithelial ovarian cancer • Mantle Cell (Non-Hodgkin lymphoma) • Multiple sclerosis • Scleroderma • Scleroderma-SSc (severe, progressive) • Systemic lupus erythematosus • Systemic sclerosis *Procedures require review for medical necessity and benefit determination by an external medical director. National Transplant Program (NTP) – We are a member of the Blue Distinction Centers for Transplants.	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay
Organ/tissue transplants (cont.)	**High**
Transportation and lodging services are limited to a maximum benefit of $10,000 per Transplant Benefit Period.	Nothing
Donor testing for up to four bone marrow transplant donors from individuals unrelated to the patient in addition to testing of family members.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except as shown above* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	**High**
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center Note: General Anesthesia from a Hospital, outpatient surgical Facility or other Facility, and for the Hospital or facility charges needed for dental care for a covered Dependent child who: • Has a physical, mental or medically compromising condition; • Has dental needs for which local Anesthesia is not effective because of acute infection, anatomic variation or allergy; • Is extremely uncooperative, unmanageable, uncommunicative or anxious and whose dental needs are deemed sufficiently important that dental care cannot be deferred; or • Has sustained extensive orofacial and dental trauma.	Nothing
• Office	$20 per Primary Care Physician $30 per Specialist visit

Section 5(c). Services Provided by a Hospital or Other Facility, and Ambulance Services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage.
- 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 in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRECERTIFICATION FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.
- This plan has no calendar year deductible.

Benefit Description	You pay
Inpatient hospital	**High**
Room, board, and General Nursing Services such as • A room with two or more beds; • A private room, but only if it is determined by your physician that it is medically necessary that you occupy a private room. For example a private room may be needed for isolation. If it is medically necessary for you to be in Hospital, but not in a private room, We will only allow benefits for the Hospital's average rate for a semi-private room; and • A room in a special care unit approved by Us. The special care unit must be set up to give intensive care and support to critically ill patients.	$400 per day for a maximum of 3 days
Other hospital services and supplies, such as: • Operating, delivery and treatment rooms and supplies; • Prescribed drugs given as part of the inpatient stay; • Medical and surgical dressings, supplies, casts and splints; • Diagnostic services; • Therapy services; • General nursing care • Anesthesia, Anesthesia supplies and services • Charges for processing, transportation, handling and giving of blood. Charges for blood, blood plasma and blood products are covered unless the blood, blood plasma or blood products were given to you from a blood bank.	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds*	*All charges*

Inpatient hospital - continued on next page

Benefit Description	You pay
Inpatient hospital (cont.)	**High**
• *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	**High**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medications • Diagnostic laboratory tests, X-rays, and pathology services • Charges for processing, transportation, handling and giving of blood. • Charges for blood, blood plasma and blood products are covered unless the blood, blood plasma or blood products were given to you from a blood bank. • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service	$300 per outpatient surgery admission at an ambulatory surgical center or outpatient facility. Note: This copay only applies when a surgical procedure is performed.
• Other non-surgical care	20% of plan allowance
• CT Scans, MRI, MRA, PET, nuclear cardiology imaging studies and non-maternity related ultrasounds. Note: Prior approval is required. See Section 3.	20% of plan allowance
Extended care benefits/Skilled nursing care facility benefits	**High**
Care in a skilled nursing facility for up to **100 days in a calendar year** when full-time skilled nursing care is necessary and confinement in a skilled nursing facility is medically necessary as determined by a Plan physican and approved by the Plan.	$400 per day for a maximum of 3 days
Not covered: • *Custodial care, domiciliary or convalescent care*	*All charges*
Hospice care	**High**
We cover the following hospice care if you are terminally ill and likely have less than 6 months to live. Your Physician must agree to care by the Hospice and must be consulted in the development of the care plan. The Hospice must keep a written care plan on file and give it to Us upon request. • Care from an interdisciplinary team with the development and maintenance of an appropriate plan of care; • Short-term Inpatient Hospital care when needed in periods of crisis or as respite care; • Skilled nursing services, home health aide services, and homemaker services given by or under the supervision of a registered nurse; • Physician services and diagnostic testing; • Social services and counseling services from a licensed social worker; • Nutritional support such as intravenous feeding and feeding tubes and nutritional counseling; • Physical therapy, occupational therapy, speech therapy, and respiratory therapy given by a licensed therapist;	Nothing

Hospice care - continued on next page

Benefit Description	You pay
Hospice care (cont.)	**High**
• Pharmaceuticals, medical equipment, and supplies needed for the palliative care of your condition, including oxygen and related respiratory therapy supplies; • Prosthetics and orthopedic appliances; • Bereavement (grief) services, including a review of the needs of the bereaved family and the development of a care plan to meet those needs, both before and after the Member's death. Bereavement services are available to the patient/family consisting of those individuals who are closely linked to the patient, including the immediate family, the primary or designated care giver and individuals with significant personal ties; and • Transportation.	Nothing
Ambulance	**High**
Medically necessary Ambulance Services are covered when: • You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation. And one or more of the following criteria are met: • For ground Ambulance, you are taken: - From your home, the scene of an accident or medical Emergency to a Hospital; - Between Hospitals, including when We require you to move from an Out-of-Network Hospital to an In-Network Hospital; - Between a Hospital and a Skilled Nursing Facility or other approved Facility; - From a Hospital or Skilled Nursing Care Facility to your home. • For air or water Ambulance, you are taken: - From the scene of an accident or medical Emergency to a Hospital; - Between Hospitals, including when We require you to move from an Out-of-Network Hospital to an In-Network Hospital; • Between a Hospital and an approved Facility. Note: Benefits are only available for air Ambulance when it is not appropriate to use a ground or water Ambulance. For example, if using a ground Ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground Ambulance can provide, We will cover the air Ambulance. Air Ambulance will also be covered if you are in an area that a ground or water Ambulance cannot reach.	Nothing

Section 5(d). Emergency Services/Accidents

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 Coordinating benefits with Medicare and other coverage.
- This plan has no calendar year deductible

What is a medical emergency?

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

What to do in case of emergency.

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 physician to call your primary care physician.
- Your primary care physician will approve any other medically necessary care or will take over your care

Emergencies within our service area.

If possible, when an unexpected condition arises, call your physician – unless you believe any delay would be harmful. This applies even if it's after office hours. Your physician will tell you whether to go to the emergency room.

If you need additional care after an emergency condition is stabilized, precertification is required.

Emergencies outside our service area

If possible, when an unexpected condition arises, call your physician unless you believe any delay would be harmful. This applies even if it's after office hours. Your physician will tell you whether to go to the emergency room.

If you are admitted as an inpatient in a non-network hospital as a result of an emergency, you, your physician or a family member should call Blue Advantage HMO on the Pathway HMO Network as soon as possible for precertification of the case.

If you need additional care after an emergency condition is stabilized, precertification is required

After Hours Care

If you need care after normal business hours, your physician may have several options for you. You should call your physician's office for instructions if you need care in the evenings, on weekends, or during the holidays and cannot wait until the office reopens. If you have an Emergency, call 911 or go to the nearest Emergency Room.

Benefit Description	You pay
Emergency within our service area	**High**
• Emergency care at a physician's office	$30 per office visit
• Emergency care at an urgent care center	$30 per visit
• Emergency care on an outpatient basis at a hospital (if care results in admission to a hospital, the copayment will not apply)	$200 per visit. Copayment is waived if admitted, then $400 per day for a 3-day maximum.
Emergency outside of our service area	**High**
• Emergency care at a physician's office	$30 per office visit
• Emergency care at an urgent care center	$30 per visit
• Emergency care on an outpatient basis at a hospital (if care results in admission to a hospital, the copayment will not apply)	$200 per visit. Copayment is waived if admitted, then $400 per day for a 3-day maximum.
Ambulance	**High**
Medically necessary Ambulance Services are covered when: • You are transported by a state licensed vehicle that is designed, equipped, and used only to transport the sick and injured and staffed by Emergency Medical Technicians (EMT), paramedics, or other certified medical professionals. This includes ground, water, fixed wing, and rotary wing air transportation And one or more of the following criteria are met: • For ground Ambulance, you are taken: - From your home, the scene of an accident or medical Emergency to a Hospital - Between Hospitals, including when We require you to move from an Out-of-Network Hospital to an In-Network Hospital; - Between a Hospital and a Skilled Nursing Facility or other approved Facility; - From a Hospital for Skilled Nursing Care Facility to your home • For air or water Ambulance, you are taken: - From the scene of an accident or medical Emergency to a Hospital; - Between Hospitals, including when We require you to move from an Out-of-Network Hospital to an In-Network Hospital; • Between a Hospital and an approved Facility Note: Benefits are only available for air Ambulance when it is not appropriate to use a ground or water Ambulance. For example, if using a ground Ambulance would endanger your health and your medical condition requires a more rapid transport to a Facility than the ground Ambulance can provide, We will cover the air Ambulance. Air Ambulance will also be covered if you are in an area that a ground or water Ambulance cannot reach.	Nothing

Section 5(e). Mental Health and Substance Use Disorder Benefits

Important things you should 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 for 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 Coordinating benefits with Medicare and other coverage.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.
- This plan has no calendar year deductible.

Benefit Description	You pay
Professional services	**High**
We cover professional services by licensed professional mental health and substance use disorder treatment practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers, licensed professional counselors, or marriage and family therapists	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy) • Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or group therapy visits) • Diagnosis and treatment of alcoholism and drug use, including detoxification, treatment and counseling • Professional charges for intensive outpatient treatment in a provider's office or other professional setting • Electroconvulsive therapy • Intensive in-home behavioral health services, when available in your area. These services do not require confinement to the home	$30 Per Mental Health Office Visit
Inpatient hospital physician visit	Nothing
Individual and group psychotherapy for the treatment of smoking cessation	Nothing
Nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa	Nothing

Benefit Description	You pay
Diagnostics	**High**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance use disorder treatment practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility • Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing
Inpatient hospital or other covered facility	**High**
Inpatient services provided and billed by a hospital or other covered facility. • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Residential treatment center	$400 per day for a maximum of 3 days
Outpatient hospital or other covered facility	**High**
Outpatient services provided and billed by a hospital or other covered facility. • Services in approved treatment programs, such as partial hospitalization, half-way house, full-day hospitalization, or facility-based intensive outpatient treatment.	Nothing
Not covered: • *Marital counseling or personal growth*	*All charges*

Section 5(f). Prescription Drug Benefits

Important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on page 53.
- 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.
- Members must make sure their prescribers obtain prior approval/authorizations for certain prescription drugs and supplies before coverage applies. Prior approval/authorizations must be renewed periodically.
- Federal law prevents the pharmacy from accepting unused medications.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage.
- This plan has no calendar year deductible.

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

Who can write your prescription?

A licensed physician or dentist, and in states allowing it, licensed/certified providers with prescriptive authority prescribing within their scope of practice must prescribe your medication. Certain over-the-counter items for smoking cessation, nicotine replacement, FDA-approved contraceptives for women, vitamins, supplements, and health aids, may be covered when obtained with a physician's prescription. This rule does not apply to pneumonia or seasonal flu vaccinations provided at a member drug store.

Where you can obtain them.

You may fill the prescription at any licensed retail participating pharmacy or by the mail service program for a maintenance medication. When using a plan pharmacy you have two levels to choose from. Level 1 pharmacies will have lower copayments and Level 2 pharmacies will have higher copayments. Call us at 833-611-6919 or visit our website at www.anthem.com/federal-employees/health-plans-co/ for information on how to obtain a listing of the Level 1 and Level 2 pharmacies.

We use a formulary.

We use a four-tier formulary. Drugs are prescribed by Plan physicians and dispensed in accordance with Blue Advantage HMO on the Pathways HMO Network's drug formulary. The Essential prescription drug list is a list of pharmaceutical products, developed in consultation with physicians and pharmacists, approved for their quality and cost effectiveness. The covered prescription drug list is subject to periodic review and amendment. Except as otherwise stated, certain drugs may not be covered if they are not on the Essential prescription drug list. To obtain our formulary, you may check the Blue Advantage HMO website at www.anthem.com/federal-employees/health-plans-co/ or call Client Services at 833-611-6919. The Plan may require authorization for certain drugs before they are dispensed. It is the prescribing physician's responsibility to obtain the Plan's authorization.

These are the dispensing limitations.

Prescription drugs prescribed by Plan physicians and obtained at Plan pharmacies will be dispensed for up to a 30-day supply for retail pharmacies; 90-day supply from the mail order program or 30-day supply for the Specialty Pharmacy. If a member is called to active military duty, or in times of national or other emergency, call us to arrange for a medium-term supply of covered medications.

Why use generic drugs?

Generic drugs normally cost considerably less than brand name drugs. So, the copayment you pay for generic drugs is also lower. The generic name of a drug is its chemical name. The brand name is the trade name under which the drug is advertised and sold. By law, generic and brand name drugs must meet the same standards for safety, purity, strength and effectiveness. They are dispensed in the same dosage and taken in the same way.

Specialty Pharmacy

Certain Specialty Drugs are only available from the Specialty Pharmacy and you will not be able to get them at a Retail Pharmacy or through the Home Delivery (Mail Order) Pharmacy.

When you use the PBM's Specialty Pharmacy, its patient care coordinator will work with you and your physician to get prior authorization and to ship your Specialty Drugs to your home or your preferred address. Your patient care coordinator will also tell you when it is time to refill your prescription.

You can get the list of covered Specialty Drugs by calling member services at the phone number on the back of your Health Benefit ID Card or check our website at www.anthem.com/federal-employees/health-plans-co/.

Prescription drug tiers

Your share of the cost for Prescription Drugs may vary based on the tier the Drug is in.

- Tier 1 Drugs have the lowest Coinsurance or Copayment. This tier contains low cost and preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, or Interchangeable Biologic Products.
- Tier 2 Drugs have a higher Coinsurance or Copayment than those in Tier 1. This tier may contain preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, or Interchangeable Biologic Products.
- Tier 3 Drugs have a higher Coinsurance or Copayment than those in Tier 2. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, or Interchangeable Biologic Products.
- Tier 4 Drugs have a higher Coinsurance or Copayment than those in Tier 3. This tier may contain higher cost, preferred, and non-preferred Drugs that may be Generic, single source Brand Drugs, Biosimilars, or Interchangeable Biologic Products.

When you need to file a claim.

See instructions for filing claims in Section 7.

Benefit Description	You pay
Covered medications and supplies	**High**
We cover the following medications and supplies prescribed by a physician and obtained from a retail pharmacy or through our mail order program: • Drugs and medications which need a prescription by law. Formulas prescribed by a physician for the treatment of phenylketonuria. These formulas are subject to the copay for brand name drugs. • Insulin, glucagon, and other prescription drugs for the treatment of diabetes • Syringes for use with insulin and other medications you inject yourself • Drugs that have FDA labeling to be injected under the skin by you or a family member • Disposable diabetic supplies (that is, testing strips, lancets, and alcohol swabs) • Off label use of covered drugs if prescribed by a Plan physician Note: Written prescriptions are valid for 12 months from the date the prescription is written.	**Level 1 Retail Pharmacy (up to a 30-day supply):** Tier 1 - $5 Tier 2 - $50 Tier 3 - $70 **Level 2 Retail Pharmacy (up to a 30-day supply):** Tier 1 - $15 Tier 2 - $60 Tier 3 - $80 **Tier 4:** 25% of our allowance up to a maximum out-of-pocket of $250 per prescription order for a 30-day supply. **Mail order (up to a 90-day supply)**: Tier 1 - $10 Tier 2 - $125 Tier 3 - $175

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High**
Note: A 90-day supply of maintenance drugs can be obtained at a maintenance drugstore. For more details contact the member services number on the back of your identification card. Note: Specialty drugs must be obtained through the Specialty Pharmacy. You cannot obtain specialty drugs from a retail pharmacy unless we have granted an exception.	**Level 1 Retail Pharmacy (up to a 30-day supply):** Tier 1 - $5 Tier 2 - $50 Tier 3 - $70 **Level 2 Retail Pharmacy (up to a 30-day supply):** Tier 1 - $15 Tier 2 - $60 Tier 3 - $80 **Tier 4:** 25% of our allowance up to a maximum out-of-pocket of $250 per prescription order for a 30-day supply. **Mail order (up to a 90-day supply)**: Tier 1 - $10 Tier 2 - $125 Tier 3 - $175
• FDA approved drugs for the treatment of tobacco use. Note: This includes prescription and physician prescribed over-the-counter medications.	Nothing
• Women's contraceptive drugs and devices, including the morning after pill, if prescribed by a physician and purchased at a network pharmacy Note: Over-the-counter contraceptive drugs and devices approved by the FDA require a written prescription by an approved provider.	Nothing
Preventive care medications Medications to promote better health as recommended by ACA. The following drugs and supplements are covered without cost-share, even if over-the-counter, are prescribed by a health care professional and filled at a network pharmacy. The list includes but is not limited to: • Aspirin (81 mg) for men age 45-79 and women age 55-79 and women of childbearing age • Folic acid supplements for women of childbearing age 400 & 800 mcg • Pre-natal vitamins for pregnant women • Fluoride tablets, solution (not toothpaste, rinses) for children age 0-6 Note: To receive this benefit a prescription from a physician must be presented to pharmacy.	Nothing

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High**
Preventive drugs for the following conditions: • Asthma • Blood clots • Diabetes • Heart health and high blood pressure • High cholesterol • Osteoporosis • Stroke Note: You may obtain a copy of the drug list by calling the customer service number on the back of your identification card or visit the web site at www.anthem.com/federal-employees/health-plans-co/.	Nothing
Not covered: • *Drugs and medications used to induce spontaneous and non-spontaneous abortions* • *Prescription Drugs and supplies received from an Out-of-Network pharmacy* • *Prescription Drugs and supplies received as an inpatient in a hospital or other covered inpatient Facility, except where covered as part of the inpatient stay* • *Medication or preparations used for Cosmetic purposes to promote hair growth, prevent hair growth, or medicated cosmetics. These included but are not limited to Rogaine®, Viniqa®, and Tretinoin (sold under such brand names as Retin-A®)* • *Drugs not approved by the FDA* • *Any medications used to treat infertility* • *Charges for the administration of any drug unless dispensed in a Physician's office or through home health care* • *Drugs not requiring a prescription by federal law (including drugs requiring a prescription by state law, but not federal law) except for injectable insulin, or where applicable law requires coverage of the drug* • *Prescription Drugs, which are dispensed in quantities or refill frequency which exceed the applicable limits established by Us, at Our sole discretion* • *Refills of prescriptions in excess of the quantity prescribed by the Provider, or refilled more than one year from the date prescribed* • *Replacement of lost or stolen Prescription Drugs* • *Drugs not on the Prescription Drug List (a formulary). You can get a copy of the list by calling Us or visiting Our website at www.anthem.com/federal-employees/health-plans-co/* • *Drugs for Onychomycosis (toenail fungus) except when we allow it to treat members who are immune-compromised or diabetic* • *Drugs and supplies for cosmetic purposes*	*All charges*

Covered medications and supplies - continued on next page

Benefit Description	You pay
Covered medications and supplies (cont.)	**High**
• *Drugs to enhance athletic performance* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Nonprescription medications medicines* *Note: Over-the-counter and appropriate prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco Cessation benefit (see page 36)*	*All charges*

Section 5(g). Dental Benefits

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.
- If you are enrolled in a Federal Employees Dental/Vision Insurance Program (FEDVIP) Dental Plan, your FEHB Plan will be First/Primary payor of any Benefit payments and your FEDVIP Plan is secondary to your FEHB Plan. See Section 9 Coordinating benefits with Medicare and other coverage.
- Plan dentists 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 5(c)).
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 Coordinating benefits with Medicare and other coverage.

Benefit Description	You Pay
Accidental injury benefit	**High**
We cover the initial repair of an Accidental Injury to the jaw, sound natural teeth, or related body tissue, mouth or face and only if received within seventy-two (72) hours of the accident. Such dental services do not include dental restoration. Injury as a result of chewing or biting is not considered an Accidental Injury, unless the chewing or biting results from a medical or mental condition.	Cost-share is based upon place of service. See specific benefit descriptions in Sections 5(a), 5(b), and 5(c).
Not covered: • *All dental services received after seventy-two (72) hours following the accident are not covered.* • *Excluded dental services include, but are not limited to, preventive care and fluoride treatments; dental x-rays, supplies, appliances and all associated expenses; and diagnosis and treatment related to the teeth, jawbones or gums such as extraction (including dental prosthesis and any treatment for teeth, gums, tooth or upper or lower jaw augmentation or reduction (orthognathic Surgery), extraction of impacted wisdom tooth), restoration and replacement of teeth, and services to improve dental clinical outcomes.*	*All charges*

Section 5(h). Wellness and Other Special Features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. Note: Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefit decision under the OPM disputed claim process (see Section 8).
24/7 Nurse Line (24-hour nurse assessment service)	This is a free 24-hour phone service link to non-emergency health information. Simply call the toll-free number on the back of your Plan ID card day or night to speak to a registered nurse. You also have access, through the internet www.anthem.com, to receive customized health information.

Feature	Description
Reciprocity	**BlueCard® Program** With the BlueCard® Program, Plan members have access to benefits when traveling outside the Plan's service area for urgent care and emergency room services. To find a nearby health care provider, members can simply call BlueCard Access at 800-810-BLUE (2583). **Guest Membership Program** If you will be in a different Service Area outside of Colorado for at least 90 consecutive days, the Guest Membership benefits helps to ensure that you have ongoing access to your BlueAdvantage HMO on the Pathway HMO Network health care benefits. To set-up your membership, follow these steps: • Call Guest Membership toll free at 1-800-827-6422 for eligibility and specific location information. Guest Membership is not available in all areas. • If a participating HMO (Host HMO) is in your destination area, Guest Membership will send you an application to complete, sign and return in an enclosed self-addressed envelope. Guest Membership will forward your completed application to the Host HMO. Please allow 20-30 calendar days for processing your application. • The Host HMO will send you a health plan identification card, the name of your PCP (in some cases, you may be asked to choose a PCP), and information on how to use your Guest Membership. • The Host HMO does not cover dental, vision, chiropractic care, massage therapy, acupuncture, nutritional counseling and substance abuse rehabilitation. • Use your health plan identification card to access prescription benefits in the Host HMO area.
Centers of Excellence	A network of health care facilities, which have been selected to give specific services to our members based on their experiences, outcomes, efficiency, and effectiveness. We use the Blue Distinction Centers for Transplants as our transplant network. The network consists of leading medical facilities throughout the nation. For a list of transplant hospitals near you, call 800-824-0581. The Plan also has Blue Distinction Centers for: • Cardiac Care • Knee and Hip Replacement • Complex and Rare Cancer • Bariatric Surgery • Spine Surgery

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 the FEHB out-of-pocket maximum. Your medical program copay does not apply to these services. You must pay for the services or supplies when you receive them.

Discount programs

You can receive negotiated savings on selected health and wellness services and programs simply by being an eligible BlueAdvantage HMO on the Pathway HMO Network member. To obtain information about these programs please call us at 833-611-6919 or visit our website at www.anthem.com. Services available through the discount program includes but are not limited to:

- **Puritan's Pride** – discounts on various vitamins, minerals and supplements
- **LivingFree** – discount on smoking cessation classes
- **LivingEasy** – discounts on stress management programs
- **LivingLean** – discounts on weight-loss programs
- **LifeMart** – deals on beauty/skin care, diet plans, fitness clubs, spas and more
- **Safebeginnings** – discounts on baby-proofing products
- **HelpCare Plus** – Senior Care Services with access to a pharmacy discount card
- **EyeMed** – discounts on glasses and accessories
- **HearPO** – discounts on hearing aids
- **TruVision** – preferred pricing on LASIK eye surgery
- **GlobalFit–** discounts on gym memberships, fitness equipment, coaching and more

Anthem Protect short-term disability insurance

Income protection exclusively for federal employees

Plan highlights:

- Flexible design; customize insurance plan and benefits specific to your budget and life circumstances.
- Guaranteed acceptance; federal employees are eligible regardless of health history
- Quick-and-easy enrollment process
- Lump-sum cash benefits provided if you suffer a covered disability

Who is eligible?

An applicant is eligible for Anthem Protect short-term disability insurance if they are a federal civilian employee working in the United States for a minimum of 20 hours per week. Applicant can enroll in insurance during the annual open enrollment period or within 60 days from date they become eligible.

Make sure help is available when you need it!

Questions? Please contact the number listed on your ID card or visit www.anthem.com/federal-employees/health-plans-co/ to sign up today.

Section 6. General Exclusions – Services, Drugs, and Supplies We Do Not Cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. **Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition.** For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services.*

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies 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 (see specifics regarding transplants).
- 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 you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Services or supplies furnished by yourself, immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption.

Section 7. Filing a Claim for Covered Services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan providers, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and you pay your copayment, coinsurance or deductible, if applicable.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

If you need to file the claim, here is the process:

Medical and Hospital benefits

In most cases, providers and facilities file claims for you. Providers must file on the form CMS-1500, Health Insurance Claim Form. Your facility will file on the UB-04 form. To obtain claim forms, or for claims questions and assistance, call us at 833-611-6919 or at our website at www.anthem.com/federal-employees/health-plans-co/.

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

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

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

Submit your claims to: BlueAdvantage HMO on the Pathway HMO Network, P.O. Box 5747 Denver, CO 80217-5747.

Prescription drugs

You normally won't have to submit claims to us unless you receive prescriptions from a non-participating pharmacy. You need to take a claim form with you to the non-participating pharmacy. If you need a claim form or if you have questions, call the Pharmacy Member Services number on the back of your Plan Identification Card, or at our website at www.anthem.com. Have the pharmacist fill out the form and sign it. Then send the claim form (within 90 days).

Submit your claims to: Claims Department: P.O. Box 52065, Phoenix, AZ 85072-2065

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive your post-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

If you do not agree with our initial decision, you may ask us to review it by following the disputed claims process detailed in Section 8 of this brochure.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, a health care professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Notice Requirements

If you live in a county where at least 10 percent of the population is literate only in a non-English language (as determined by the Secretary of Health and Human Services), we will provide language assistance in that non-English language. You can request a copy of your Explanation of Benefits (EOB) statement, related correspondence, oral language services (such as telephone customer assistance), and help with filing claims and appeals (including external reviews) in the applicable non-English language. The English versions of your EOBs and related correspondence will include information in the non-English language about how to access language services in that non-English language.

Any notice of an adverse benefit determination or correspondence from us confirming an adverse benefit determination will include information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount, if applicable), and a statement describing the availability, upon request, of the diagnosis and procedure codes.

Section 8. The Disputed Claims Process

You may appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information or to make an inquiry about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please call your plan's customer service representative at the phone number found on your enrollment card, plan brochure, or plan website.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-services claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision*, we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing to BlueAdvantage HMO on the Pathway HMO Network, Attn: Anthem Member Appeals: BlueAdvantage HMO on the Pathway HMO Network, Attn: Anthem Member Appeals, 700 Broadway, Denver, CO 80273 or calling 833-611-6919.

Our reconsideration will take into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based (in whole or in part) on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not involved in making the initial decision.

Our reconsideration will not take into account the initial decision. The review will not be conducted by the same person, or his/her subordinate, who made the initial decision.

We will not make our decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

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: BlueAdvantage HMO on the Pathway HMO Network, Attn: Member Appeals, Mail No. OH3402-B014, 3075 Vandercar Way, Cincinnati, OH 45209; 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. e) Include your email address (optional for members), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stare described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or

	b) Write to you and maintain our denial or c) Ask you or your provider for more information You or your provider must send 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.
3	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: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, FEHB 2, 1900 E Street, NW, Washington, DC 20415. 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 physician's 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 letter we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. 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 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. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	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 file a lawsuit, 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 file a lawsuit 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 you did not indicate that your claim was a claim for urgent care, then call us at 833-611-6919. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 2 at 202-606-3818 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about plan eligibility issues. For example, we do not determine whether you or a dependent is covered under this plan. You must raise eligibility issues with your Agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

Section 9. Coordinating Benefits with Medicare and Other Coverage

When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' (NAIC) guidelines. For more information on NAIC rules regarding the coordinating of benefits, visit our website at www.anthem.com.

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

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

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 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 TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You (or a covered family member) 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 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

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we pay benefits for that injury or illness, you must agree to the provisions listed below. In addition, if you are injured and no other person or entity is responsible but you receive (or are entitled to) a recovery from another source, and if we provide benefits for that injury, you must agree to the following provisions:

- All recoveries you obtain (whether by lawsuit, settlement, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or, if applicable, to your heirs, administrators, successors, or assignees.
- Reimbursement to us out of your recoveries shall take first priority (before any of the rights of any other parties are honored). Our right of reimbursement is not subject to reduction based on attorney fees or costs under the "common fund" doctrine. Our right of reimbursement is fully enforceable regardless of whether you are "made whole" (you are fully compensated for the full amount of damages claimed). We will not reduce our share of any recovery unless we agree in writing to a reduction, because (1) you do not receive the full amount of damages that you claimed, or (2) you had to pay attorneys' fees. This is our right of recovery.
- If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.
- If we pursue a recovery of the benefits we have paid, you must cooperate in doing what is reasonably necessary to assist us. You must not take any action that may prejudice our rights to recover.

You must tell us promptly if you have a claim against another party for a condition that we have paid or may pay benefits for, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay.

We may request that you assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the assignment.

Note: We will pay the costs of any covered services you receive that are in excess of any recoveries made.

The following are examples of circumstances in which we may subrogate or assert a right of recovery:

- When you or your dependent are injured on premises owned by a third party; or
- When you or your dependent are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to:

  - Personal injury protection benefits
  - Uninsured and underinsured motorist coverage (does not include no-fault automobile insurance)
  - Workers' compensation benefits
  - Medical reimbursement coverage

Contact us if you need more information about subrogation.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB Plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, or by phone 877-888-3337, TTY 877-889-5680, you will be asked to provide information on your FEHB Plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Clinical Trials

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as physician visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by the Plan.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan does not cover these costs.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis or results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This Plan does not cover these costs.

When you have Medicare

For more detailed information on “What is Medicare?” and “Should I Enroll in Medicare?” please contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

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 is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept 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 when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at 833-611-6919 or see our website at www.anthem.com.

We do not waive any costs if the Original Medicare Plan is your primary payor.

Please review the following table as it illustrates your cost share if you are enrolled in Medicare Part B as Medicare will be primary for all Medicare eligible services. Members must use providers who accept Medicare's assignment.

Benefit Description	You Pay without Medicare	You Pay with Medicare Part B
Deductible	$0	$0
Out of Pocket Maximum	$5,000 for Self Only or $5,000 per person for Self Plus One or $10,000 for Family	$5,000 for Self Only or $5,000 per person for Self Plus One or $10,000 for Family
Part B Premium Reimbursement Offered	NA	NA
Primary Care Physician	$20	$20
Specialist	$30	$30
Inpatient Hospital	$400 per day for a maximum of 3 days	$400 per day for a maximum of 3 days
Outpatient Hospital	$300 per visit for surgical admissions or 20% of plan allowance for non-surgical admission.	$300 per visit for surgical admissions or 20% of plan allowance for non-surgical admission.
Incentives Offered	NA	NA

Tell us about your Medicare coverage

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

Medicare Advantage (Part C)

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage Plans in this section.

To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and our Medicare Advantage plan: You may enroll in an Anthem Medicare Advantage 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.

In the Anthem Medicare Advantage Plan we offer benefits, such as wellness programs like SilverSneakers®.

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers).

However, we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage 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 Advantage plan's service area.

Medicare prescription drug coverage (Part D)

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor 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. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) 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) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

Section 10. Definitions of Terms We Use in This Brochure

Calendar year

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

Clinical Trials Cost Categories

An approved clinical trial includes a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is either Federally funded; conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this health plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs - costs for routine services such as physician visits, lab test, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy.
- Extra care costs - costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.
- Research costs - costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials. This plan does not cover these costs.

Coinsurance

See Section 4, page 23.

Copayment

See Section 4, page 23.

Cost-sharing

See Section 4, page 23.

Covered services

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

Custodial care

Custodial care is care primarily 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 Provider are not needed.

Experimental or investigational services

Experimental or Investigational -

(a) Any Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation or treatment of a disease, injury, illness or other health condition which We determine in Our sole discretion to be Experimental or Investigational.

We will deem any Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be Experimental or Investigational if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought.

The Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA) or any other state or federal regulatory agency, and such final approval has not been granted;
- Has been determined by the FDA to be contraindicated for the specific use;

- Is provided as part of a clinical research protocol or clinical trial (except as noted in the Clinical Trials section under Covered Services in this brochure as required by state law), or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (IRB) or other body serving a similar function; or
- Is provided pursuant to informed consent documents that describe the Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as Experimental or Investigational, or otherwise indicate that the safety, toxicity or efficacy of the Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation.

(b) Any service not deemed Experimental or Investigational based on the criteria in subsection (a) may still be deemed to be Experimental or Investigational by Us. In determining whether a service is Experimental or Investigational, We will consider the information described in subsection (c) and assess all of the following:

- Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes;
- Whether the evidence demonstrates that the service improves the net health outcomes of the total population for whom the service might be proposed as any established alternatives; or
- Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the service might be proposed under the usual conditions of medical practice outside clinical investigatory settings.

(c) The information We consider or evaluate to determine whether a Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is Experimental or Investigational under subsections (a) and (b) may include one or more items from the following list, which is not all-inclusive:

- Randomized, controlled, clinical trials published in authoritative, peer-reviewed United States medical or scientific journal;
- Evaluations of national medical associations, consensus panels and other technology evaluation bodies;
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate or investigate the use of the Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply;
- Documents of an IRB or other similar body performing substantially the same function;
- Consent documentation(s) used by the treating Physicians, other medical professionals or facilities, or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply;
- The written protocol(s) used by the treating Physicians, other medical professionals or facilities or by other treating Physicians, other medical professionals or facilities studying substantially the same Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply;
- Medical records; or
- The opinions of consulting Providers and other experts in the field.

(d) We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a Drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is Experimental or Investigational.

Health care professional A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Maintenance drugs A Maintenance Medication is a Drug you take on a regular basis to treat or control a chronic illness such as heart disease, high blood pressure, epilepsy, or diabetes. If you are not sure the Prescription Drug you are taking is a Maintenance Medication or need to determine if your Pharmacy is a Maintenance Pharmacy, please call member services at the number on the back of your Health Benefit ID Card or check Our website at www.anthem.com for more details.

Maintenance drugstore A member drugstore that is contracted with our pharmacy benefit manager to dispense a 90-day supply of maintenance drugs.

Medically Necessary The diagnosis, evaluation and treatment of a condition, illness, disease or injury that We solely decide to be:

- Medically appropriate for and consistent with your symptoms and proper diagnosis or treatment of your condition, illness, disease or injury;
- Obtained from a Physician or Provider;
- Provided in line with medical or professional standards;
- Known to be effective, as proven by scientific evidence, in improving health;
- The most appropriate supply, setting or level of service that can safely be provided to you and which cannot be omitted. It will need to be consistent with recognized professional standards of care. In the case of a Hospital stay, also means that safe and adequate care could not be obtained as an outpatient;
- Cost-effective compared to alternative interventions, including no intervention. Cost effective does not always mean lowest cost. It does mean that as to the diagnosis or treatment of your illness, injury or disease, the service is: (1) not more costly than an alternative service or sequence of services that is medically appropriate, or (2) the service is performed in the least costly setting that is medically appropriate;
- Not Experimental or Investigational;
- Not primarily for you, your families, or your Provider’s convenience; and
- Not otherwise an exclusion under this brochure.

The fact that a Physician or Provider may prescribe, order, recommend or approve care, treatment, services or supplies does not, of itself, make such care, treatment, services or supplies Medically necessary.

Plan allowance The maximum amount that We will allow for Covered Services that you receive.

Post-service claims Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order the apply for benefits.

Pre-service claims Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Reimbursement A carrier's pursuit of a recovery if a covered individual has suffered an illness or injury and has received, in connection with that illness or injury, a payment from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, and the terms of the carrier's health benefits plan require the covered individual, as a result of such payment, to reimburse the carrier out of the payment to the extent of the benefits initially paid or provided. The right of reimbursement is cumulative with and not exclusive of the right of subrogation.

Subrogation

A carrier's pursuit of a recovery from any party that may be liable, any applicable insurance policy, or a workers' compensation program or insurance policy, as successor to the rights of a covered individual who suffered an illness or injury and has obtained benefits from that carrier's health benefits plan.

Urgent care claims

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve pre-service claims and not post-service claims. We will determine whether or not a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Customer Service Department at 833-611-6919. You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refers to BlueAdvantage HMO on the Pathway HMO Network.

You

You refers to the enrollee and each covered family member.

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 BlueAdvantage HMO on the Pathway HMO Network - 2021

- **Do not rely on this chart alone.** This is a summary. All benefits are subject to the definitions, limitations, and exclusions in this brochure. Before making a final decision, please ready this FEHB brochure. You can also obtain a copy of our Summary of Benefits and Coverage as required by the Affordable Care Act at www.anthem.com/federal-employees/health-plans-co/.
- 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	PCP office visit copay: $20 Specialist office visit copay: $30	27
Services provided by a hospital:		
• Inpatient	$400 per day for a maximum of 3 days.	45
• Outpatient	20% of plan allowance per admission unless surgery is performed, otherwise $300 outpatient surgery per admission.	46
Emergency visit to a hospital emergency room:		
• In-area or out-of-area	$200 per visit	49
Mental health and substance use disorder treatment:		
• Inpatient	$400 per day for a maximum of 3 days	51
• Outpatient	Regular cost-sharing	51
Prescription drugs:		
• **Retail pharmacy** - Up to a 30-day supply from a participating retail pharmacy. Note: You must obtain specialty medications from the Specialty Pharmacy Program.	<table><tr><td></td><td>Level 1</td><td>Level 2</td></tr><tr><td>Tier 1</td><td>$5</td><td>$15</td></tr><tr><td>Tier 2</td><td>$50</td><td>$60</td></tr><tr><td>Tier 3</td><td>$70</td><td>$80</td></tr><tr><td colspan="3">Tier 4: 25% of our allowance up to a maximum of $250</td></tr></table>	53
• **Mail-order Program -** up to a 90-day supply Note: Tier 4 medication is not available through the mail order pharmacy.	Tier 1: $10 Tier 2: $125 Tier 3: $175	54
Dental care: Restorative services for accidental injury only	Cost-share is based upon place of service. See specific benefit description in Sections 5(a), 5(b), and 5(c).	56
Vision care:	Annual eye refraction; $20 PCP or $30 Specialist visit.	33
Special features: 24/7 Nurse Line		57
Protection against catastrophic costs: (your catastrophic protection out-of-pocket maximum)	Nothing after $5,000/Self Only or $5,000 per person/Self Plus One or $10,000/Self and Family per year	23

Notes

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Notes

2021 Rate Information for BlueAdvantage HMO on the Pathway HMO Network

To compare your FEHB health plan options please go to www.opm.gov/fehbcompare.

To review premium rates for all FEHB health plan options please go to **www.opm.gov/FEHBpremiums** or **www.opm.gov/Tribalpremium**.

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, contact the agency that maintains your health benefits enrollment.

Postal rates apply to certain United States Postal Service employees as follows:

- **Postal Category 1** rates apply to career bargaining unit employees who are represented by the following agreement: NALC.
- **Postal Category 2** rates apply to career bargaining unit employees who are represented by the following agreement: PPOA.

Non-Postal rates apply to all career non-bargaining unit Postal Service employees and career bargaining unit employees who are represented by the following agreements: APWU, IT/AS, NPMHU, NPPN and NRLCA. Postal rates do not apply to non-career Postal employees, Postal retirees, and associate members of any Postal employee organization who are not career Postal employees.

USPS Human Resources Shared Service Center: 1-877-477-3273, option 5, Federal Relay Service 1-800-877-8339

Premiums for Tribal employees are shown under the monthly non-Postal column. The amount shown under employee contribution is the maximum you will pay. Your Tribal employer may choose to contribute a higher portion of your premium. Please contact your Tribal Benefits Officer for exact rates.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Colorado							
High Option Self Only	WW1	$220.28	$73.42	$477.26	$159.09	$70.49	$60.94
High Option Self Plus One	WW3	$501.11	$167.04	$1,085.75	$361.91	$160.36	$138.64
High Option Self and Family	WW2	$536.36	$178.79	$1,162.12	$387.37	$171.64	$148.39