Enclosure 2B - HMO brochure examples

HMO TYPESETTING EXAMPLES

This is the key for the "Print size" and "Print style". Follow the visual in making text: **bold,** ***bold-italicized,*** and *italicized*, and for shading degrees.

Times New Roman, 32-point

Times New Roman, 14-point

Times New Roman, 16-point

Times New Roman, 13-point

Times New Roman, 10 point

{Use Graphic for logo AND its text}

Times New Roman, 11-point

Times New Roman, 12-point

Tahoma, 14-point (or equivalent)

Attach Your Logo

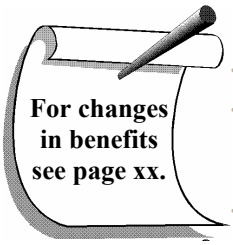
HMO name

http://www.planAddress.org

2004

HMO TYPESETTING EXAMPLES

A Health Maintenance Organization with a point of service product



Serving: *{insert general service area in relationship to the nearest Metropolitan area, e.g., "Baltimore metropolitan area"}*

Enrollment in this Plan is limited. You must live or work in our Geographic service area to enroll. See page X for requirements. *{Plan specific whether it is "live in" or "live or work in".}*

Add logo for any accreditation you have and say below it:

This Plan has _____ accreditation from the _____. See the 2004 Guide for more information on accreditation.

Enrollment codes for this Plan:

001 Self Only
002 Self and Family

Special notice: This Plan is offered for the first time under the Federal Employees Health Benefits Program during the 2004 Open Season. *{add this if applicable}*

Authorized for distribution by the:

United States
Office of Personnel Management

Center for
Retirement and Insurance Services
http://www.opm.gov/insure

FEHB
Federal Employees
Health Benefits Program

Table of Contents

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{ Section 2. How we change for 2004

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 3 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is clarification that does not change benefits. *{Plan -- add from below all that apply, along with your changes }*

☐ **Program-wide changes**

-

Changes to this Plan

-

HMO TYPESETTING EXAMPLES

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at xxx-xxx-xxxx or write to us at *{Plan address}*. You may also request replacement cards through our Web site at *{Plan Web site, if applicable}*.

Where you get covered care

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

• Plan providers

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

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

•Plan facilities

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site. {*Plan specific - list optional}*

What you must do to get covered

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

•Primary care

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

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

• Specialty care

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals. The primary care physician must provide or

authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral. However, you

Section 5. Benefits -- OVERVIEW

(See page xx for how our benefits changed this year and page xx for a benefits summary.)

Note: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at *{phone number}* or at our Web site at www. *{insert Web address}*.

(a) Medical services and supplies provided by physicians and other health care professionals .....xx-xx*{page #'s of section}*

- Diagnostic and treatment services
- Lab, X-ray, and other diagnostic tests
- Preventive care, adult
- Preventive care, children
- Maternity care
- Family planning
- Infertility services
- Allergy care
- Treatment therapies
- Physical and occupational therapy
- Speech therapy
- Hearing services (testing, treatment, and supplies)
- Vision services (testing, treatment, and supplies)
- Foot care
- Orthopedic and prosthetic devices
- Durable medical equipment (DME)
- Home health services
- Chiropractic
- Alternative treatments
- Educational classes and programs

(b) Surgical and anesthesia services provided by physicians and other health care professionals.....xx-xx

- Surgical procedures
- Reconstructive surgery
- Oral and maxillofacial surgery
- Organ/tissue transplants
- Anesthesia

(c) Services provided by a hospital or other facility, and ambulance services.....xx-xx

- Inpatient hospital
- Outpatient hospital or ambulatory surgical center
- Extended care benefits/skilled nursing care facility benefits
- Hospice care
- Ambulance

(d) Emergency services/accidents.....xx-xx

- Medical emergency
- Ambulance *{Note, if you STET Accidental injury in the text, add it back here}}*

(e) Mental health and substance abuse benefits.....xx-xx

(f) Prescription drug benefits.....xx

(g) Special features.....xx

- Flexible benefits option
- *{Bullet list your other special features}*

(h) Dental benefits *{do not remove this-in benefit section show "no benefit" if you don't have dental benefits}*.....xx

(i) Point of service benefits *{remove this & renumber if you don't have POS benefits}* xx

(j) Non-FEHB benefits available to Plan members *{remove this if you don't have non-FEHB benefits}* xx

Summary of benefits.....xx

{insert page # for summary at back of brochure}

HMO TYPESETTING EXAMPLES

Section 5 (a) Medical services and supplies provided by physicians and other health care professionals

IMPORTANT

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

- ☐ Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- ☐ Plan physicians must provide or arrange your care.
- ☐ The calendar year deductible is: *{plan specific}* $275 per person ($550 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply. . *{If you want, you can say, "We added asterisks - * - to show when the calendar year deductible does not apply."}. {If HMO – if you don't have deductible, remove this check mark or say "We have no calendar year deductible.}*
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

40% shading

Benefit Description	You pay After the calendar year deductible…	
☐ **NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.** *{Delete the row if you don't' have a deductible.}*		
Diagnostic and treatment services	**You pay - Standard Option**	**You pay - High Option**
☐ Professional services of physicians • In physician's office	$10 per visit ***{Minimum copay for primary care office visit is $10 per 2000 negotiations.}*** *{{When you have different copay for primary care and specialty care, say:* $10 per visit to your primary care physician $5 per visit to a specialist *{Change copay descriptions to fit your circumstances}*	

10% shading

HMO TYPESETTING EXAMPLES

{ Section 6. General exclusions -- things we don't cover

☐The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.**

[[Alternate ending for plans with precertification/prior approval:]] . . . or condition and we agree, as discussed under *Services Requiring our prior approval* on page xx.

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest {*plan specific—can vary; discuss with contract specialist }*;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program, or
- Services, drugs, or supplies you receive without charge while in active military service.

*{{Insert other "**General** Exclusions" that apply—your contract specialist will help you edit for plain language and necessity – BE SURE TO PUT "; or" after the next to last entry and then a period after the last entry}}*

HMO TYPESETTING EXAMPLES

Section 7. Filing a claim for covered services

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

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. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at xxx.

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

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

Submit your claims to: **{{*insert Plan address*}}**

Prescription drugs

{*Insert Plan-specific process; if same as above, change the header in the above to "Medical, Hospital and Drug benefits"*}

Submit your claims to: *{{insert plan address}}*

Other supplies or services

{*Insert Plan-specific process, such as dental, DME, vision, chiropractic; if same as above, don't put this header in*}

Submit your claims to: **{{***insert plan address}}*

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.

HMO TYPESETTING EXAMPLES

Section 8. The disputed claims process

{NOTE: For step numbers below, sample below is 16pt Tahoma. But as long as the numbers stand out and look balanced, it won't matter what type face you use.}

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

☐Step	Description
1	☐Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: {{Plan address}}; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	☐We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group 3, 1900 E Street, NW, Washington, DC 20415-3630. *{PO Box being discontinued. Now use zip+4 extensions. Others: Health Insurance Group 2...20415-3620}*