Blue Cross and Blue Shield Service Benefit Plan

http://www.fepblue.org

2001

A fee-for-service plan with a preferred provider organization and a point-of-service product

Sponsored and administered by: The Blue Cross and Blue Shield Association and participating local Blue Cross and Blue Shield Plans

Who may enroll in this Plan: All Federal employees and annuitants who are eligible to enroll in the FEHBP

Enrollment codes for this Plan:

101 High Option - Self Only
102 High Option - Self and Family
104 Standard Option - Self Only
105 Standard Option - Self and Family

Authorized for distribution by the:

OPM
United States
Office of Personnel Management
Retirement and Insurance Service
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FEHB
Federal Employees Health Benefits Program

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Introduction

Blue Cross and Blue Shield Service Benefit Plan
1310 G Street, NW, Suite 900
Washington, DC 20005

This Plan is underwritten by participating Blue Cross and Blue Shield Plans (Local Plans) that administer this Plan on behalf of the Blue Cross and Blue Shield Association (the Carrier).

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan** under our contract (CS 1039) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits (FEHB) law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

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

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on pages 7 and 8. Rates are shown at the end of this brochure.

Plain Language

The President and Vice President are making the Government's communication more responsive, accessible, and understandable to the public by requiring agencies to use plain language. In response, a team of health plan representatives and OPM staff worked cooperatively to make this brochure clearer. Except for necessary technical terms, we use common words. "You" means the enrollee or family member; "we" means the Blue Cross and Blue Shield Service Benefit Plan or the local Blue Cross and Blue Shield Plans that administer it.

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

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

Section 1. Facts about this fee-for-service plan

This Plan is a fee-for-service (FFS) plan. You can choose your own hospitals, physicians, and other professional health care providers.

We reimburse you or your provider for your covered services, usually based on a percentage of the amount we allow. The type and extent of covered services, and the amount we allow, may be different from other plans. Read brochures carefully.

We have Preferred Provider Organizations (PPO):

Our fee-for-service plan offers services through a PPO. When you use our PPO providers, you will receive covered services at a reduced cost. Your Local Plan (or for retail pharmacies, PCS Health Systems, Inc.) is solely responsible for the selection of PPO providers in your area. Contact your Local Plan for the names of PPO providers and to verify their continued participation. You can also go to our web page, which you can reach through the FEHB web site, www.opm.gov/insure. Do not call OPM or your agency for our provider directory. Contact your Local Plan to request a PPO directory.

PPO benefits apply only when you use a PPO provider. PPO networks may be more extensive in some areas than in others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply.

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

In certain areas, our fee-for-service plan offers POS benefits to members who select Standard Option. This means you can get better benefits at less out-of-pocket costs by signing up with us for the POS program, selecting a contracted POS primary care physician (PCP), and letting the PCP manage your care. In Minnesota and North Dakota, you select a primary care clinic rather than a primary care physician. If you go to another provider without a referral from your PCP, we will provide only regular Standard Option non-PPO benefits. We offer the POS program in the following areas: Connecticut, Georgia, Kansas, Louisiana (New Orleans area), Massachusetts, Minnesota, New Jersey, New York (areas served by the Empire Plan), North Dakota (Fargo area), and Oklahoma. You can obtain a brochure addendum from your Local Plan in these areas that describes our POS service areas, benefit levels, and special requirements.

How we pay professional and facility providers:

We pay benefits when we receive a claim for covered services. Each Local Plan contracts with hospitals and other health care facilities, physicians, and non-physician health care professional providers in its service area, and is responsible for processing and paying claims for services you receive within that area. Most, but not all, of these contracted providers are in our PPO network.

- **PPO providers.** PPO providers have agreed to accept a specific negotiated amount as payment in full for services provided to you. We refer to PPO facility and professional providers as "Preferred." They will generally bill the Local Plan directly, who will then pay them directly. You do not file a claim. Your out-of-pocket costs are generally less when you receive services from PPO providers, and are limited to your applicable deductible, and coinsurance or copayments, for covered services. We provide benefits for some services (such as a routine physical exam) only when you use PPO providers.

- **Participating providers.** Some Local Plans also contract with other providers that are not in our PPO network. If they are professionals, we refer to them as "Participating" providers, and if they are facilities, we refer to them as "Member" facilities. They have agreed to accept a different negotiated amount than our PPO providers as payment in full. They will also generally file your claims for you. They have agreed not to bill you for more than your applicable deductible, and coinsurance or copayments, for covered services. We pay them directly, but at our non-PPO benefit levels. Your out-of-pocket costs will be greater than if you use PPO providers.

  Note: Not all areas have participating providers and/or member facilities. To verify the status of a provider, please contact the Local Plan serving the area where the services are to be performed.

- **Non-participating providers.** Providers who are not PPO or Participating providers do not have contracts with us, and may or may not accept our allowance. We refer to them as "Non-participating providers" generally, although if they are facilities we may refer to them as "Non-member facilities." When you use Non-participating providers, you may have to file your claim with us. We will then pay our benefits to you, and you must pay the provider.

  You must pay any difference between the amount Non-participating providers charge and our allowance, in addition to any applicable coinsurance amounts, copayment amounts, amounts applied to your calendar year deductible, and amounts for noncovered services. **Important: Your out-of-pocket costs may be substantially higher when you use Non-participating providers than when you use PPO or Participating providers.**

Note: In Local Plan areas other than those described below, PPO and Participating providers who contract with us will generally accept 100% of the Plan allowance as payment in full for covered services. As a result, you are only responsible for applicable coinsurance amounts, copayment amounts, amounts applied to the calendar year deductible, and any charges for noncovered services. **However, this may not apply when there is another source of payment besides you and us**. When you have other coverage (see Section 9), the following exceptions exist in our arrangements with PPO and Participating professional providers. Contact your Local Plan if you have questions about the amounts PPO and Participating providers may collect from you.

- In Arizona, when there is any other source of payment (whether we pay primary or secondary), PPO and Participating physicians are not obligated to accept our allowance as payment in full.

- In New York areas served by the Rochester Plan and in West Virginia, except when we pay secondary to other Blue Cross and Blue Shield coverage administered by the same Local Plan, PPO and Participating physicians may collect the difference between the total payments made by us and the primary carrier and the physician's charge.

- In Pennsylvania and Utah, when we pay secondary, PPO physicians are not obligated to accept our allowance as payment in full unless we make a payment as the secondary payer.

- In Puerto Rico, when we pay secondary, PPO physicians may collect the difference between the total payments made by us and the primary carrier and the physician's charge.

- In Montana, when we pay secondary, PPO and Participating physicians may collect the difference between the total payments made by us and the primary carrier and the physician's charge.

- In Rhode Island, South Carolina, and Vermont, except when we pay secondary to other Blue Cross and Blue Shield coverage, PPO and Participating physicians may collect the difference between the total payments made by us and the primary carrier and the physician's charge.

Patients' Bill of Rights

OPM requires that all FEHB Plans comply with the Patients' Bill of Rights, recommended by the President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. You may get information about us, our networks, and providers. You can also find out about care management, including medical practice guidelines, disease management programs, and how we determine if procedures are experimental or investigational. OPM's website (www.opm.gov/insure) lists the specific types of information that we must make available to you.

If you want more information about us, call or write to us. Our telephone number and address are shown on the back of your Service Benefit Plan ID card. You may also visit our website at www.fepblue.org.

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare FEHB Plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for network mental health, substance abuse, medical, surgical, and hospital services from providers in our PPO network will be the same with regard to deductibles, coinsurance, copayments, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed higher patient cost sharing or shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many health care organizations have turned their attention this past year to improving health care quality and patient safety. OPM asked all FEHB Plans to join them in this effort. You can find specific information on our patient safety activities by calling the telephone number on the back of your Plan ID card, **or** checking our website www.fepblue.org. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your health care, take these five steps:
  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.
- We clarified the brochure language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.
- North Dakota is deleted from the list of states designated as medically underserved in 2001. See page 10 for information on medically underserved areas.

Changes to this Plan

- Your share of the non-Postal Standard Option premium will increase by 14.0% for Self Only or 21.2% for Self and Family.
- Your share of the non-Postal High Option premium will increase by 5.8% for Self Only or 3.7% for Self and Family.
- We have enhanced our Mental Health and Substance Abuse benefits. See Section 5(e).
- Your share for outpatient facility services is now based on coinsurance:
  - Under Standard Option, you now pay 10% of the Plan allowance at PPO facilities, and 25% of the Plan allowance at Member and Non-member facilities. You also pay any difference between the Plan allowance and a Non-member facility's actual charge. Previously, your cost share was $25 per day at PPO facilities, $100 per day at Member facilities, and $150 per day at Non-member facilities. See Section 5(c).
  - Under High Option, you now pay 5% of the Plan allowance at PPO facilities, and 20% of the Plan allowance at Member and Non-member facilities. You also pay any difference between the Plan allowance and a Non-member facility's actual charge. Previously, your cost share was $10 per day at PPO facilities, $50 per day at Member facilities, and $100 per day at Non-member facilities. See Section 5(c).

- Under Standard Option, your calendar year deductible is now $250 per person/$500 per family. Previously, your calendar year deductible was $200 per person/$400 per family. See Section 4.
- Under Standard Option, your copayment for PPO home and office visits is now $15. Previously, your copayment was $12. See Sections 5(a), 5(c) and 5(e).
- Under Standard Option, your hospital inpatient per admission copayment is now $100 per admission at PPO hospitals and $300 per admission at Member and Non-member hospitals. Previously, you paid nothing per admission at Preferred hospitals and $250 per admission at Member and Non-member hospitals. See Section 5(c).
- Under Standard Option, your catastrophic protection out-of-pocket limit is now $3,000 per contract when you use only PPO providers and $5,000 per contract when you use a combination of PPO and non-PPO providers. Previously, your out-of-pocket limit was $2000 (PPO only) and $3,750 (PPO and non-PPO). See Section 4.
- Your cost sharing (deductibles, coinsurance or copayments) for In-Network (Preferred) mental health and substance abuse services is now included under the catastrophic protection out-of-pocket limit. See Section 4.
- You now pay $15 per visit under Standard Option and $12 per visit under High Option for PPO office visits associated with hepatitis immunizations, and nothing for the immunization. Previously, you paid (subject to the applicable calendar year deductible) 10% of the Plan allowance under Standard Option and 5% of the Plan allowance under High Option. See Section 5(a).
- We now provide limited benefits under Standard and High Option for audiologists, diabetic educators, dieticians, and nutritionists who bill independently for covered services. See Section 3 and Section 5(a).
- We now provide benefits under Standard and High Option for outpatient cardiac rehabilitation when you obtain prior approval from your Local Plan. See Sections 5(a) and 5(c) for benefits, and Section 3 for prior approval procedures.
- For your safety, we have placed additional limits on the quantities of prescription drugs you may obtain through the Retail Pharmacy Program and the Mail Service Prescription Drug Program, in accordance with FDA guidelines.
- We have expanded our benefits for organ/tissue transplants to include all phagocytic deficiency diseases. See Section 5(b).
- We now provide benefits for inpatient stays in sub-acute units during a medically necessary hospital admission. See Section 5(c).
- Our Standard Option Point-of-Service (POS) program is no longer offered in the Cincinnati area of Ohio.
- Under our Standard Option POS program, you now pay $15 per visit for home, office, and clinic visits, nurse or home health aide visits, and visits for physical, occupational, or speech therapy. Previously, you paid $10 per visit. See your POS brochure addendum.
- Under our Standard Option POS program, you now pay $50 per hospital emergency room visit and $40 per urgent care center visit. Previously, you paid $35 (ER) and $25 (urgent care) per visit. See your POS brochure addendum.
- Under our Standard Option POS program, you now pay the lesser of the actual charge, or $10 per generic prescription or $20 per brand name prescription, for drugs obtained from a POS retail pharmacy. Previously, your copayments were $5 (generic) and $15 (brand name). See your POS brochure addendum.

Section 3. How you receive benefits

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 covered provider, or fill a prescription at a pharmacy participating in our Retail Pharmacy Program. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation letter (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 the Local Plan serving the area where you reside and ask them to assist you, or write to us directly at: FEP Enrollment Services, 550 12th Street, SW, Washington, DC 20065-1463.

Where you get covered care

You can get care from any "covered professional provider" or "covered facility provider." How much we pay – and you pay – depends on the type of covered provider you use. If you use our PPO, Participating, or Member providers, or our point-of-service program, you will pay less.

- **Covered professional providers**

We consider the following to be covered professionals when they perform services within the scope of their license or certification:

- **Physician -** Doctors of medicine (M.D.); osteopathy (D.O.); dental surgery (D.D.S.); medical dentistry (D.M.D.); podiatric medicine (D.P.M.); and optometry (O.D.).
- **Independent Laboratory -** A laboratory that is licensed under State law or, where no licensing requirement exists, that is approved by the Local Plan.
- **Qualified Clinical Psychologist -** A psychologist who (1) is licensed or certified in the state where the services are performed; (2) has a doctoral degree in psychology (or an allied degree if, in the individual state, the academic licensing/certification requirement for clinical psychologist is met by an allied degree) or is approved by the Local Plan; and (3) has met the clinical psychological experience requirements of the individual State Licensing Board.
- **Nurse Midwife -** A person who is certified by the American College of Nurse Midwives or, if the state requires it, is licensed or certified as a nurse midwife.
- **Nurse Practitioner/Clinical Specialist -** A person who (1) has an active R.N. license in the United States; (2) has a baccalaureate or higher degree in nursing; and (3) if the state requires it, is licensed or certified as a nurse practitioner or clinical nurse specialist.
- **Clinical Social Worker -** A social worker who (1) has a master's or doctoral degree in social work; (2) has at least two years of clinical social work practice; and (3) if the state requires it, is licensed, certified, or registered as a social worker where the services are performed.
- **Physical, Speech, and Occupational Therapist -** A professional who is licensed where the services are performed or meets the requirements of the Local Plan to provide physical, speech, or occupational therapy services.

- **Nursing School Administered Clinic -** A clinic that (1) is licensed or certified in the state where services are performed; and (2) provides ambulatory care in an outpatient setting - primarily in rural or inner-city areas where there is a shortage of physicians. Services billed for by these clinics are considered outpatient "office" services rather than facility charges.
- **Audiologist -** A professional who, if the state requires it, is licensed, certified, or registered as an audiologist where the services are performed.
- **Dietician -** A professional who, if the state requires it, is licensed, certified, or registered as a dietician where the services are performed.
- **Diabetic educator -** A professional who, if the state requires it, is licensed, certified, or registered as a diabetic educator where the services are performed.
- **Nutritionist -** A professional who, if the state requires it, is licensed, certified, or registered as a nutritionist where the services are performed.
- Other professional providers specifically shown in the benefits descriptions in Section 5.

Medically underserved areas. *Note:* In medically underserved areas, we cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are "medically underserved." For 2001, the states are: Alabama, Idaho, Kentucky, Louisiana, Mississippi, Missouri, New Mexico, South Carolina, South Dakota, Utah, and Wyoming.

- **Covered facility providers**

Covered facilities include:

- **Hospital -** An institution, or a distinct portion of an institution, that:

(1) Primarily provides diagnostic and therapeutic facilities for surgical and medical diagnoses, treatment, and care of injured and sick persons provided or supervised by a staff of licensed doctors of medicine (M.D.) or licensed doctors of osteopathy (D.O.), for compensation from its patients, on an inpatient or outpatient basis;
(2) Continuously provides 24-hour-a-day professional registered nursing (R.N.) services; and
(3) Is not, other than incidentally, an extended care facility; a nursing home; a place for rest; an institution for exceptional children, the aged, drug addicts, or alcoholics; or a custodial or domiciliary institution having as its primary purpose the furnishing of food, shelter, training, or non-medical personal services.

Note: We consider college infirmaries to be Non-member hospitals. In addition, we may, at our discretion, recognize any institution located outside the 50 states and the District of Columbia as a Non-member hospital.

- **Freestanding Ambulatory Facility -** A freestanding facility, such as an ambulatory surgical center, freestanding surgi-center, freestanding dialysis center, or freestanding ambulatory medical facility, that:

(1) Provides services in an outpatient setting;
(2) Contains permanent amenities and equipment primarily for the purpose of performing medical, surgical, and/or renal dialysis procedures;
(3) Provides treatment performed or supervised by doctors and/or nurses, and may include other ancillary professional services performed at the facility; and
(4) Is not, other than incidentally, an office or clinic for the private practice of a doctor or other professional.

Note: We may, at our discretion, recognize any other similar facilities, such as birthing centers, as freestanding ambulatory facilities.

•• **Cancer Research Facility -** A facility that is:

(1) A National Cooperative Center Cancer Study Group institution that is funded by the National Cancer Institute (NCI) and has been approved by a Cooperative Group as a bone marrow transplant center;
(2) An NCI-designated Cancer Center; or
(3) An institution that has an NCI-funded, peer-reviewed grant to study allogeneic or autologous bone marrow transplants and blood stem cell transplant support.

•• Other facilities specifically listed in the benefits descriptions in Section 5(c).

What you must do to get covered care

It depends on the kind of care you want to receive. You can go to any provider you want, but in some circumstances, we must approve care in advance.

Transitional care

Specialty Care: If you have a chronic or disabling condition and lose access to PPO benefits for your specialist's services because we:

- terminate our contract with your specialist for other than cause; or
- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan;

you may be able to continue to receive PPO benefits for your specialist's services 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 PPO benefits for your specialist's services based on the above circumstances, you can continue to receive PPO benefits for your specialist's services until the end of your postpartum care, even if it is beyond the 90 days.

Hospital care

Hospital care: If you are in the hospital when your enrollment in our Plan begins, call us immediately. If you have not yet received your Service Benefit Plan ID card, you can contact your Local Plan at the telephone number listed in your local telephone directory. If you already have your new Service Benefit Plan ID card, call us at the number on the back of the card. If you are new to the FEHB Program, we will reimburse you for your covered expenses while in the hospital.

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

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

These provisions apply only to the benefits of the hospitalized person.

How to get approval for…

• Your hospital stay

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. Unless we are misled by the information given to us, we will not change our decision on medical necessity.

In most cases, your physician or hospital will take care of precertification. Because you are still responsible for ensuring that we are asked to precertify your care, you should always ask your physician or hospital whether they have contacted us.

Warning:

We will reduce our benefits for the inpatient hospital stay by $500 if no one contacts us for precertification. If the stay is not medically necessary, we will not pay any benefits.

How to precertify an admission:

- You, your representative, your doctor, or your hospital must call us at the telephone number listed on the back of your Service Benefit Plan ID card any time prior to 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, your doctor, or your hospital must telephone us within two business days following the day of the emergency admission, even if you have been discharged from the hospital.
- Provide the following information:
  - Enrollee's name and Plan identification number;
  - Patient's name, birth date, and phone number;
  - Reason for hospitalization, proposed treatment, or surgery;
  - Name and phone number of admitting doctor;
  - Name of hospital or facility; and
  - Number of planned days of confinement.
- We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

Maternity care

You do not need to precertify a maternity admission for a routine delivery. However, if your medical condition requires you to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then your physician or the hospital must contact us for precertification of additional days. Further, if your baby stays after you are discharged, then your physician or the hospital must contact us for precertification of additional days for your baby.

If your hospital stay needs to be extended:

If your hospital stay, including for maternity care, needs to be extended, your doctor or the hospital must ask us to approve the additional days.

What happens when you do not follow the precertification rules

- When we precertified the admission but you remained in the hospital beyond the number of days we approved and did not get the additional days precertified, then:
  - for the part of the admission that was medically necessary, we will pay inpatient benefits, but
  - for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and we will not pay inpatient benefits.
- If no one contacted us, we will decide whether the hospital stay was medically necessary.
  - If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty.
  - If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.
- If we denied the precertification request, we will not pay inpatient hospital benefits or inpatient physician care benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

Exceptions:

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payer for the hospital stay.
- Your Medicare Part A is the primary payer for the hospital stay. *Note*: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payer and you **do** need precertification.

• Other services

These services require prior approval:

- **Home health care (High Option) -** Contact us at the number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination and advise you which home health care agencies have agreements with us.

- **Home hospice care -** Contact us at the number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination and advise you which home hospice care agencies we have approved.

- **Partial hospitalization or intensive outpatient treatment for mental health/substance abuse -** Contact us at the number listed on the back of your ID card for mental health and substance abuse before obtaining services for intensive outpatient treatment or partial hospitalization. We will request the medical evidence we need to make our coverage determination. We will also consider the necessary duration of either of these services.

- **Organ/tissue transplants -** Contact us at the number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination. We will consider whether the facility is approved for the procedure and whether you meet the facility's criteria.

- **Clinical trials for certain organ/tissue transplants -** Contact our Clinical Trials Information Unit at 1-800-225-2268 for information or to request prior approval before obtaining services. We will request the medical evidence we need to make our coverage determination. Use this number **only** for prior approval of clinical trials for bone marrow and peripheral blood stem cell transplant support procedures for those conditions shown on page 46 as covered only in clinical trials.

- **Cardiac rehabilitation -** Contact us at the number listed on the back of your ID card prior to starting treatment. We will request the information we need to make our coverage determination.

- **Prescription drugs -** Contact our Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077 for the hearing impaired) to request prior approval, or to obtain an updated list of prescription drugs that require prior approval. We will request the information we need to make our coverage determination. You must periodically renew prior approval for certain drugs.

  Note: Until we approve them, you must pay for these drugs in full when you purchase them at any retail pharmacy, even at Preferred pharmacies, and submit the expense(s) to us on a claim form. Preferred pharmacies will not file these claims for you. Our Mail Service Prescription Drug Program also will not fill your prescription until you have prior approval. Merck-Medco Rx Services, the administrator of the Mail Service Prescription Drug Program, will return your prescription to you along with a Prior Approval Request Form and a letter explaining the prior approval procedures.

Section 4. Your costs for covered services

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

• Copayments

A copayment is a fixed amount of money you pay to the provider when you receive certain services.

Example: When you see your PPO physician you pay a copayment of $15 per visit.

We also have a **per admission copayment** for inpatient hospital stays (except under High Option in Preferred hospitals). This is a fixed amount of covered hospital room and board expenses you must pay once during each hospital admission before we pay benefits. The per admission copayment does not apply to Preferred maternity care and High Option Preferred hospitals.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than your copayment, you pay the lower amount.

• Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. When a covered service or supply is subject to a deductible, only the Plan allowance for the service or supply that you then pay counts toward meeting your deductible.

•• We have a **calendar year deductible.** The calendar year deductible is $250 per person under Standard Option and $150 per person under High Option. Under a family enrollment, the calendar year deductible for each family member is satisfied and benefits are payable for all family members when the combined covered expenses of the family reach $500 under Standard Option and $300 under High Option.

Note: If the billed amount (or the Plan allowance that providers we contract with have agreed to accept as payment in full) is less than the remaining portion of your deductible, you pay the lower amount.

Example: If the billed amount is $100, the provider has an agreement with us to accept $80, and you have not paid any amount toward meeting your Standard Option calendar year deductible, you must pay $80. We will apply $80 to your deductible. We will begin paying benefits once the remaining portion of your Standard Option calendar year deductible ($170) has been satisfied.

Note: If you change plans during Open Season and the effective date of your new plan is after January 1 of the next year, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

And, if you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the calendar year deductible of your old option to the calendar year deductible of your new option.

• Coinsurance

Coinsurance is the percentage of the Plan allowance that you must pay for your care. Coinsurance does not begin until you meet your deductible.

Example: You pay 20% of the Plan allowance under High Option, or 25% of the Plan allowance under Standard Option, for ambulance transport services.

Note: Your coinsurance is based on the Plan allowance, or the billed amount, whichever is less.

Note: **If your provider routinely waives** (does not require you to pay) your deductible, coinsurance or copayments, the provider is misstating the fee and may be violating the law. In this case, when we calculate our share, we will reduce the provider's fee by the amount waived.

Example: If your physician ordinarily charges $100 for a service but routinely waives your 25% Standard Option coinsurance, the actual charge is $75. We will pay $56.25 (75% of the actual charge of $75).

• Differences between our allowance and the bill

Our "Plan allowance" is the amount we use to calculate our payment for covered services. Fee-for-service plans arrive at their allowances in different ways, so their allowances vary. For information about how we determine our Plan allowance, see the definition of Plan allowance in Section 10.

Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the provider you use.

- **PPO providers** agree to limit what they bill you. Because of that, when you use a PPO provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example: You see a PPO physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 10% of our $100 allowance ($10). Because of the agreement, your PPO physician will not bill you for the $50 difference between our allowance and his/her bill. See page 6 for exceptions.

- **Participating providers** also agree to limit what they bill you. Because of that, when you use a Participating provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example: You see a Participating physician who charges $150, but the Plan allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 25% of our $100 allowance ($25). Because of the agreement, your Participating physician will not bill you for the $50 difference between our allowance and his/her bill. See page 6 for exceptions.

- **Non-participating providers**, on the other hand, have no agreement to limit what they will bill you. When you use a Non-participating provider, you will pay your deductible and coinsurance - **plus** any difference between our allowance and the charges on the bill. For example, you see a Non-participating physician who charges $150. The Plan allowance is again $100, and you have met your deductible. You are responsible for your coinsurance, so you pay 25% of the $100 Plan allowance or $25. Plus, because there is no agreement between the Non-participating physician and us, the physician can bill you for the $50 difference between our allowance and his/her bill.

The following table illustrates this example of how much you have to pay out-of-pocket for services from a PPO physician, a Participating physician, and a Non-participating physician. The table uses our example of a service for which the physician charges $150 and the Plan allowance is $100. The table shows the amount you pay if you have met your calendar year deductible.

EXAMPLE	PPO physician	Participating physician	Non-participating physician
Physician's charge	$150	$150	$150
Our allowance	We set it at: 100	We set it at: 100	We set it at: 100
We pay	90% of our allowance: 90	75% of our allowance: 75	75% of our allowance: 75
You owe: Coinsurance	10% of our allowance: 10	25% of our allowance: 25	25% of our allowance: 25
+Difference up to charge?	No: 0	No: 0	Yes: 50
TOTAL YOU PAY	$10	$25	$75

Note: Had you not met any of your deductible in the above examples, only our allowance ($100), which you would pay in full, would count toward your deductible.

- **Overseas providers.** We pay overseas claims at PPO benefit levels, using an Overseas Fee Schedule as our Plan allowance. Most overseas providers are under no obligation to accept our allowance, and you must pay any difference between our payment and the provider's bill. See Section 5(g) for more information about our overseas benefits.

Note: Under Standard Option, we pay scheduled amounts for routine dental services and you pay any balance. See Section 5(h) for information about your costs for routine dental services.

Your out-of-pocket maximum for deductibles, coinsurance and copayments

If the total amount of out-of-pocket expenses in a calendar year for you and your covered family members for deductibles, coinsurance, and copayments (other than those indicated on the following page) exceeds $5000 under Standard Option, or $2,700 under High Option, then you and any covered family members will not have to continue paying them for the remainder of the calendar year.

PPO maximum: If the total amount of these out-of-pocket expenses in a calendar year from using PPO providers for you and your covered family members exceeds $3,000 under Standard Option, or $1,000 under High Option, then you and any covered family members will not have to pay them for the remainder of the calendar year when you continue to use PPO providers. You will, however, have to pay them when you use non-PPO providers, until your out-of-pocket expenses reach $5000 under Standard Option, or $2,700 under High Option, as shown above.

The following expenses are not included under this feature. These expenses do not count toward your out-of-pocket maximum, and you must continue to pay them even after your expenses exceed the limits described on page 17:

- The difference between the Plan allowance and the billed amount. See page 16;
- Expenses for services, drugs, and supplies in excess of our maximum benefit limitations;
- Your 30% coinsurance for inpatient care in a Non-member hospital;
- Your 25% (Standard Option) and 20% (High Option) coinsurance for outpatient care by a Non-member facility;
- Your expenses for mental conditions and substance abuse care by a non-PPO professional or facility provider;
- Your expenses for dental services in excess of our fee schedule payments under Standard Option. See Section 5(h); and
- The $500 penalty for failing to obtain precertification, and any other amounts you pay because we reduce benefits for not complying with our cost containment requirements.

Note: If you change to another plan during Open Season, we will continue to provide benefits between January 1 and the effective date of your new plan.

- If you had already paid the out-of-pocket maximum, we will continue to provide benefits as described above until the effective date of your new plan.
- If you had not yet paid the out-of-pocket maximum, we will apply any expenses you incur in January (before the effective date of your new plan) to our prior year's out-of-pocket maximum. Once you reach the maximum, you don't need to pay our deductibles, copayments or coinsurance amounts (except as shown above) from that point until the effective date of your new plan.

Note: Because benefit changes are effective January 1, we will apply our next year's benefits to any expenses you incur in January.

Note: If you change options in this Plan during the year, we will credit the amounts already accumulated toward the PPO and non-PPO out-of-pocket limits of your old option to the out-of-pocket limits of your new option. If you change from Self Only to Self and Family, or vice versa, during the calendar year, please contact your Local Plan about your out-of-pocket accumulations and how they carry over.

When government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service 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.

If we overpay you

We will make diligent efforts to recover benefit payments we made in error but in good faith. We may reduce subsequent benefit payments to offset overpayments.

Note: We will generally first seek recovery from the provider if we paid the provider directly, or from the person (covered family member, guardian, custodial parent, etc.) to whom we sent our payment.

When you are age 65 or over and you do not have Medicare

Under the FEHB law, we must limit our payments for those benefits you would be entitled to if you had Medicare. And, your physician and hospital must follow Medicare rules and cannot bill you for more than they could bill you if you had Medicare. The following chart has more information about the limits.

If you…

- are age 65 or over, and
- do not have Medicare Part A, Part B, or both; and
- have this Plan as an annuitant, as a former spouse, **or** as a family member of an annuitant or former spouse; and
- are not employed in a position that gives FEHB coverage. (Your employing office can tell you if this applies.)

Then, for your inpatient hospital care,

- the law requires us to base our payment on an amount - the "equivalent Medicare amount" - set by Medicare's rules for what Medicare will pay and not on the actual charge;
- you are responsible for your applicable deductible and coinsurance or copayments you owe under this Plan;
- you are not responsible for any charges greater than the equivalent Medicare amount; we will show that amount on the explanation of benefits (EOB) form that we send you; and
- the law prohibits a hospital from collecting more than the equivalent Medicare amount.

And, for your physician care, the law requires us to base our payment and your applicable coinsurance on…

- an amount - set by Medicare and called the "Medicare approved amount" or
- the actual charge if it is lower than the Medicare approved amount.

If your physician…	Then you are responsible for…
Participates with Medicare or accepts Medicare assignment for the claim and is in our PPO network	your deductibles, coinsurance, and copayments
Participates with Medicare or accepts Medicare assignment and is **not** in our PPO network	your deductibles, coinsurance, and copayments, and any balance up to the Medicare approved amount
Does not participate with Medicare, and is in our PPO network	your deductibles, coinsurance, and copayments, and any balance up to 115% of the Medicare approved amount *Note:* In many cases, your payment will be less because of our PPO agreements. Contact your Local Plan for information about what your specific PPO provider can collect from you.
Does not participate with Medicare and is **not** in our PPO network	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are only permitted to collect up to the Medicare approved amount.

Our explanation of benefits (EOB) form will tell you how much the physician or hospital can collect from you. If your physician or hospital tries to collect more than allowed by law, ask the physician or hospital to reduce the charges. If you have paid more than allowed, ask for a refund. If you need further assistance, call us.

When you have the Original Medicare Plan

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), regardless of whether Medicare pays.

Note: We pay our regular benefits for emergency services to a facility provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

If you are covered by Medicare Part B and it is primary, your out-of-pocket costs for services that both we and Medicare cover depend on whether your physician accepts Medicare assignment for the claim.

- If your physician accepts Medicare assignment, then you pay nothing for covered charges.
- If your physician does not accept Medicare assignment, then you pay the difference between our payment combined with Medicare's payment, and the charge.

Note: The physician who does not accept Medicare assignment may not bill you for more than 115% of the amount Medicare bases its payment on, called the "limiting charge." The Medicare Summary Notice (MSN) form that you receive from Medicare will have more information about the limiting charge. If your physician tries to collect more than allowed by law, ask them to reduce their charges. If they do not, report them to your Medicare carrier who sent you the MSN form. Call us if you need further assistance.

When you have a Medicare Private Contract

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

Please see Section 9, *Coordinating benefits with other coverage*, for more information about how we coordinate benefits with Medicare.

Section 5. Benefits - OVERVIEW

(See pages 7-8 for how our benefits changed this year and pages 102-103 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at the telephone number on the back of your Service Benefit Plan ID card or at our website at www.fepblue.org.

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

IMPORTANT

Here are some 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.
- The calendar year deductible is: $250 per person ($500 per family) under **Standard Option** and $150 per person ($300 per family) under **High Option**. 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.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.

IMPORTANT

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.		
Diagnostic and treatment services	**You pay – Standard Option**	**You pay – High Option**
Professional services of physicians: • Outpatient consultations • Second surgical opinions • Office visits • Home visits	Preferred: $15 copayment for the office visit charge (No deductible); 10% of the Plan allowance for all other services (deductible applies) Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: $12 copayment for the office visit charge (No deductible); 5% of the Plan allowance for all other services (deductible applies) Participating: 20% of the Plan allowance Non-participating: 20% of the Plan allowance, plus any difference between our allowance and the physician's actual charge

Diagnostic and treatment services – Continued on next page

Diagnostic and treatment services - *Continued*	**You pay – Standard Option**	**You pay – High Option**
Professional services of physicians (cont'd): • During a hospital stay • Services for nonsurgical procedures when ordered, provided, and billed by a physician during a covered inpatient hospital admission • Medical care by the attending physician (the physician who is primarily responsible for your care when you are hospitalized) on days we pay Inpatient Hospital Benefits. *Note:* A consulting physician employed by the hospital is not the attending physician • Consultations when requested by the attending physician • Concurrent care – hospital inpatient care by a physician other than the attending physician for a condition not related to your primary diagnosis, or because the medical complexity of your condition requires this additional medical care • Physical therapy by a physician other than the attending physician • Initial examination of a newborn needing definitive treatment when covered under a family enrollment • Pharmacotherapy (See Section 5(f) for coverage for prescription drugs) • Neurological testing	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: 5% of the Plan allowance (No deductible) Participating: 20% of the Plan allowance (No deductible) Non-participating: 20% of the Plan allowance (No deductible), plus any difference between our allowance and the physician's actual charge

Diagnostic and treatment services – Continued on next page

Diagnostic and treatment services - *Continued*	**You pay – Standard Option**	**You pay – High Option**
Not covered: • *Routine services except for those Preventive care services described on pages 26-28* • *Inpatient private duty nursing* • *Standby physicians* • *Routine radiological and staff consultations required by hospital rules and regulations* • *Inpatient physician care when your hospital admission or portion of an admission is not covered [(see Section 5(c)]* *Note: If we determine that a hospital admission is not covered, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inhospital physician care at the level that we would have paid if they had been provided in some other setting.*	*All charges*	*All charges*

Lab, X-ray and other diagnostic tests	You pay – Standard Option	You pay – High Option
Diagnostic tests provided, or ordered and billed by a physician, such as: • Blood tests • CT Scans/MRIs • EKGs and EEGs • Laboratory tests • Pathological services • Ultrasounds • Urinalysis • X-rays • Fecal occult blood tests* • Non-routine mammograms* • Non-routine Pap tests* • PSA tests* • Sigmoidoscopies* Laboratory and pathological services billed by an independent laboratory *Note*: If your PPO provider uses a non-PPO laboratory or radiologist, we will pay non-PPO benefits for any laboratory and X-ray charges.	Preferred: 10% of the Plan allowance; For services marked with (*), $15 copayment for associated office visits (No deductible); nothing for services or tests Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: 5% of the Plan allowance; For services marked with (*), $12 copayment for associated office visits (No deductible); nothing for services or tests Participating: 20% of the Plan allowance Non-participating: 20% of the Plan allowance, plus any difference between our allowance and the physician's actual charge

Preventive care, adult	You pay – Standard Option	You pay – High Option
Home and office visits for routine (screening) physical examinations • Under age 65 – once every three calendar years • Age 65 and older – once each calendar year A routine physical examination may consist of: • History and risk assessment • Chest X-ray • EKG • Urinalysis • Basic or comprehensive metabolic panel test • CBC • Cholesterol tests (may be done by any independent laboratory) *Note*: These benefits do not apply to children. (See benefits under Preventive care, children, this section.) *Note:* When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the provider. *Note:* We provide benefits for adult routine physical examinations only when you receive these services from a Preferred provider.	Preferred: $15 copayment for associated office visits (No deductible); nothing for services or tests Participating: *All charges* Non-participating: *All charges*	Preferred: $12 copayment for associated office visits (No deductible); nothing for services or tests Participating: *All charges* Non-participating: *All charges*

Preventive care, adult – Continued on next page

Preventive care, adult – *Continued*	You pay – Standard Option	You pay – High Option
Cancer screening • Colorectal cancer screening, including: •• Fecal occult blood test – one annually starting at age 40 * •• Sigmoidoscopy – one every five years starting at age 50 * • Prostate cancer screening - Prostate Specific Antigen (PSA test) – one annually for males age 40 and older * • Cervical cancer screening – one routine Pap test annually for females of any age * • Breast cancer screening – routine mammograms for females age 35 and older, as follows* •• From age 35 through 39, one during this five-year period •• From age 40 through 64, one annually •• At age 65 and older, one every two consecutive calendar years * Scheduled limits apply only to Participating and Non-participating providers *Note*: We provide benefits in full for preventive (screening) tests and immunizations only when you receive these services from a Preferred physician on an outpatient basis. If these services are billed separately from the routine physical examination, you may be responsible to pay an additional copayment for each office visit billed. *Note*: When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the provider.	Preferred: $15 copayment for associated office visits (No deductible); nothing for services or tests Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: $12 copayment for associated office visits (No deductible); nothing for services or tests Participating: 20% of the Plan allowance Non-participating: 20% of the Plan allowance, plus any difference between our allowance and the physician's actual charge

Preventive care, adult – Continued on next page.

Preventive care, adult -*Continued*	**You pay – Standard Option**	**You pay – High Option**
Routine immunizations without regard to age, limited to: • Hepatitis immunizations for patients with increased risk or family history • Influenza and pneumococcal vaccines, annually • Lyme disease vaccine • Tetanus-diphtheria (Td) booster – once every 10 years	Preferred: $15 copayment for associated office visits (No deductible); nothing for services or tests Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: $12 copayment for associated office visits (No deductible); nothing for services or tests Participating: 20% of the Plan allowance Non-participating: 20% of the Plan allowance, plus any difference between our allowance and the physician's actual charge
Not covered: Office visit charges associated with preventive services and routine immunizations performed by Participating and Non-participating providers.	*All charges*	*All charges*
Preventive care, children	**You pay – Standard Option**	**You pay – High Option**
We provide benefits for the following services: • All healthy newborn visits including routine screening (inpatient or outpatient) • The following routine services as recommended by the American Academy of Pediatrics for children up to the age of 22, including children living, traveling, or adopted from outside the United States: •• Routine physical examinations •• Routine hearing tests •• Laboratory tests •• Immunizations •• Related office visits *Note:* When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the provider.	Preferred: Nothing (No deductible) Participating: Nothing (No deductible) Non-participating: Nothing (No deductible) up to the Plan allowance. You are responsible only for any difference between our allowance and the physician's actual charge	Preferred: Nothing (No deductible) Participating: Nothing (No deductible) Non-participating: Nothing (No deductible) up to the Plan allowance. You are responsible only for any difference between our allowance and the physician's actual charge

Maternity care	You pay – Standard Option	You pay – High Option
Complete maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage when provided, or ordered and billed by a physician or nurse midwife, such as: • Prenatal care • Delivery • Postpartum care *Note*: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary, but you must precertify the extended stay. See Section 3 for information on requesting additional days. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay, or if the child is covered under the father's Self and Family enrollment. We cover other care of a newborn who requires definitive treatment as a patient, such as circumcision, or incubation for prematurity, only if we cover the newborn under a Self and Family enrollment. • We pay assistant surgeon services (delivery) and anesthesia the same as for illness or injury. See Surgery benefits (Section 5b). • For inpatient and outpatient facility care related to maternity, we waive the per admission copay and services are paid in full when you use Preferred providers.	Preferred: Nothing (No deductible) Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: Nothing (No deductible) Participating: 20% of the Plan allowance (No deductible) Non-participating: 20% of the Plan allowance (No deductible), plus any difference between our allowance and the physician's actual charge
Not covered: *Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest.*	*All charges*	*All charges*

Family planning	You pay – Standard Option	You pay – High Option
We provide benefits for: • Depo-Provera • Diaphragms • Intrauterine devices (IUDs) • Norplant • Oral contraceptives • Voluntary sterilization *Note*: See Prescription Drugs, Section 5(f), for our coverage for IUDs, Norplant, Depo-Provera, diaphragms and oral contraceptives obtained from a retail pharmacy. Oral contraceptives may also be obtained through the Mail Service Prescription Drug Program.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: 5% of the Plan allowance (No deductible) Participating: 20% of the Plan allowance (No deductible) Non-participating: 20% of the Plan allowance (No deductible), plus any difference between our allowance and the physician's actual charge
Not covered: • *Reversal of voluntary sterilization* • *Contraceptive devices not described above*	*All charges*	*All charges*

Infertility services	You pay – Standard Option	You pay – High Option
Diagnosis and treatment of infertility, except as excluded below *Note*: See Section 5(f) for prescription drug coverage.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: 5% of the Plan allowance (No deductible) Participating: 20% of the Plan allowance (No deductible) Non-participating: 20% of the Plan allowance (No deductible), plus any difference between our allowance and the physician's actual charge
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* •• *artificial insemination (AI)* •• *in vitro fertilization (IVF)* •• *embryo transfer and Gamete Intrafallopian Transfer (GIFT)* •• *intravaginal insemination (IVI)* •• *intra-cervical insemination (ICI)* •• *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures, such as sperm banking*	*All charges*	*All charges*

Allergy care	You pay – Standard Option	You pay – High Option
Testing and treatment, including materials (such as allergy serum) and injections	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: 5% of the Plan allowance Participating: 20% of the Plan allowance Non-participating: 20% of the Plan allowance, plus any difference between our allowance and the physician's actual charge
Not covered: • *Provocative food testing and sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**You pay – Standard Option**	**You pay – High Option**
• Chemotherapy and radiation therapy *Note*: We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under Organ/tissue transplants in Section 5(b). See also, *Services requiring our prior approval,* in Section 3. • Renal dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion therapy – Home IV therapy *Note*: Home nursing visits associated with Home IV therapy are covered as shown under Home health services on page 37. • Outpatient cardiac rehabilitation. (Prior approval is required. See Section 3.)	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: 5% of the Plan allowance Participating: 20% of the Plan allowance Non-participating: 20% of the Plan allowance, plus any difference between our allowance and the physician's actual charge

Rehabilitative therapies	You pay – Standard Option	You pay – High Option
Physical therapy, occupational therapy, and speech therapy – when performed by a physical therapist, occupational therapist, speech therapist or physician Physical therapy: • Up to 50 visits for physical therapy per person, per calendar year under **Standard Option** • Up to 75 visits for physical therapy per person, per calendar year under **High Option** Acupuncture as a physical therapy modality and for pain management if performed by a physician or licensed physical therapist Occupational and Speech therapy: • Up to 25 visits for occupational therapy, speech therapy, or a combination of both, per person, per calendar year under both **Standard Option** and **High Option** *Note*: Visits that you pay for while meeting your calendar year deductible count toward the limits cited above. When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for professional care, according to the contracting status of the therapist.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the provider's actual charge	Preferred: 5% of the Plan allowance Participating: 20% of the Plan allowance Non-participating: 20% of the Plan allowance, plus any difference between our allowance and the provider's actual charge
Not covered: • *Maintenance or palliative rehabilitative therapy* • *Exercise programs* • *Hippotherapy* • *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay or through an approved home health care program*	*All charges*	*All charges*

Hearing services (testing, treatment, and supplies)	You pay – Standard Option	You pay – High Option
Hearing tests related to illness or injury	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: 5% of the Plan allowance Participating: 20% of the Plan allowance Non-participating: 20% of the Plan allowance, plus any difference between our allowance and the physician's actual charge
Not covered: • *Routine hearing tests (except as indicated under Preventive care, children)* • *Hearing aids (including implanted bone conduction hearing aids)* • *Testing and examinations for the prescribing or fitting of hearing aids*	*All charges*	*All charges*

Vision services (testing, treatment, and supplies)	You pay – Standard Option	You pay – High Option
• One pair of eyeglasses, replacement lenses, or contact lenses to correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery *Note*: This benefit may also be used to obtain one pair of eyeglasses or lenses prescribed in lieu of surgery when the condition can be corrected by surgery, but surgery is precluded because of age or medical condition. • Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 12 *Note*: See Section 5(b), *Surgical procedures*, for coverage for surgical treatment of amblyopia and strabismus.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: 5% of the Plan allowance Participating: 20% of the Plan allowance Non-participating: 20% of the Plan allowance, plus any difference between our allowance and the physician's actual charge

Vision services – Continued on next page

Vision services (testing, treatment, and supplies) - *Continued*	**You pay – Standard Option**	**You pay – High Option**
Not covered: • *Eyeglasses, contact lenses, routine eye examinations or vision testing for the prescribing or fitting of eyeglasses or contact lenses, except as described on page 33* • *Eye exercises, visual training or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described on page 33* • *Radial keratotomy and other refractive services*	*All charges*	*All charges*
Foot care	**You pay – Standard Option**	**You pay – High Option**
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.	Preferred: $15 copayment for the office visit (No deductible); 10% of the Plan allowance for all other services (deductible applies) Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: $12 copayment for the office visit (No deductible); 5% of the Plan allowance for all other services (deductible applies) Participating: 20% of the Plan allowance Non-participating: 20% of the Plan allowance, plus any difference between our allowance and the physician's actual charge
Not covered: • *Routine foot care, such as cutting, trimming or removal of corns, calluses or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above*	*All charges*	*All charges*

Orthopedic and prosthetic devices	You pay – Standard Option	You pay – High Option
Orthopedic braces and prosthetic appliances such as: • Artificial limbs and eyes • Functional foot orthotics when prescribed by a physician • Rigid devices attached to the foot or a brace, or placed in a shoe • Replacement, repair and adjustment of covered devices • Following a mastectomy, externally worn breast prostheses and surgical bras, including necessary replacements *Note*: A **prosthetic appliance** is a device that is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body. We provide hospital benefits for internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b).	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the provider's actual charge	Preferred: 5% of the Plan allowance Participating: 20% of the Plan allowance Non-participating: 20% of the Plan allowance, plus any difference between our allowance and the provider's actual charge
Not covered: • *Shoes and over-the-counter orthotics* • *Arch supports* • *Heel pads and heel cups* • *Penile implants* • *Wigs* • *Implanted bone conduction hearing aids*	*All charges*	*All charges*

Durable medical equipment (DME)	You pay – Standard Option	You pay – High Option
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment, such as oxygen and home dialysis equipment. Under this benefit, we also cover: • Hospital beds • Wheelchairs • Crutches • Walkers • Other items that we determine to be DME	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the provider's actual charge	Preferred: 5% of the Plan allowance Participating: 20% of the Plan allowance Non-participating: 20% of the Plan allowance, plus any difference between our allowance and the provider's actual charge
Not covered: • *Exercise and bathroom equipment* • *Lifts, such as seat, chair or van lifts* • *Car seats* • *Air conditioners, humidifiers, dehumidifiers and purifiers* • *Breast pumps* • *Computer "story boards" or "light talkers" for communication-impaired individuals* • *Equipment for cosmetic purposes*	*All charges*	*All charges*

Medical supplies	You pay – Standard Option	You pay – High Option
• Medical foods for children with inborn errors of amino acid metabolism • Ostomy and catheter supplies • Oxygen, regardless of the provider • Blood and blood plasma except when donated or replaced, and blood plasma expanders	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the provider's actual charge	Preferred: 5% of the Plan allowance Participating: 20% of the Plan allowance Non-participating: 20% of the Plan allowance, plus any difference between our allowance and the provider's actual charge
Home health services	**You pay – Standard Option**	**You pay – High Option**
Home nursing care for two (2) hours per day, up to 25 visits per calendar year under **Standard Option** and 50 visits per calendar year under **High Option**, when: • A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; and • A physician orders the care *Note*: Visits that you pay for while meeting your calendar year deductible count toward the limits cited above.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the provider's actual charge	Preferred: 5% of the Plan allowance Participating: 20% of the Plan allowance Non-participating: 20% of the Plan allowance, plus any difference between our allowance and the provider's actual charge
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Nursing care primarily for bathing, feeding, exercising, moving the patient, homemaking, giving medication, or acting as a companion or sitter*	*All charges*	*All charges*

Alternative treatments	You pay – Standard Option	You pay – High Option
Acupuncture – when performed and billed by a physician or licensed physical therapist, for: • pain relief, and • as a modality of physical therapy *Note:* See page 32 for limitations. *Note:* We may also cover services of certain alternative treatment providers in medically underserved areas. See page 10 for additional information.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the provider's actual charge	Preferred: 5% of the Plan allowance Participating: 20% of the Plan allowance Non-participating: 20% of the Plan allowance, plus any difference between our allowance and the provider's actual charge
Not covered: • *Services you receive from non-covered providers such as:* •• *chiropractors* •• *naturopaths* •• *hypnotherapists* • *Biofeedback (or other forms of self-care or self-help training)*	*All charges*	*All charges*
Educational classes and programs	**You pay – Standard Option**	**You pay – High Option**
Coverage is limited to: • Smoking cessation—enrollment in one smoking cessation program per member per lifetime *Note*: Services may be provided by any covered provider or by a smoking cessation clinic. See Section 5(f) for our coverage for smoking cessation drugs	You pay all charges after we pay $100 per member, per lifetime (calendar year deductible applies)	You pay all charges after we pay $100 per member, per lifetime (calendar year deductible applies)
• Diabetic education when billed by a covered provider *Note:* We cover diabetic educators, dieticians, and nutritionists who bill independently only as part of a covered diabetic education program.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: 5% of the Plan allowance Participating: 20% of the Plan allowance Non-participating: 20% of the Plan allowance, plus any difference between our allowance and the physician's actual charge

Educational classes and programs – Continued on next page

Educational classes and programs - *Continued*	**You pay – Standard Option**	**You pay – High Option**
Not covered: • *Marital, family, educational or other counseling or training services when performed as part of an educational class or program* • *Premenstrual (PMS), lactation, headache, eating disorder and other educational clinics* • *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay or through an approved home health care program* • *Services performed or billed by a school or halfway house or a member of its staff*	*All charges*	*All charges*

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

IMPORTANT

Here are some 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.
- The calendar year deductible is: $250 per person ($500 per family) under **Standard Option** and $150 per person ($300 per family) under **High Option**. The Calendar Year deductible applies to almost all benefits under Standard Option in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRIOR APPROVAL for all organ transplant surgical procedures;** and if your surgical procedure requires an inpatient admission, **YOU MUST GET PRECERTIFICATION. Please refer to the prior approval and precertification information shown in Section 3 to be sure which services require prior approval or precertification.**
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

IMPORTANT

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.		
Surgical procedures	**You pay – Standard Option**	**You pay – High Option**
We pay for the following services provided, or ordered, and billed by a physician: • Operative procedures • Treatment of fractures and dislocations, 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 on page 42) • Treatment of burns	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: 5% of the Plan allowance (No deductible) Participating: 20% of the Plan allowance (No deductible) Non-participating: 20% of the Plan allowance (No deductible), plus any difference between our allowance and the physician's actual charge

Surgical procedures – Continued on next page

Surgical procedures – *Continued*	**You pay – Standard Option**	**You pay – High Option**
• Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic and prosthetic devices, and Section 5(c) – Other hospital services and supplies – for our coverage for the device. • Voluntary sterilization, Norplant (a surgically implanted contraceptive), and intrauterine devices (IUDs) • Assistant surgeons/surgical assistance by a physician if required because of the complexity of the surgical procedures • Gastric bypass surgery or gastric stapling procedures for morbid obesity – a condition in which an individual weighs 100 pounds over, or 100% over, his or her normal weight according to current underwriting standards; eligible members must be age 18 or over When multiple surgical procedures that add time or complexity to patient care are performed during the same operative session, the Local Plan determines our allowance for the combination of multiple, bilateral, or incidental surgical procedures. Generally, we will allow a reduced amount for procedures other than the primary procedure. *Note*: We do not pay extra for "incidental" procedures (those that do not add time or complexity to patient care). *Note*: When unusual circumstances require the removal of casts or sutures by a physician other than the one who applied them, the Local Plan may determine that a separate allowance is payable.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: 5% of the Plan allowance (No deductible) Participating: 20% of the Plan allowance (No deductible) Non-participating: 20% of the Plan allowance (No deductible), plus any difference between our allowance and the physician's actual charge
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby physician* • *Routine surgical treatment of conditions of the foot (see Section 5(a) – Foot care)* • *Cosmetic surgery* • *Radial Keratotomy and other refractive surgery*	*All charges*	*All charges*

Reconstructive surgery	You pay – Standard Option	You pay – High Option
• Surgery to correct a functional defect • Surgery to correct a congenital anomaly – a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. *Note:* Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth. • Treatment to restore the mouth to a pre-cancer state • All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast •• treatment of any physical complications, such as lymphedemas *Note*: Internal breast prostheses are paid as medical services and supplies [see Section 5(a)], or hospital services [see Section 5(c)]. *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.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: 5% of the Plan allowance (No deductible) Participating: 20% of the Plan allowance (No deductible) Non-participating: 20% of the Plan allowance (No deductible), plus any difference between our allowance and the physician's actual charge
Not covered: • *Cosmetic surgery – any operative procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form –unless required for a congenital anomaly or to restore or correct a part of the body that has been altered as a result of accidental injury, disease or surgery (does not include anomalies related to the teeth or structures supporting the teeth)* • *Surgeries related to sex transformation, sexual dysfunction or sexual inadequacy*	*All charges*	*All charges*

Oral and maxillofacial surgery	You pay – Standard Option	You pay – High Option
Oral surgical procedures, limited to: • Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when pathological examination is necessary • Surgery needed to correct accidental injuries (see Definitions) to jaws, cheeks, lips, tongue, roof and floor of mouth • Excision of exostoses of jaws and hard palate • External incision and drainage of cellulitis • Incision and surgical treatment of accessory sinuses, salivary glands or ducts • Reduction of dislocations and excision of temporomandibular joints • Removal of impacted teeth	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: 5% of the Plan allowance (No deductible) Participating: 20% of the Plan allowance (No deductible) Non-participating: 20% of the Plan allowance (No deductible), plus any difference between our allowance and the physician's actual charge
Not covered: • *Oral implants and transplants* • *Surgical procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), except as shown above and in Section 5(h)* • *Surgical procedures involving orthodontic care, dental implants or preparation of the mouth for the fitting or the continued use of dentures, except as specifically shown above and in Section 5(h)*	*All charges*	*All charges*

Organ/tissue transplants	You pay – Standard Option	You pay – High Option
• Cornea • Heart • Heart-lung • Kidney • Liver • Pancreas • Small bowel • Single or double lung: only for the following end-stage pulmonary diseases: pulmonary fibrosis, primary pulmonary hypertension, and emphysema • Double lung: only for patients with end-stage cystic fibrosis	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: 5% of the Plan allowance (No deductible) Participating: 20% of the Plan allowance (No deductible) Non-participating: 20% of the Plan allowance (No deductible), plus any difference between our allowance and the physician's actual charge

Organ/tissue transplants – Continued on next page

Organ/tissue transplants – *Continued*	**You pay – Standard Option**	**You pay – High Option**
Bone marrow and stem cell transplants, limited to: • Allogeneic bone marrow transplants and allogeneic cord blood stem cell transplants (from related or unrelated donors) for: •• Advanced neuroblastoma •• Infantile malignant osteopetrosis •• Severe combined immunodeficiency •• Wiskott-Aldrich syndrome •• Mucopolysaccharidosis (e.g., Hunter, Hurler's, Sanfilippo, Maroteaux-Lamy variants) •• Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) •• Severe or very severe aplastic anemia •• Thalassemia major (homozygous beta-thalassemia) •• Sickle cell anemia •• Phagocytic deficiency diseases • Allogeneic bone marrow transplants, allogeneic cord blood stem cell transplants (from related or unrelated donors) and allogeneic peripheral blood stem cell transplants for: •• Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia •• Advanced Hodgkin's lymphoma •• Advanced non-Hodgkin's lymphoma •• Chronic myelogenous leukemia •• Advanced forms of myelodysplastic syndromes • Autologous bone marrow transplants and autologous peripheral blood stem cell transplants (collectively referred to as autologous stem cell support) for: •• Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia •• Advanced Hodgkin's lymphoma •• Advanced non-Hodgkin's lymphoma •• Advanced neuroblastoma •• Testicular, Mediastinal, Retroperitoneal and Ovarian germ cell tumors •• Multiple myeloma	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: 5% of the Plan allowance (No deductible) Participating: 20% of the Plan allowance (No deductible) Non-participating: 20% of the Plan allowance (No deductible), plus any difference between our allowance and the physician's actual charge

Organ/tissue transplants – Continued on next page

Organ/tissue transplants – *Continued*	**You pay – Standard Option**	**You pay – High Option**
• Extraction or reinfusion of bone marrow, blood stem cells, or cord blood as a source of stem cells as part of a covered allogeneic or autologous bone marrow transplant or blood stem cell transplant support procedure • Marrow harvesting in anticipation of a covered autologous bone marrow transplant, for patients diagnosed at the time of harvesting with one of the conditions listed above • Collection, processing, storage and distribution of cord blood only when performed by a cord blood bank approved by the FDA • Storage of harvested bone marrow, blood stem cells, or cord blood as a source of stem cells, only when a covered transplant has already been scheduled • Related medical and hospital expenses of the donor, as part of a covered transplant procedure • Related services or supplies provided to the recipient *Note:* See Section 5(a) for coverage for related services, such as chemotherapy and/or radiation therapy and drugs administered to stimulate or mobilize stem cells for covered transplant procedures.	See page 44	See page 44
Limitations (1) You must obtain prior approval (see page 14) from the Local Plan, for both the procedure and the facility, for the following transplant procedures: • Bone marrow, cord blood stem cell and peripheral blood stem cell transplant support procedures • Heart • Heart-lung • Liver • Lung (single/double) • Pancreas • Small bowel		

Organ/tissue transplants – Continued on next page

Organ/tissue transplants --- *Continued*	**You pay – Standard Option**	**You pay – High Option**
(2) For the following procedures, we provide benefits **only** when conducted at a Cancer Research Facility and performed as part of a clinical trial that meets the requirements shown below: • Allogeneic bone marrow transplants, syngeneic bone marrow transplants, and allogeneic peripheral blood stem cell transplants for: •• Multiple myeloma •• Chronic lymphocytic leukemia •• Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Autologous bone marrow transplants and autologous peripheral blood stem cell transplants (collectively referred to as autologous stem cell support) for: •• Breast cancer •• Epithelial ovarian cancer •• Chronic myelogenous leukemia •• Chronic lymphocytic leukemia •• Early stage (indolent or non-advanced) small cell lymphocytic lymphoma For these bone marrow transplant procedures and related services or supplies covered only through clinical trials: 1. You must contact our Clinical Trials Information Unit at 1-800-225-2268 for prior approval (see page 14); 2. The clinical trial must be reviewed and approved by the Institutional Review Board of the Cancer Research Facility where the procedure is to be delivered; and 3. The patient must be properly and lawfully registered in the clinical trial, meeting all the eligibility requirements of the trial. If a non-randomized clinical trial meeting these requirements is not available at a Cancer Research Facility where you are eligible, we will arrange for the transplant to be provided at another Plan-designated transplant facility.	See page 44	See page 44

Organ/tissue transplants – Continued on next page

Organ/tissue transplants - *Continued*	**You pay – Standard Option**	**You pay – High Option**
Not covered: • *Transplants for any diagnosis not listed as covered* • *Donor screening tests and donor search expenses, except those performed for the actual donor*	*All charges*	*All charges*
Anesthesia	**You pay – Standard Option**	**You pay – High Option**
Anesthesia (including acupuncture) for covered surgical services when requested by the attending physician and performed by: • a certified registered nurse anesthetist (CRNA), or • a physician other than the operating physician (surgeon) or the assistant Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Anesthesia services consist of administration by injection or inhalation of a drug or other anesthetic agent (including acupuncture) to obtain muscular relaxation, loss of sensation, or loss of consciousness. *Note:* See Section 5(c) for anesthesia services billed by a facility.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the physician's actual charge	Preferred: 5% of the Plan allowance (No deductible) Participating: 20% of the Plan allowance (No deductible) Non-participating: 20% of the Plan allowance (No deductible), plus any difference between our allowance and the physician's actual charge

Section 5(c). Services provided by a hospital or other facility, and ambulance services

IMPORTANT

Here are some 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.
- Unlike Sections 5(a) and (b), in this Section the calendar year deductible applies to only a few benefits. In that case, we added "(calendar year deductible applies)" when it applies.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your inpatient surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are listed in Section 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information listed in Section 3 to be sure which services require precertification.
- You should be aware that some PPO hospitals may have Non-PPO professional providers on staff. If you use a PPO facility, we may still pay Non-PPO benefits if you receive treatment from a radiologist, pathologist, anesthesiologist, assistant surgeon, or other provider who is not a PPO provider.
- We base payment on whether the facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

IMPORTANT

Benefit Description	You pay	
NOTE: The calendar year deductible applies ONLY when we say below: "calendar year deductible applies."		
Inpatient hospital	**You pay – Standard Option**	**You pay – High Option**
Room and board, such as: • semiprivate or intensive care accommodations • general nursing care • meals and special diets *Note*: We cover a private room only when you must be isolated to prevent contagion, when your isolation is required by law, or when a Preferred or Member hospital only has private rooms. Otherwise, we will pay the hospital's average daily rate for semiprivate rooms as determined by the Local Plan. If a Non-member hospital only has private rooms, we base our payment on the average daily rate as determined by the Local Plan.	Preferred: $100 per admission copayment for unlimited days Member: $300 per admission copayment for unlimited days Non-member: $300 per admission copayment plus 30% of the Plan allowance, and any remaining balance after our payment *Note:* You pay nothing for facilities outside of the United States and Puerto Rico	Preferred: Nothing for unlimited days Member: $100 per admission copayment for unlimited days Non-member: $100 per admission copayment plus 30% of the Plan allowance, and any remaining balance after our payment *Note:* You pay nothing for facilities outside of the United States and Puerto Rico

Inpatient hospital – Continued on next page.

Inpatient hospital – *Continued*	**You pay – Standard Option**	**You pay – High Option**
Other hospital services and supplies, such as: • Operating, recovery, maternity and other treatment rooms • Prescribed drugs • Diagnostic laboratory tests, pathology services, MRIs, machine diagnostic tests and X-rays • Administration of blood or blood plasma • Dressings, splints, casts and sterile tray services • Internal prosthetic devices • Other medical supplies and equipment, including oxygen • Anesthetics and anesthesia services • Take-home items • Pre-admission testing recognized as part of the hospital admissions process *Note*: Here are some things to keep in mind: • We base payment on whether the facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility. • You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby. • If you need to stay longer in the hospital than initially planned, we will cover an extended stay if it is medically necessary. However, you must precertify the extended stay. See Section 3 for information on requesting additional days. We pay Inpatient hospital benefits for an admission in connection with dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient. We provide benefits for dental procedures as shown in Section 5(h). *Note:* See page 29 for covered maternity services. *Note:* See page 37 for coverage of blood and blood products.	See page 48	See page 48

Inpatient hospital – Continued on next page.

Inpatient hospital – *Continued*	**You pay – Standard Option**	**You pay – High Option**
Not covered: *Hospital room and board expenses when in our judgement, a hospital admission or portion of an admission is:* • *Custodial care* • *Convalescent care or a rest cure* • *Domiciliary care provided because care in the home is not available or unsuitable* • *Not medically necessary, such as when services did not require the acute/subacute hospital inpatient (overnight) setting but could have been provided safely and adequately in a physician's office, the outpatient department of a hospital, or some other setting, without adversely affecting your condition or the quality of medical care you receive. Some examples are:* •• *Admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting (such as a physician's office)* •• *Admissions primarily for diagnostic studies, laboratory and pathological services, X-rays, MRIs, or machine diagnostic tests that could have been provided safely and adequately in some other setting (such as the outpatient department of a hospital or a physician's office)* *Note: If we determine that a hospital admission is one of the types listed above, we will not provide benefits for inpatient room and board or inhospital physician care. However, we will provide benefits for covered services or supplies other than room and board and inhospital physician care at the level that we would have paid if they had been provided in some other setting.* • *Admission to non-covered facilities, such as nursing homes, extended care facilities, schools, residential treatment centers* • *Personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services* • *Inpatient private duty nursing*	*All charges*	*All charges*

Outpatient hospital or ambulatory surgical center	You pay – Standard Option	You pay – High Option
Outpatient **medical services** performed and billed for by a hospital or freestanding ambulatory facility, such as: • Operating, recovery and other treatment rooms • Prescribed drugs • Diagnostic tests, such as laboratory and pathology services, MRIs, machine diagnostic tests and X-rays • Administration of blood, blood plasma and other biologicals • Blood and blood plasma, if not donated or replaced • Dressings, splints, casts and sterile tray services • Other medical supplies, including oxygen • Renal dialysis *Note:* See pages 26-28 for covered preventive services for adults and children.	Preferred facilities: 10% of the Plan allowance (calendar year deductible applies) Member facilities: 25% of the Plan allowance (calendar year deductible applies) Non-member facilities: 25% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the provider's actual charge *Note*: You pay nothing for facilities outside the United States and Puerto Rico.	Preferred facilities: 5% of the Plan allowance (calendar year deductible applies) Member facilities: 20% of the Plan allowance (calendar year deductible applies) Non-member facilities: 20% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the provider's actual charge *Note*: You pay nothing for facilities outside the United States and Puerto Rico.

Outpatient hospital or ambulatory surgical center – Continued on next page

Outpatient hospital or ambulatory surgical center – *Continued*	**You pay – Standard Option**	**You pay – High Option**
Outpatient **surgery and related services** performed and billed for by a hospital or freestanding ambulatory facility, such as: • Operating, recovery and other treatment rooms • Prescribed drugs • Pre-surgical testing performed within one business day of the covered surgical services • Facility supplies for hemophilia home care • Diagnostic tests, such as laboratory and pathology services, MRIs, machine diagnostic tests and X-rays • Administration of blood, blood plasma and other biologicals • Blood and blood plasma, if not donated or replaced • Dressings, splints, casts and sterile tray services • Other medical supplies, including oxygen *Note*: We cover outpatient hospital services and supplies related to dental procedures only when a non-dental physical impairment exists that makes the hospital setting necessary to safeguard the health of the patient. See Section *5*(h), *Dental benefits*, for additional benefit information. *Note*: See page 29 for covered maternity services.	Preferred facilities: 10% of the Plan allowance (No deductible) Member facilities: 25% of the Plan allowance (No deductible) Non-member facilities: 25% of the Plan allowance (No deductible), plus any difference between our allowance and the provider's actual charge *Note*: You pay nothing for facilities outside the United States and Puerto Rico.	Preferred facilities: 5% of the Plan allowance (No deductible) Member facilities: 20% of the Plan allowance (No deductible) Non-member facilities: 20% of the Plan allowance (No deductible), plus any difference between our allowance and the provider's actual charge *Note*: You pay nothing for facilities outside the United States and Puerto Rico.

Extended care benefits/Skilled nursing care facility benefits	You pay – Standard Option	You pay – High Option
Limited to the following benefits for Medicare Part A copayments: When Medicare Part A is the primary payer (meaning that it pays first) and has made payment, **Standard** and **High Options** provide limited secondary benefits. We pay the applicable Medicare Part A copayments incurred **in full** during the first through the 30th day of confinement for each benefit period (as defined by Medicare) in a qualified skilled nursing facility. A qualified skilled nursing facility is a facility that specializes in skilled nursing care performed by or under the supervision of licensed nurses, skilled rehabilitation services, and other related care and meets Medicare's special qualifying criteria, but is not an institution that primarily cares for and treats mental diseases. If Medicare pays the first 20 days in full, Plan benefits will begin on the 21st day (when Medicare Part A copayments begin) and will end on the 30th day. *Note:* See page 32 for benefits provided for outpatient speech, occupational and physical therapy when billed by a skilled nursing facility. See Section 5(f) for benefits for prescription drugs. *If you do not have Medicare Part A, we do not provide benefits for skilled nursing facility care.*	Preferred: Nothing Participating/Member: Nothing Non-participating/Non-member: Nothing *Note:* You pay all charges not paid by Medicare after the 30th day.	Preferred: Nothing Participating/Member: Nothing Non-participating/Non-member: Nothing *Note:* You pay all charges not paid by Medicare after the 30th day.

Hospice care	You pay – Standard Option	You pay – High Option
Hospice care is an integrated set of services and supplies designed to provide palliative and supportive care to terminally ill patients in their homes. We provide the following **home hospice care** benefits for members with a life expectancy of six months or less **when prior approval is obtained from the Local Plan** and the home hospice agency is approved by the Local Plan: • Physician visits • Nursing care • Medical social services • Physical therapy • Services of home health aides • Durable medical equipment rental • Prescription drugs • Medical supplies	Nothing	Nothing
Inpatient hospice for members receiving home hospice care benefits: Benefits are provided for up to five (5) consecutive days in a hospital or a freestanding hospice inpatient facility. Each inpatient stay must be separated by at least 21 days. These covered inpatient hospice benefits are available only when inpatient services are necessary to: •• control pain and manage the patient's symptoms; or •• provide an interval of relief (respite) to the family. *Note:* **You are responsible for making sure that the home hospice care provider has received prior approval from the Local Plan** (see page 14 for instructions). Please check with your Local Plan and/or your PPO directory for listings of approved agencies.	Preferred: $100 per admission copayment Member: $300 per admission copayment Non-member: $300 per admission copayment plus 30% of the Plan allowance, and any remaining balance after our payment	Preferred: Nothing (No deductible) Member: $100 per admission copayment Non-member: $100 per admission copayment plus 30% of the Plan allowance, and any remaining balance after our payment
Not covered: • *Homemaker or bereavement services*	*All charges*	*All charges*

Ambulance	You pay – Standard Option	You pay – High Option
Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and: • Associated with covered hospital inpatient care • Related to and within 72 hours after an accidental injury or medical emergency • During covered home health care	Preferred: 10% of the Plan allowance (calendar year deductible applies) Participating: 25% of the Plan allowance (calendar year deductible applies) Non-participating: 25% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the provider's actual charge	Preferred: 5% of the Plan allowance (calendar year deductible applies) Participating: 20% of the Plan allowance (calendar year deductible applies) Non-participating: 20% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the provider's actual charge

Home Health Care	You pay – Standard Option	You pay – High Option
Under **High Option** only, for up to 90 days per calendar year, the covered Home health care services listed below if: 1) The services you receive are billed by a home health care agency (such as the hospital or a visiting nurse association) that has a written agreement with the Local Plan to provide home health care services, and 2) **Prior approval is obtained from the Local Plan**. If prior approval is not obtained, benefits will be provided as applicable under Section 5(a), Medical services and supplies. ***Note*: You are responsible for making sure that the home health care provider has received prior approval from the Local Plan** (see page14 for instructions). Please check with your Local Plan and/or your PPO directory for listings of approved agencies. Covered services: • Nursing care such as dressing changes, injections, and monitoring of vital signs • Physical therapy • Respiratory or inhalation therapy • Prescription drugs • Medical supplies that serve a specific therapeutic or diagnostic purpose • Infusion therapy • Other medically necessary services or supplies that would have been provided by a hospital if you were hospitalized *Note:* See Section 5(a) for **High Option** coverage for physician home visits while receiving covered home health care services, and for **Standard Option** coverage for home nursing visits.	*All charges* *See Section 5(a) for coverage of Home health services.*	Nothing (No deductible)
Not covered: • *Home health care services for routine maternity care, for routine monitoring of a condition, for intermittent care of a stable condition, or for initial evaluation of the patient to determine whether or not home health care is appropriate* • *Homemaking services, including housekeeping, preparing meals, or acting as a companion or sitter*		

Section 5 (d). Emergency services/accidents

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.
- The calendar year deductible is: $250 per person ($500 per family) under **Standard Option** and $150 per person ($300 per family) under **High Option**. 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.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

IMPORTANT

What is an accidental injury? An accidental injury is an injury caused by an external force or element such as a blow or fall and which requires immediate medical attention, including animal bites and poisonings. (See Section 5(h) for dental care for accidental injury.)

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.		
Accidental injury	**You pay – Standard Option**	**You pay – High Option**
If you receive care in connection with, and within 72 hours after an accidental injury, we cover: • Physician services in the office or hospital outpatient department including X-rays, MRIs, laboratory and pathological services, and machine diagnostic tests • Related outpatient hospital services and supplies, including X-rays, MRIs, laboratory, pathological and machine diagnostic tests *Note*: For services received after 72 hours, please see Section 5(a), Medical services and supplies, and Section 5(c), Outpatient hospital, for the benefits we provide. We pay Inpatient hospital benefits if you are admitted [see Section 5(c)]. See Section 5(h) for dental benefits for accidental injuries.	Preferred: Nothing (No deductible) Participating: Nothing (No deductible) Non-participating: Any difference between the Plan allowance and the billed amount (No deductible)	Preferred: Nothing (No deductible) Participating: Nothing (No deductible) Non-participating: Any difference between the Plan allowance and the billed amount (No deductible)

Accidental injury – Continued on next page

Accidental injury – *Continued*	**You pay – Standard Option**	**You pay – High Option**
Not covered: • *Oral surgery except as shown in Section 5(b)* • *Injury to the teeth while eating*	*All charges*	*All charges*
Medical emergency	**You pay – Standard Option**	**You pay – High Option**
For medical emergency services, other than those services performed within 72 hours after an accidental injury for which we pay under Accidental injury above, see the following benefits sections: • Section 5(a), Medical services and supplies • Section 5(b), Surgical procedures • Section 5(c), Outpatient hospital • Section 5(c), Inpatient hospital *Note*: We pay Inpatient hospital benefits if you are admitted as a result of a medical emergency (see Section 5(c), Inpatient hospital). Please refer to Section 3 for information about precertifying emergency hospital admissions.	Same as for illness (Regular benefits)	Same as for illness (Regular benefits)
Ambulance	**You pay – Standard Option**	**You pay – High Option**
Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat the patient's condition, when medically appropriate, and: • Associated with covered hospital inpatient care • Related to and within 72 hours after an accidental injury or medical emergency • During covered home health care *Note*: See Section 5(c) for non-emergency ambulance services.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the provider's actual charge	Preferred: 5% of the Plan allowance Participating: 20% of the Plan allowance Non-participating: 20% of the Plan allowance, plus any difference between our allowance and the provider's actual charge

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

IMPORTANT

Beginning in 2001, all FEHB plans' mental health and substance abuse benefits will achieve "parity" with other benefits. This means that we will provide mental health and substance abuse benefits differently than in the past.

You may choose to get care from Non-preferred providers (same as before) or from Preferred providers (new in 2001). When you receive care from Preferred providers, generally your cost sharing for your mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible or, for facility care, the inpatient per admission copay, applies to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not apply.
- There is a maximum of 25 visits per year under Standard Option and 50 visits per year under High Option for office visits, partial hospitalization, intensive outpatient treatment, and other hospital outpatient treatment. The first 25 visits under Standard Option and 50 visits under High Option each calendar year by Preferred providers and Non-preferred providers count toward this maximum. This maximum may be waived for services received from Preferred providers.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS: FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information listed in Section 3. Some other services also require prior approval. See the instructions after the benefits descriptions below.
- Preferred mental health and substance abuse benefits are presented below. Non-preferred benefits begin on page 62.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

IMPORTANT

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.		
Preferred (In-Network) benefits	**You pay – Standard Option**	**You pay – High Option**
All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. *Note*: Preferred benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care from a Preferred provider as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.

Preferred benefits – Continued on next page

Preferred benefits – *Continued*	You pay – Standard Option	You pay – High Option
Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, clinical social workers or psychiatric nurses *Note:* Additional licensed provider types may be available to you for mental health and substance abuse services. Consult your PPO directory or contact your Local Plan at the mental health phone number on the back of your ID card. • Office and home visits • Medication management • Psychological testing	$15 copayment for the visit, up to two hours per visit (No deductible); 10% of the Plan allowance for all other services (deductible applies)	$12 copayment for the visit, up to two hours per visit (No deductible); 5% of the Plan allowance for all other services (deductible applies)
• Inpatient visits • Intensive outpatient treatment – not limited to two hours per visit but you must obtain prior approval • Outpatient diagnostic tests	10% of the Plan allowance	5% of the Plan allowance (No deductible for inpatient visits)
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 • Diagnostic tests *Note*: You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	$100 per admission copayment for medically necessary days (No deductible)	Nothing for medically necessary days (No deductible)
Outpatient services provided and billed by a hospital or other covered facility • Diagnostic tests • Services in the following approved treatment programs (must be prior approved): •• partial hospitalization •• facility-based intensive outpatient treatment	10% of the Plan allowance	5% of the Plan allowance

Preferred benefits – Continued on next page

Preferred benefits – *Continued*	You pay – Standard Option	You pay – High Option
Not covered: • *Services we have not approved* • *Educational or training services* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present* *Note:* 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.	*All charges*	*All charges*

Authorization Procedures

To be eligible to receive enhanced mental health and substance abuse benefits you must see a Preferred provider, follow your treatment plan and follow the applicable authorization processes.

To locate a Preferred provider, please refer to your PPO directory, visit our website at www.fepblue.org or contact the Local Plan at the mental health and substance abuse phone number shown on the back of your ID card.

Precertification

You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty. Please refer to the precertification information listed in Section 3 for additional information.

Prior Approval

Prior approval is required for partial hospitalization and intensive outpatient treatment programs. Prior to starting treatment, you, someone acting on your behalf, your physician or your hospital must call the Local Plan at the mental health and substance abuse phone number on the back of your ID card. We will not pay for partial hospitalization or intensive outpatient treatment programs, even in-network, until you obtain prior approval.

Treatment Plans

In order to maximize your benefits, your provider must submit a treatment plan to the Local Plan **prior to your ninth outpatient visit**. When the Local Plan approves the treatment plan, your provider will be given authorization for additional visits. The number of additional visits will depend on the treatment plan. Subsequent treatment plans may be requested by the Local Plan. If a treatment plan is not submitted or not approved, we will provide only Non-preferred (out-of-network) benefits. If you change providers, a new treatment plan must be submitted. We will be flexible in allowing additional visits while your treatment plan is being prepared or under review.

Preferred limitation

If you do not obtain and follow an approved treatment plan, we will provide only Non-preferred (out-of-network) benefits.

Non-preferred benefits	You pay – Standard Option	You pay – High Option
Professional services, including individual or group therapy, by providers such as psychiatrists, psychologists, clinical social workers or psychiatric nurses, limited to 25 outpatient visits* per calendar year under Standard Option, or 50 outpatient visits* per calendar year under High Option, for: • Office and home visits • Psychological testing • In a hospital outpatient department (except for emergency rooms) *The visit limit is a combined maximum for all outpatient professional care, partial hospitalization and outpatient facility care, whether performed by Preferred or Non-preferred providers, or applied to your calendar year deductible.	40% of the Plan allowance for up to two hours per visit; all charges after 25 visits*	30% of the Plan allowance for up to two hours per visit; all charges after 50 visits*
Inpatient visits, limited to 100 days per calendar year under Standard Option, and 120 days per calendar year under High Option	40% of the Plan allowance; all charges after 100 days	30% of the Plan allowance; all charges after 120 days

Non-preferred benefits – Continued on next page

Non-preferred benefits – *Continued*	**You pay – Standard Option**	**You pay – High Option**
Inpatient services provided and billed by a hospital or other covered facility; limited to 100 days per calendar year under Standard Option or 120 days per calendar year under High Option • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets and other hospital services You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	$400 copayment per day (No deductible); all charges after 100 days	$300 copayment per day (No deductible); all charges after 120 days
Outpatient services provided and billed by a hospital or other covered facility • Psychological testing	25% of the Plan allowance, plus any difference between the Plan allowance and the provider's actual charge	20% of the Plan allowance, plus any difference between the Plan allowance and the provider's actual charge
Partial hospitalization, for up to 25 visits* per calendar year under Standard Option and 50 visits* per calendar year under High Option *Note:* Visits that you pay for while meeting your deductible count toward the limits cited above. *The visit limit is a combined maximum for all outpatient professional care, partial hospitalization and outpatient facility care, whether performed by Preferred or Non-preferred providers, or applied to your calendar year deductible.	25% of the Plan allowance, plus any difference between the Plan allowance and the provider's actual charge; all charges after 25 visits*	20% of the Plan allowance, plus any difference between the Plan allowance and the provider's actual charge; all charges after 50 visits*

Non-preferred benefits – Continued on next page

Non-preferred benefits – *Continued*	**You pay – Standard Option**	**You pay – High Option**
Inpatient care to treat substance abuse includes room and board and ancillary charges for confinements in a treatment facility for rehabilitative treatment of alcoholism or substance abuse *Note*: Non-preferred inpatient care for the treatment of substance abuse is limited to one treatment program (28-day maximum) per lifetime under **Standard** and **High Options**.	Non-preferred facility: $400 copayment per day (No deductible); all charges after 28 days per lifetime Non-preferred professional: 40% of the Plan allowance; all charges after 28 days per lifetime	Non-preferred facility: $300 copayment per day (No deductible); all charges after 28 days per lifetime Non-preferred professional: 20% of the Plan allowance; all charges after 28 days per lifetime
Not covered : • *Marital, family, educational, or other counseling or training services* • *Services performed by a non-covered provider* • *Testing and treatment for learning disabilities and mental retardation* • *Services performed or billed by schools, residential treatment centers, halfway houses, or members of their staffs* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present* • *Home health care services related to the treatment of mental health and substance abuse*	*All charges*	*All charges*

Lifetime maximum

Non-preferred inpatient care for the treatment of substance abuse is limited to one treatment program (28-day maximum) per lifetime under **Standard** and **High Options**.

Precertification

You must get precertification of the medical necessity of your admission to a hospital or other covered facility. Report emergency admissions within two business days following the day of admission, even if you have been discharged. Otherwise, we will reduce the benefits payable by $500. See Section 3 for more information on precertification.

See these sections of the brochure for more valuable information about these benefits:

- Section 4, *Your costs for covered services,* for information about catastrophic protection for mental health and substance abuse benefits.
- Section 7, *Filing a claim for covered services*, for information about submitting Non-preferred claims.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescription drugs and supplies, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible does not apply to prescriptions filled through the Retail Pharmacy Program or Mail Service Prescription Drug Program. We added "(calendar year deductible applies)" when it applies.
- **YOU MUST GET PRIOR APPROVAL FOR CERTAIN DRUGS, and prior approval must be renewed periodically. Please refer to the prior approval information shown in Section 3.**
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- The non-PPO benefits are the standard benefits of this Plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

IMPORTANT

We will send each new enrollee a description of our prescription drug program, a combined prescription drug/Plan identification card, a mail order form/patient profile, and a preaddressed reply envelope.

- **Who can write your prescriptions.** A physician or dentist licensed in the United States or Puerto Rico, or a nurse practitioner in states that permit it, must write your prescriptions.
- **Where you can obtain them.** You may fill prescriptions at a Preferred retail pharmacy, at a Non-preferred retail pharmacy, and through our Mail Service Prescription Drug Program. We pay a higher level of benefits when you use a Preferred retail pharmacy or our Mail Service Prescription Drug Program.
- **We use an open formulary.** This is a list of preferred name brand drugs selected to meet patient needs at a lower cost to us. If your physician believes a name brand drug is necessary or there is no generic equivalent available, ask your physician to prescribe a name brand drug from our formulary list. We may ask your doctor to substitute a formulary drug in order to help achieve the best clinical outcome while at the same time help control costs. We cover drugs that require a prescription (whether or not they are on our formulary list). There is no penalty to you if you do not choose a drug from our formulary. However, your cooperation with our cost-savings efforts helps keep your premium affordable. You can view our formulary on our website at www.fepblue.org or request a copy by mail by calling 1-800-624-5060 (TDD: 1-800-624-5077). Any savings we receive on the cost of drugs purchased under this Plan from drug manufacturers are credited to the reserves held for this Plan.
- **Generic equivalents**. By submitting your prescription (or those of family members covered by the Plan) to your retail pharmacy or the Mail Service Prescription Drug Program, you authorize them to substitute any available Federally approved generic equivalent, unless you or your physician specifically request a name brand drug.
- **Disclosure of information**. As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including the names of your prescribing physicians, to any treating physicians or dispensing pharmacies.
- **These are the dispensing limitations.** You may purchase up to a 90-day supply of covered drugs and supplies through the Retail Pharmacy Program. You may purchase a supply of more than 21 days up to 90 days through the Mail Service Prescription Drug Program. Certain drugs such as narcotics may have additional FDA limits on the quantities that a pharmacy may dispense. In most cases, refills cannot be obtained until 75% of the prescription has been used. Call the Retail Pharmacy Program or the Mail Service Prescription Drug Program at the numbers shown below for exceptions to this policy, and further information about dispensing limits for specific drugs.
- **Important phone numbers.** Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077)
  Mail Service Prescription Drug Program: 1-800-262-7890 (TDD: 1-800-446-7292)

Prescription drug benefits - Continued on next page

Covered medications and supplies	You pay – Standard Option	You pay – High Option
• Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a prescription for their purchase • Insulin • Needles and disposable syringes for the administration of covered medications • Drugs to aid smoking cessation that require a prescription by Federal law (limited to one course of treatment per calendar year) • Contraceptive drugs and devices, limited to: ●● Depo-Provera * ●● Diaphragms * ●● Intrauterine Device (IUD) * ●● Norplant * ●● Oral contraceptives *available only through retail pharmacies Here is how to obtain your prescription drugs: **Retail Pharmacy Program**		
• You must present your Plan ID card at the time of purchase at a Preferred retail pharmacy.	Preferred Retail Pharmacy: 25% of the Plan allowance	Preferred Retail Pharmacy: 15% of the Plan allowance
• If you use a Non-preferred retail pharmacy, or your prescription requires prior approval, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.	Non-preferred Retail Pharmacy: 45% of the Plan allowance, plus any difference between our allowance and the billed amount	Non-preferred Retail Pharmacy: 35% of the Plan allowance, plus any difference between our allowance and the billed amount
Note: For prescription drugs billed for by a skilled nursing facility, nursing home, or extended care facility, we provide benefits as shown above for retail pharmacy-obtained drugs, according to the Preferred or Non-preferred status of the pharmacy supplying the drugs to the facility. For a list of our Preferred Network Long Term Care pharmacies that service nursing homes, call 1-800-624-5060 (TDD: 1-800-624-5077) or visit our web site at www.fepblue.org.		
Note: For coordination of benefits purposes, if you need a statement of Preferred retail pharmacy benefits in order to file claims with your other coverage when this Plan is the primary payer, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077).		

Covered medications and supplies – Continued on next page

Covered medications and supplies – *Continued*	You pay – Standard Option	You pay – High Option
Mail Service Prescription Drug Program If your doctor orders more than a 21-day supply of covered drugs or supplies, up to a 90-day supply, you can use this service for your prescriptions and refills. Please refer to Section 7 for instructions on how to use the Mail Service Prescription Drug Program. *Note*: Not all drugs are available through the Mail Service Prescription Drug Program.	Mail Service Program: $12 generic $20 brand-name *Note:* If there is no generic equivalent available, you must still pay the brand-name copayment when you receive a brand-name drug. *Note*: If the cost of your prescription is less than your copayment, you pay only the cost of your prescription. The Mail Service Prescription Drug Program will charge you the lesser of the prescription cost or the copayment when you place your order. If you have already sent in your copayment, they will credit your account with any difference.	Mail Service Program: $8 generic $14 brand-name *Note:* If there is no generic equivalent available, you must still pay the brand-name copayment when you receive a brand-name drug. *Note*: If the cost of your prescription is less than your copayment, you pay only the cost of your prescription. The Mail Service Prescription Drug Program will charge you the lesser of the prescription cost or the copayment when you place your order. If you have already sent in your copayment, they will credit your account with any difference.
Drugs from other sources • Covered prescription drugs and supplies not obtained at a retail pharmacy or through the Mail Service Prescription Drug Program. *Note:* Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription. *Note:* For covered prescription drugs and supplies purchased outside of the United States and Puerto Rico, please submit claims on an Overseas Claim Form. See Section 7 for information on how to file claims for overseas services. • Please refer to Sections 5(a) and 5(c) for additional benefit information when you purchase drugs from a: •• Hospital (inpatient or outpatient) •• Hospice agency •• Home health care agency •• Physician's office	Preferred: 10% of the Plan allowance (calendar year deductible applies) Participating/Member: 25% of the Plan allowance (calendar year deductible applies) Non-participating/Non-member: 25% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the billed amount	Preferred: 5% of the Plan allowance (calendar year deductible applies) Participating/Member: 20% of the Plan allowance (calendar year deductible applies) Non-participating/Non-member: 20% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the billed amount

Covered medications and supplies – Continued on next page

Covered medications and supplies – *Continued*	You pay – Standard Option	You pay – High Option
Prior Approval • You must request and receive prior approval for certain prescription drugs and supplies, whether you choose to fill your prescription with a Preferred retail pharmacy, a Non-preferred retail pharmacy, or the Mail Service Prescription Drug Program. Prior approval must be renewed periodically. To obtain a list of prescription drugs and supplies requiring prior approval and to obtain prior approval request forms, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077). You can also obtain the list through our web site at www.fepblue.org. • Please read Section 3 for more information about prior approval.	---	---
Not covered: • *Medical supplies such as dressings and antiseptics* • *Drugs and supplies for cosmetic purposes* • *Drugs and supplies for weight loss* • *Drugs for orthodontic care, dental implants, and periodontal disease* • *Medication that does not require a prescription under Federal law even if your doctor prescribes it or a prescription is required under your State law* • *Drugs for which prior approval has been denied or not obtained*	*All charges*	*All charges*

Section 5 (g). Special features

Special features	Description
Health support programs	The Service Benefit Plan is developing and may offer patient support programs for certain diagnoses in select locations on a pilot basis. We will notify you about programs available in your area.
Flexible benefits option	Under the flexible benefits option (also referred to as case management), we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and/or direct the provision of Plan benefits to a less costly alternative benefit. • Alternative benefits are subject to ongoing review by the Local Plan. • By approving an alternative benefit, we cannot guarantee you will receive it in the future. • The decision to offer an alternative benefit is solely ours, and we may withdraw it at any time and resume regular contract benefits. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24-hour nurse line	Help with health concerns is available 24 hours a day, 365 days a year, by calling a toll-free telephone number, 1-888-258-3432, or by accessing our Internet web site, www.fepblue.org. The service, called Blue Health Connection, offers health advice or health information and counseling by registered nurses. Also available is the AudioHealth Library with hundreds of tapes, ranging from first aid to infectious diseases to general health issues. You can get information about health care resources to help you find local doctors, hospitals or other health care services affiliated with the Blue Cross and Blue Shield Service Benefit Plan. Contact us at the number above or visit our web site for more information.
Services for the deaf and hearing impaired	All Blue Cross and Blue Shield Plans provide TDD access for the hearing impaired to access information and receive answers to their questions.
Travel benefit/services overseas	Members located overseas who need assistance locating providers who accept our Plan allowance for overseas services, should contact the Worldwide Assistance Center (provided by World Access Service Corporation), at 1-804-673-1678. Members in the United States, Puerto Rico or the Virgin Islands should call 1-800-699-4337. World Access Service Corporation offers emergency evacuation services, translation services and conversion of foreign medical bills to U.S. currency. You may contact World Access Service Corporation 24 hours per day, 365 days per year. We pay overseas claims at Preferred benefit levels. See Sections 5(a)-5(f). This payment arrangement is based on an Overseas Fee Schedule. You must pay any difference between our payment and the provider's bill, in addition to any applicable deductible, coinsurance, or copayment amounts.

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible applies only to the accidental injury benefit below. We added "calendar year deductible applies" when it applies.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- *Note*: We cover hospitalization for dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient (even if the dental procedure itself is not covered).

IMPORTANT

Accidental injury benefit	You pay- Standard Option	You pay – High Option
We provide benefits for services, supplies or appliances for dental care necessary to promptly repair injury to sound natural teeth required as a result of, and directly related to, an accidental injury. *Note:* An **accidental injury** is an injury caused by an external force or element such as a blow or fall and that requires immediate attention. Injuries to the teeth while eating are not considered accidental injuries. *Note:* A **sound natural tooth** is a tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth with a crown is not considered a sound natural tooth. *Note*: Under Standard Option, we first provide benefits as shown in the Schedule of Dental Allowances on the following pages. We then pay benefits as shown here for any balances.	Preferred: 10% of the Plan allowance (calendar year deductible applies) Participating: 25% of the Plan allowance (calendar year deductible applies) Non-participating: 25% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the physician's actual charge	Preferred: 5% of the Plan allowance (calendar year deductible applies) Participating: 20% of the Plan allowance (calendar year deductible applies) Non-participating: 20% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the physician's actual charge

Dental benefits – Continued on next page.

What is Covered

Under Standard Option only, we pay billed charges for the following services, up to the amounts shown per service as listed in the following Schedule of Dental Allowances on the following pages below. This is a complete list of dental services covered under this benefit for Standard Option. There are no deductibles, copayments or coinsurance. You pay all charges in excess of our listed fee schedule amounts. These benefits are **not** available under High Option.

Note: See Section 5(b) for our benefits for Oral and maxillofacial surgery, and Section 5(c) for our benefits for hospital services (inpatient/outpatient) in connection with dental services, available under both Standard Option and High Option.

Preferred Dental Network

All Local Plans contract with Preferred dentists who are available in most areas. Preferred dentists agree to accept a negotiated, discounted amount called the Maximum Allowable Charge (MAC) as payment in full for the following services. They will also file your dental claims for you. You are responsible, as an out-of-pocket expense, for the difference between the amount specified in this Schedule of Dental Allowances and the MAC. To find a Preferred dentist near you or to obtain a copy of the applicable MAC listing, refer to the Preferred provider directory, our web site, or contact your Local Plan.

Note: These dentists may not be Preferred for other services covered by this Plan under other benefit provisions (such as oral and maxillofacial surgery).

Dental benefits		**Standard Option Only**		
Service **ADA Code**		**We pay**		**You pay**
	Clinical oral evaluations	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
0120	Periodic oral evaluation*	$12	$8	
0140	Limited oral evaluation	$14	$9	
0150	Comprehensive oral evaluation	$14	$9	
0160	Detailed and extensive oral evaluation	$14	$9	
** Limited to two per person per calendar year*				
	Radiographs			
0210	Intraoral complete series	$36	$22	
0220	Intraoral periapical first film	$7	$5	
0230	Intraoral periapical each additional film	$4	$3	
0240	Intraoral occlusal film	$12	$7	
0250	Extraoral first film	$16	$10	
0260	Extraoral each additional film	$6	$4	
0270	Bitewing – single film	$9	$6	
0272	Bitewings – two films	$14	$9	
0274	Bitewings – four films	$19	$12	

Standard Option dental benefits—Continued on next page

Dental benefits --*Continued*		**Standard Option Only**		
Service **ADA Code**		**We pay**		**You pay**
	Radiographs – continued	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
0277	Bitewings – vertical	$12	$7	
0290	Posterior-anterior or lateral skull and facial bone survey film	$45	$28	
0330	Panoramic film	$36	$23	
	Tests and laboratory exams			
0460	Pulp vitality tests	$11	$7	
	Palliative treatment			
9110	Palliative (emergency) treatment of dental pain – minor procedure	$24	$15	
2940	Sedative filling	$24	$15	
	Preventive			
1120	Prophylaxis – child*	$22	$14	
1110	Prophylaxis – adult*	---	$16	
1201	Topical application of flouride (including prophylaxis) – child*	$35	$22	
1203	Topical application of flouride (prophylaxis not included) – child	$13	$8	
1205	Topical application of flouride (including prophylaxis) – adult*	---	$24	
1204	Topical application of flouride (prophylaxis not included) – adult	---	$8	
* *Limited to two per person per calendar year*				
	Space maintenance (passive appliances)			
1510	Space maintainer – fixed – unilateral	$94	$59	
1515	Space maintainer – fixed - bilateral	$139	$87	
1520	Space maintainer – removable – unilateral	$94	$59	
1525	Space maintainer – removable – bilateral	$139	$87	
1550	Recementation of space maintainer	$22	$14	

Dental benefits – Continued on next page.

Dental benefits --*Continued*		**Standard Option Only**		
Service **ADA Code**		**We pay**		**You pay**
	Amalgam restorations (including polishing)	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
2110	Amalgam – one surface, primary	$22	$14	
2120	Amalgam – two surfaces, primary	$31	$20	
2130	Amalgam – three surfaces, primary	$40	$25	
2131	Amalgam – four or more surfaces, primary	$49	$31	
2140	Amalgam – one surface, permanent	$25	$16	
2150	Amalgam – two surfaces, permanent	$37	$23	
2160	Amalgam – three surfaces, permanent	$50	$31	
2161	Amalgam – four or more surfaces, permanent	$56	$35	
	Filled or unfilled resin restorations			
2330	Resin – one surface, anterior	$25	$16	
2331	Resin – two surfaces, anterior	$37	$23	
2332	Resin – three surfaces, anterior	$50	$31	
2335	Resin – four or more surfaces or involving incisal angle (anterior)	$56	$35	
2380	Resin – one surface, posterior-primary	$22	$14	
2381	Resin – two surfaces, posterior-primary	$31	$20	
2382	Resin – three or more surfaces, posterior-primary	$40	$25	
2385	Resin – one surface, posterior-permanent	$25	$16	
2386	Resin – two surfaces, posterior-permanent	$37	$23	
2387	Resin – three surfaces, posterior-permanent	$50	$31	
2388	Resin – four or more surfaces, posterior-permanent	$50	$31	
	Inlay restorations			
2510	Inlay – metallic – one surface	$25	$16	
2520	Inlay – metallic – two surfaces	$37	$23	
2530	Inlay – metallic – three or more surfaces	$50	$31	
2610	Inlay – porcelain/ceramic – one surface	$25	$16	
2620	Inlay – porcelain/ceramic – two surfaces	$37	$23	
2630	Inlay – porcelain/ceramic – three or more surfaces	$50	$31	

Dental benefits – Continued on next page.

Dental benefits --*Continued*		**Standard Option Only**		
Service **ADA Code**		**We pay**		**You pay**
	Inlay restorations – *Continued*	**To age 13**	**Age 13 and over**	All charges in excess of the scheduled amounts listed to the left
2650	Inlay – composite/resin – one surface	$25	$16	
2651	Inlay – composite/resin – two surfaces	$37	$23	
2652	Inlay – composite/resin – three or more surfaces	$50	$31	
	Other restorative services			
2951	Pin retention – per tooth, in addition to restoration	$13	$8	
	Extractions – includes local anesthesia and routine post-operative care			
7110	Single tooth	$30	$19	
7120	Each additional tooth	$27	$17	
7130	Root removal – exposed roots	$71	$45	
7210	Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	$43	$27	
7250	Surgical removal of residual tooth roots (cutting procedure)	$71	$45	
9220	General anesthesia in connection with covered extractions	$43	$27	
Not covered: *Any service not specifically listed above*		*Nothing*		*All charges*

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

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB dispute regarding these benefits**. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

Vision Care Program

Service Benefit Plan members may obtain eye exams and eyewear at substantial savings from EyeMed* Vision Care providers. EyeMed Vision Care operates a national provider network consisting of over 7,000 providers, including LensCrafters locations and doctors located next to LensCrafters, independent optometrists, ophthalmologists, and opticians. The names, addresses, and telephone numbers of EyeMed providers are available by calling 1-800-551-3337. Location information is available 24-hours a day; customer service is available from 8:00 a.m. to 11:00 p.m. EST, Monday through Saturday, and from 11:00 a.m. to 8:00 p.m. EST on Sunday. Or, visit www.fepblue.org for a complete description of the program and provider locations.

You may also obtain contact lenses through the Advantage Program. Contact one of the participating optometrists next to a LensCrafters for information on how to enroll in this program. You can also save 15% of the retail price on Lasik or PRK vision correction procedures provided by the U.S. Laser Network. Simply call 1-877-552-7376 for the nearest laser facility and to receive authorization for the discount.

There are no enrollment fees and no additional paperwork or claim forms to be filed in this program. All charges for eye exams and eyewear are handled directly between you and the EyeMed provider.

Complementary and Alternative Medicine

Service Benefit Plan members now have access to a national network of chiropractors, acupuncturists, and massage therapists at discounted rates, through American Specialty Health (ASH)*. The program is simple to use. Members may call providers directly and schedule appointments; no physician referral is required. There are no enrollment fees and no additional paperwork or claim forms for this program. All charges for health services are handled directly between you and the ASH provider.

For more information, visit our website at www.fepblue.org or call ASH Member Services at 1-877-258-7283. This discount provider network is available to members nationwide, unless prohibited by state law or regulation.

Through ASH, members may also purchase health and wellness products at discounted prices including vitamins, minerals, herbal supplements, homeopathic remedies, sports nutrition products, books, videotapes, and skin care products. Shipping is free to Service Benefit Plan members. You may order products online at www.fepblue.org or request a free catalog by calling American Specialty Health (ASH) at 1-877-258-7283.

ASH Customer Service hours are from 8:00 a.m. to 11:00 p.m. EST, Monday through Friday, and from 9:00 a.m. to 6:00 p.m. EST on Saturday.

Federal DentalBlue (Standard Option Only)

Federal DentalBlue is an optional dental product with an additional premium that supplements the dental benefits included in your **Standard Option** coverage. To apply for Federal DentalBlue, you must be enrolled in **Standard Option** and reside in a Plan area listed below. To purchase this additional coverage, complete and sign the Federal DentalBlue enrollment form, which you can obtain from your Local Plan.

Federal DentalBlue is available in only the following Plan areas: Alabama, Massachusetts, Oklahoma, and Washington State (only counties served by Regence BlueShield).

Many other Blue Cross and Blue Shield Plans offer dental insurance to FEP members for an additional premium. If interested, contact your Local Plan about the availability of a non-FEHB dental program in your area.

Medicare Prepaid Plan Enrollment

Some local Blue Cross and Blue Shield Plans offer Medicare recipients the opportunity to enroll in a Medicare prepaid plan without payment of an FEHB premium. Contact your local Blue Cross and Blue Shield Plan to find out if a Medicare prepaid plan is available in your area and the cost, if any, of that enrollment.

* The Blue Cross and Blue Shield Association and participating Local Plans will receive remuneration from EyeMed and ASH to cover their administrative costs for offering these programs, and for other purposes.

Section 6. General exclusions – things we don't cover

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

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice in the United States;
- Experimental or investigational procedures, treatments, drugs, or devices;
- Services, drugs, or supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations, sexual dysfunction, or sexual inadequacy;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you would not be charged for if you had no health insurance coverage;
- Services, drugs, or supplies you receive without charge while in active military service; or that you require as a result of an act of war within the United States, its territories, or possessions; or during combat;
- Amounts charged that neither you nor we are legally obligated to pay, such as amounts over the Medicare limiting charge or equivalent Medicare amount as described in Section 4 under *Your costs for covered services,* or State premium taxes, however applied;
- Services, drugs, or supplies you receive from immediate relatives or household members, such as spouse, parent, child, brother, or sister, by blood, marriage, or adoption;
- Services or supplies (except for medically necessary prescription drugs) that you receive from a noncovered facility, such as an extended care facility or nursing home, except as specifically described in Section 5(c);
- Services, drugs, or supplies you receive from noncovered providers such as chiropractors, except in medically underserved areas as specifically described on page 10**;**
- Services, drugs, or supplies you receive for cosmetic purposes;
- Services, drugs, or supplies for the treatment of obesity, weight reduction, or dietary control, except for gastric bypass surgery or gastric stapling procedures;
- Any dental or oral surgical procedures or drugs involving orthodontic care, the teeth, dental implants, periodontal disease, or preparing the mouth for the fitting or continued use of dentures, except as specifically described in Section 5(h), *Dental benefits*, and Section 5(b) under *Oral and maxillofacial surgery*;
- Orthodontic care for temporomandibular joint (TMJ) syndrome;
- Services of standby physicians;
- Self-care or self-help training;
- Custodial care;
- Personal comfort items such as beauty and barber services, radio, television, or telephone;
- Routine services, such as periodic physical exams; screening examinations; immunizations; and services or tests not related to a specific diagnosis, illness, injury, set of symptoms, or maternity care, except for those preventive services specifically covered under *Preventive care, adult and child* in Sections 5(a) and 5(c); or
- Services not specifically listed as covered.

Section 7. Filing a claim for covered services

How to claim benefits

To obtain claim forms or other claims filing advice, or answers about our benefits, contact us at the telephone number on the back of your Service Benefit Plan ID card, or at our website at www.fepblue.org.

In most cases, physicians and facilities file claims for you. Just present your Service Benefit Plan ID card when you receive services. Your physician must file on the HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form.

When you must file a claim - such as for overseas claims or when another group health plan is primary - submit it on the HCFA-1500 or a claim form that includes the information shown below. Use a separate claim form for each family member. For long or continuing hospital stays, or other long-term care, you should submit claims at least every 30 days. Bills and receipts should be itemized and show:

- Name of patient and relationship to enrollee;
- Plan identification number of enrollee;
- Name and address of person or firm providing the service or supply;
- Dates that services or supplies were furnished;
- Diagnosis;
- Type of each service or supply; and
- The charge for each service or supply.

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

In addition:

- You must send a copy of the explanation of benefits (EOB) form from any primary payer (such as the Medicare Summary Notice [MSN]) with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- Claims for rental or purchase of durable medical equipment, private duty nursing; and physical, occupational, and speech therapy, require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.

- Claims for prescription drugs and supplies that are not received from the Retail Pharmacy Program or through the Mail Service Prescription Drug Program must include receipts that include the prescription number, name of drug or supply, prescribing physician's name, date, and charge. (See below for information on how to obtain benefits from the Retail Pharmacy Program and the Mail Service Prescription Drug Program.)

- We will provide translation and currency conversion services for claims for overseas (foreign) services.

Prescription drug claims

Mail Service Prescription Drug Program - We will send you information on our Mail Service Prescription Drug Program, including an initial mail order form. To use this program:

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1) Complete the initial mail order form;

2) Enclose your prescription and copayment;

3) Mail your order to Merck-Medco Rx Services, P.O. Box 30492, Tampa, FL 33633-0144; and

4) Allow approximately two weeks for delivery.

Alternatively, your physician may call in your initial prescription at 1-800-262-7890 (TDD: 1-800-446-7292). You will be billed later for the copayment.

After that, to order refills either call the same number or access our website at www.fepblue.org and either charge your copayment to your credit card or have it billed to you later. Allow approximately one week for delivery on refills.

Retail Pharmacy Program – When you use Preferred retail pharmacies, show your Service Benefit Plan ID card. Preferred retail pharmacies will file your claims for you. We reimburse the pharmacy for your covered drugs. You pay the applicable coinsurance.

When you use Non-preferred retail pharmacies, you should use a retail prescription drug claim form to claim benefits. You may obtain these forms from your Local Plan, or by calling 1-800-624-5060. Hearing-impaired members with TDD equipment may call1-800-624-5077. Follow the instructions on the prescription drug claim form and submit the completed form to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057.

Note: Even if you use Preferred pharmacies, you will have to file a paper claim form to obtain reimbursement if:

- you do not have a valid Service Benefit Plan ID card;
- you do not show your valid Service Benefit Plan ID card at the time of purchase; or
- you failed to obtain prior approval when required (see page 14).

Records

Keep a separate record of the medical expenses of each covered family member, because deductibles and benefit maximums (such as those for smoking cessation treatment and outpatient physical therapy), apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Deadline for filing your claim

Send us your claim and appropriate documentation 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 you submitted the claim as soon as reasonably possible. If we return a claim or part of a claim for additional information, you must resubmit it within 90 days, or before the timely filing period expires, whichever is later.

Note: Once we pay benefits, there is a three-year limitation on the reissuance of uncashed checks.

Overseas claims

For covered services you receive in hospitals outside the United States and Puerto Rico and performed by physicians outside the United States and Puerto Rico, send a completed Overseas Claim Form and the itemized bills to: FEP Overseas Claims Section, CareFirst Blue Cross and Blue Shield, 550 12th Street, SW, Washington, DC 20065-8473. Send any written inquiries concerning the processing of overseas claims to this address or call us at 1-888-999-9862. You may also obtain Overseas Claim Forms from this address, or from your Local Plan.

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. Write to us at the address shown on your explanation of benefits (EOB) form. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program or Mail Service Prescription Drug Program); 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, precertify your hospital stay or grant your request for prior approval for a service, drug, or supply); 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 - if we did not send you a decision within 30 days after we received the additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division I, P.O. Box 436, Washington, D.C. 20044-0436.

The disputed claims process – Continued on next page

The disputed claims process - *Continued*

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must provide a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

5 OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service. OPM will send you a final decision within 60 days. There are no other administrative appeals.

6 If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies. 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 claims decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

***Note:* If you have a serious or life-threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

(a) We have not responded yet to your initial claim or request for precertification/prior approval, then call us at the telephone number on the back of your Service Benefit Plan ID card and we will expedite our review; or

(b) We denied your initial claim or request for precertification/prior approval, then:

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too; or
- You can call OPM's Health Benefits Contracts Division I at 1-202-606-0727 between 8 a.m. and 5 p.m., eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you are covered or a family member is covered under another group 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 payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines. For example**:**

- If you are an annuitant under our Plan and also are actively employed, any group health insurance you have from your employer will pay primary and we will pay secondary.

- When you are entitled to the payment of health care expenses under automobile insurance, including no-fault insurance and other insurance that pays without regard to fault, your automobile insurance is the primary payer and we are the secondary payer.

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

When we are the secondary payer, 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. For example, we will generally only make up the difference between the primary payer's benefits payment and 100% of the Plan allowance, subject to our applicable deductible and coinsurance or copayment amounts, except when Medicare is the primary payer (see Section 4). Thus, it is possible that the combined payments from both plans may not equal the entire amount billed by the provider.

Note: When we pay secondary to primary coverage you have from a prepaid plan (HMO), we base our benefits on your out-of-pocket liability under the prepaid plan (generally, the prepaid plan's copayments), subject to our deductible and coinsurance or copayment amounts.

In certain circumstances when we are secondary and there is no adverse effect on you (that is, you do not pay any more), we may also take advantage of any provider discount arrangements your primary plan may have and only make up the difference between the primary plan's payment and the amount the provider has agreed to accept as payment in full from the primary plan.

Remember: Even if you do not file a claim with your other plan, you must still tell us that you have double coverage, and you must also send us documents about your other coverage if we ask for them.

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age and older
- Some people with disabilities, under 65 years of age
- People with End Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A.
- Part B (Medical Insurance). Most people pay monthly for Part B.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare+Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare+Choice plan you have.

- **The Original Medicare Plan**

The Original Medicare Plan is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B benefits. You may go to any doctor, specialist, or hospital that accepts Medicare. Medicare pays its share and you pay your share. Some things are not covered under the Original Medicare Plan, such as most prescription drugs.

When you are enrolled in this Plan and the Original Medicare Plan, you still need to follow the rules in this brochure for us to cover your care. For example, you must continue to obtain prior approval for some prescription drugs and organ/tissue transplants before we will pay benefits. However, you do not have to precertify inpatient hospital stays when Medicare Part A is primary (see page 13 for exception).

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

- When we are the primary payer, we process the claim first.
- When the Original Medicare Plan is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of the covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at the number on the back of your Service Benefit Plan ID card or visit our web site at www.fepblue.org.

We waive some costs when you have Medicare: When Medicare is the primary payer, we will waive some out-of-pocket costs, as follows:

When Medicare Part A is primary, **we will waive our:**

- Inpatient hospital per-admission copayments;
- Inpatient Non-member hospital coinsurance; and
- Non-PPO inpatient per-day copayments for mental conditions/substance abuse care.

Note: Once you have exhausted your Medicare Part A benefits, we become primary. You must then pay any difference between our allowance and the billed amount at Non-member hospitals.

When Medicare Part B is primary, we will waive our:

- Calendar year deductible;
- Coinsurance for care by physicians and other health care professionals (inpatient and outpatient, including mental conditions/substance abuse care);
- PPO physician office visit copayments;
- PPO physician and facility copayments for routine physical examinations and preventive (screening) services; and

- Outpatient facility coinsurance for medical, surgical, preventive, and mental conditions/substance abuse care.

Note: We do not waive benefit limitations, such as the 25-visit limit on occupational and speech therapy visits.

You must tell us about your or your covered family members' 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.

The following chart illustrates whether the Original Medicare Plan or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability)		
2) Are an annuitant		
3) Are a re-employed annuitant with the Federal government when… a) The position is excluded from FEHB, or….. b) The position is not excluded from FEHB.. Ask your employing office which of these applies to you.		
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge)		
5) Are enrolled in Part B only, regardless of your employment status	(for Part B services)	(for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty	(except for claims related to Workers' Compensation)	
B. When you - or a covered family member - have Medicare based on End Stage Renal Disease (ESRD) and…		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD		
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD		
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision		
C. When you - or a covered family member - have FEHB and…		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or.. b) Are an active employee……		

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and Medicare Part B benefits. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov. If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and another Plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB Plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles if you receive services from providers who do not participate in the Medicare managed care plan.

Suspended FEHB coverage and enrollment in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage and enroll in a Medicare managed care plan, eliminating your FEHB premium (OPM does not contribute to your Medicare managed care plan premium). For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare managed care plan's service area.

- **Private contract**

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

- **Enrollment in Medicare Part B**

Note: We cannot require you to enroll in Medicare. If you choose not to enroll in Medicare Part B, you can still be covered under the FEHB Program.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related disease 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 a similar agency pays its maximum benefits for your treatment, we will cover your benefits.

Medicaid

When you have this Plan and Medicaid, we pay first.

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 following:

- 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.
- We will not reduce our share of any recovery unless we agree in writing to a reduction, (1) because you do not receive the full amount of damages that you claimed or (2) because 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.

Section 10. Definitions of terms we use in this brochure

Accidental injury

An injury caused by an external force or element such as a blow or fall that requires immediate medical attention, including animal bites and poisonings. *Note*: Injuries to the teeth while eating are **not** considered accidental injuries. Dental care for accidental injury is limited to dental treatment necessary to repair sound natural teeth.

Admission

The period from entry (admission) as an inpatient into a hospital (or other covered facility) until discharge. In counting days of inpatient care, the date of entry and the date of discharge count as the same day.

Assignment

An authorization by the enrollee or spouse for us to issue payment of benefits directly to the provider. We reserve the right to pay you, the enrollee, directly for all covered services.

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.

Carrier

The Blue Cross and Blue Shield Association, on behalf of the local Blue Cross and Blue Shield Plans.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 16.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 15.

Cosmetic surgery

Any surgical procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form, except for repair of accidental injury, or to restore or correct a part of the body that has been altered as a result of disease or surgery or to correct a congenital anomaly.

Covered services

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

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that a person not medically skilled could perform safely and reasonably, or that mainly assist the patient with daily living activities, such as:

1. Personal care including help in walking, getting in and out of bed, bathing, eating (by spoon, tube, or gastrostomy), exercising, or dressing;
2. Homemaking, such as preparing meals or special diets;
3. Moving the patient;

4. Acting as companion or sitter;
5. Supervising medication that can usually be self-administered; or
6. Treatment or services that any person can perform with minimal instruction, such as recording pulse, temperature, and respiration; or administration and monitoring of feeding systems.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies in a calendar year before we start paying benefits for those services. See page 15.

Durable medical equipment

Equipment and supplies that:
1. Are prescribed by your physician (i.e., the physician who is treating your illness or injury);
2. Are medically necessary;
3. Are primarily and customarily used only for a medical purpose;
4. Are generally useful only to a person with an illness or injury;
5. Are designed for prolonged use; and
6. Serve a specific therapeutic purpose in the treatment of an illness or injury.

Experimental or investigational services

A drug, device, or biological product is experimental or investigational if the drug, device, or biological product cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA); and, approval for marketing has not been given at the time it is furnished. *Note:* Approval means all forms of acceptance by the FDA.

A medical treatment or procedure, or a drug, device, or biological product, is experimental or investigational if:

1. Reliable evidence shows that it is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or

2. Reliable evidence shows that the consensus of opinion among experts regarding the drug, device, or biological product or medical treatment or procedure, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

   Reliable evidence shall mean only:

   - published reports and articles in the authoritative medical and scientific literature;
   - the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or biological product or medical treatment or procedure; or
   - the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Each Local Plan has a Medical Review department that determines whether a claimed service is experimental or investigational after consulting with internal or external experts or nationally recognized guidelines in a particular field or specialty.

For more detailed information, contact your Local Plan at the telephone number located on the back of your Plan identification card.

Group health coverage

Health care coverage that you are eligible for based on your employment, or your membership in or connection with a particular organization or group, that provides payment for medical services or supplies, or that pays a specific amount of more than $200 per day for hospitalization (including extension of any of these benefits through COBRA).

Intensive outpatient care

A comprehensive, structured outpatient treatment program that includes extended periods of individual or group therapy sessions designed to assist members with mental health and/or substance abuse conditions. It is an intermediate setting between traditional outpatient therapy and partial hospitalization, typically performed in an outpatient facility or outpatient professional office setting. Program sessions may occur more than one day per week. Timeframes and frequency will vary based upon diagnosis and severity of illness.

Lifetime maximum

The maximum amount the Plan will pay on your behalf for covered services you receive while you are enrolled in your option. Benefit amounts accrued under **Standard Option** and **High Option** are accumulated in a permanent record regardless of the number of enrollment changes.

Local Plan

A Blue Cross and/or Blue Shield Plan that serves a specific geographic area.

Medical necessity

We determine whether services, drugs, supplies, or equipment provided by a hospital or other covered provider are:

1. Appropriate to prevent, diagnose, or treat your condition, illness, or injury;
2. Consistent with standards of good medical practice in the United States;
3. Not primarily for the personal comfort or convenience of the patient, the family, or the provider;
4. Not part of or associated with scholastic education or vocational training of the patient; and
5. In the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that one of our covered providers has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary or covered under this Plan.

Mental conditions/ substance abuse

Conditions and diseases listed in the most recent edition of the International Classification of Diseases (ICD) as psychoses, neurotic disorders, or personality disorders; other nonpsychotic mental disorders listed in the ICD; or disorders listed in the ICD requiring treatment for abuse of or dependence upon substances such as alcohol, narcotics, or hallucinogens.

Partial hospitalization

An intensive facility-based treatment program during which an interdisciplinary team provides care related to mental health and/or substance abuse conditions. Program sessions may occur more than one day per week and may be full or half days, evenings, and/or weekends. The duration of care per session is less than 24 hours. Timeframes and frequency will vary based upon diagnosis and severity of illness.

Plan allowance

Our Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways . If the amount your provider bills for covered services is less than our allowance, we base our payment, and your share (coinsurance, deductible, and/or copayments), on the billed amount. We determine our allowance as follows:

- **PPO providers** – Our allowance (which we may refer to as the "PPA" for "Preferred Provider Allowance") is the negotiated amount that most Preferred providers (hospitals and other facilities, physicians, and non-physician professional providers that contract with each local Blue Cross and Blue Shield Plan, and retail pharmacies that contract with PCS Health Systems, Inc.) have agreed to accept as payment in full, when we pay primary benefits (see page 6 for exceptions).

  Our PPO allowance includes any known discounts that can be accurately calculated at the time your claim is processed. For PPO facilities, we sometimes refer to our allowance as the "Preferred rate". The Preferred rate may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf. (See page 71 for special information about limits on the amounts Preferred dentists can charge you.)

- **Participating providers** – Our allowance (which we may refer to as the "PAR" for "Participating Provider Allowance") is the negotiated amount that these providers (hospitals and other facilities, physicians, and non-physician professional providers that contract with some local Blue Cross and Blue Shield Plans) have agreed to accept as payment in full, when we pay primary benefits (see page 6 for exceptions). For facilities, we sometimes refer to our allowance as the "Member rate". The member rate includes any known discounts that can be accurately calculated at the time your claim is processed, and may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost sharing (if any) does not change.
  If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf.

- **Non-participating providers** – Since we have no agreements with these providers, we use:

  - For inpatient services by hospitals and other facilities that do not contract with your Local Blue Cross and Blue Shield Plan, our allowance is the average semiprivate room rate charged for inpatient care by similar institutions in the same area, as determined by your Local Plan;
  - For outpatient services by hospitals and other facilities that do not contract with your Local Blue Cross and Blue Shield Plan, our allowance is the billed amount (minus any amounts for non-covered services);
  - For physicians and non-physician professional providers that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greater of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained (or 60% of the billed charge if there is no equivalent Medicare fee schedule amount) or 2) 80% of the 2001 Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained. Local Plans determine the UCR amount in different ways. Contact your Local Plan if you need more information. We may refer to our allowance for Non-participating providers as the "NPA" (for "Non-participating Provider Allowance");
  - For prescription drugs furnished by retail pharmacies that do not contract with PCS Health Systems, Inc., our allowance is the average wholesale price ("AWP") of a drug on the date it is dispensed, as set forth in the most current version of First DataBank's National Drug Data File;
  - For services you receive outside of the United States and Puerto Rico from providers that do not contract with us or with World Access, Inc., our allowance is an Overseas Fee Schedule that is based on amounts comparable to what Participating providers in the Washington, DC, area have agreed to accept.

  Non-participating providers are under no obligation to accept our allowance as payment in full. If you use Non-participating providers, you will be responsible for any difference between our payment and the provider's charge, including any applicable copayments, coinsurance, or deductibles.

For more information, see Section 4, *Your costs for covered services*. For more information about how we pay providers overseas, see pages 17 and 69.

Precertification

The requirement to contact the Local Blue Cross and Blue Shield Plan serving the area where the services will be performed before being admitted to the hospital for inpatient care, or within two business days following an emergency admission.

Preferred provider organization (PPO) arrangement

An arrangement between Local Plans and physicians, hospitals, health care institutions, and other health care professionals (or for retail pharmacies, between pharmacies and PCS Health Systems, Inc.) to provide services to you at a reduced cost. The PPO provides you with an opportunity to reduce your out-of-pocket expenses for care by selecting your facilities and providers from among a specific group. PPO providers are available in most locations; using them whenever possible helps contain health care costs and reduces your out-of-pocket costs. The selection of PPO providers is solely the Local Plan's (or for pharmacies, PCS Health Systems, Inc.'s) responsibility. We cannot guarantee that any specific provider will continue to participate in these PPO arrangements.

Prior approval

Written assurance that benefits will be provided from:

1. The Local Plan where the services will be performed;
2. The Retail Pharmacy Program or Mail Service Prescription Drug Program for prescription drugs; or
3. The Blue Cross and Blue Shield Association Clinical Trials Information Unit for certain organ/tissue transplants we cover only in clinical trials. See Section 5(b).

Home health care, home hospice care, certain prescription drugs, certain organ/tissue transplants, and cardiac rehabilitation require prior approval. For more information, see the benefit descriptions in Section 5 and *How to get approval for…other services* on page 14. See Section 5(e) for special authorization requirements for mental health and substance abuse benefits.

Routine services

Services that are not related to a specific illness, injury, set of symptoms, or maternity care.

Us/We

"Us" and "we" refer to the Blue Cross and Blue Shield Service Benefit Plan, and the Local Blue Cross and Blue Shield Plans that administer it.

You

"You" refers to the enrollee (the contract holder eligible for enrollment and coverage under the Federal Employees Health Benefits Program and enrolled in the Plan) and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you are new to this Plan, your coverage and premiums begin on the first day of your first pay period that starts on or after January 1. Annuitants' premiums begin on January 1.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan, and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.

Note: As part of our administration of this contract, we may disclose your medical and claims information (including your prescription drug utilization) to any treating physicians or dispensing pharmacies.

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.

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

•Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

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

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire.

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

Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends. If you canceled your coverage or did not pay your premium, you cannot convert;
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new Plan must reduce or eliminate waiting periods, limitations, or exclusions for health-related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan.

If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital 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 the number on the back of your Service Benefit Plan ID card and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE—1-202-418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Department of Defense/FEHB Demonstration Project

What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 Open Season for the year 2000. Open Season enrollments will be effective January 1, 2001. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible

DoD determines who is eligible to enroll in the FEHB Program. Generally, you may enroll if:

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHB Demonstration Project.

The demonstration areas

- Dover AFB, DE
- Fort Knox, KY
- Dallas, TX
- New Orleans, LA
- Adair County, IA area
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA area

When you can join

You may enroll under the DoD/FEHB Demonstration Project during the 2000 Open Season, November 13, 2000, through December 11, 2000. Your coverage will begin January 1, 2001. DoD has set up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions, and forms. The toll-free phone number for the IPC is 1-877-DOD-FEHB (1-877-363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during the 2000 and 2001 Open Seasons. Your coverage will begin January 1 of the year following the Open Season during which you enrolled.

If you become eligible for the DoD/FEHB Demonstration Project outside of Open Season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a web site devoted to the Demonstration Project. You can view information such as their marketing/beneficiary education plan, frequently asked questions, demonstration area locations, and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2001 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM web site at www.opm.gov.

TCC eligibility

See Section 11, FEHB Facts; it explains Temporary Continuation of Coverage (TCC). Under this DoD/FEHB Demonstration Project the **only** individual eligible for TCC is one who ceases to be eligible as a "member of family" under your self and family enrollment. This occurs when a child turns 22, for example, or if you divorce and your spouse does not qualify to enroll as an unremarried former spouse under title 10, United States Code. For these individuals, TCC begins the day after their enrollment in the DoD/FEHB Demonstration Project ends. TCC enrollment terminates after 36 months or the end of the Demonstration Project, whichever occurs first. You, your child, or another person must notify the IPC when a family member loses eligibility for coverage under the DoD/FEHB Demonstration Project.

TCC is not available if you move out of a DoD/FEHB Demonstration Project area, you cancel your coverage, or your coverage is terminated for any reason. TCC is not available when the Demonstration Project ends.

Other features

The 31-day extension of coverage and right to convert do not apply to the DoD/FEHB Demonstration Project.

Index

Do not rely on this page; it is for your convenience and is not an official statement of benefits.

Notes

Notes

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option - 2001

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Below, an asterisk (*) means the item is subject to the $250 per person ($500 per family) calendar year deductible. If you use a Non-PPO physician or other health care professional, you generally pay any difference between our allowance and the billed amount.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	PPO: 10%* of our allowance; $15 per office visit Non-PPO: 25%* of our allowance	22
Services provided by a hospital: • Inpatient	PPO: $100 per admission Non-PPO: $300 per admission	48-50
• Outpatient	PPO: 10%* of our allowance (no deductible for surgery) Non-PPO: 25%* of our allowance (no deductible for surgery)	51-52
Emergency benefits: • Accidental injury	PPO: Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Non-PPO: Any difference between our payment and the billed amount within 72 hours; regular benefits thereafter	57-58
• Medical emergency	Regular benefits	58
Mental health and substance abuse treatment	In-Network (PPO): Regular cost sharing, such as $15 office visit copay; $100 per hospital admission Out-of-Network (Non-PPO): Benefits are limited	59-64
Prescription drugs	Retail Pharmacy Program: • PPO: 25% of our allowance • Non-PPO: 45% Average Wholesale Price (AWP) Mail Service Prescription Drug Program: • $12 generic/$20 brand-name per prescription	65-68
Dental care	Scheduled allowances for diagnostic and preventive services, fillings, and extractions; regular benefits for dental services required due to accidental injury and covered oral and maxillofacial surgery	43, 70-74
Special features: Health support programs; flexible benefits option; 24-hour nurse line; services for deaf and hearing impaired; and travel benefit/services overseas		69
Point of Service benefits – Yes, in some Plan areas		5
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $3,000 (PPO) or $5,000 (combined PPO/Non-PPO) per contract per year; some costs do not count toward this protection	17-18

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan High Option – 2001

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Below, an asterisk (*) means the item is subject to the $150 per person ($300 per family) calendar year deductible. If you use a Non-PPO physician or other health care professional, you generally pay any difference between our allowance and the billed amount.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	PPO: 5%* of our allowance; $12 per office visit Non-PPO: 20%* of our allowance	22
Services provided by a hospital: • Inpatient	PPO: Nothing Non-PPO: $100 per admission	48-50
• Outpatient	PPO: 5%* of our allowance (no deductible for surgery) Non-PPO: 20% * of our allowance (no deductible for surgery)	51-52
Emergency benefits: • Accidental injury	PPO: Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Non-PPO: Any difference between our payment and the billed amount within 72 hours; regular benefits thereafter	57-58
• Medical emergency	Regular benefits	58
Mental health and substance abuse treatment	In-Network (PPO): Regular cost sharing, such as $12 office visit copay; nothing per hospital admission Out-of-Network (Non-PPO): Benefits are limited	59-64
Prescription drugs	Retail Pharmacy Program: • PPO: 15% of our allowance • Non-PPO: 35% Average Wholesale Price (AWP) Mail Service Prescription Drug Program: • $8 generic/$14 brand-name per prescription	65-68
Dental Care	Regular benefits, limited to dental services required due to accidental injury and covered oral and maxillofacial surgery	43, 70
Special features: Health support programs; flexible benefits option; 24-hour nurse line; services for deaf and hearing impaired; and travel benefit/services overseas		69
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $1,000 (PPO) or $2,700 (combined PPO/Non-PPO) per contract per year; some costs do not count toward this protection	17-18

2001 Rate Information for
Blue Cross and Blue Shield Service Benefit Plan

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization. Refer to the applicable FEHB Guide.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	101	$86.59	$70.14	$187.61	$151.97	$102.22	$54.51
High Option Self and Family	102	$195.82	$139.32	$424.28	$301.86	$231.17	$103.97
Standard Option Self Only	104	$86.59	$34.26	$187.61	$74.23	$102.22	$18.63
Standard Option Self and Family	105	$195.82	$80.91	$424.28	$175.30	$231.17	$45.56