FREESTATE HEALTH PLAN®
An Independent Licensee of the Blue Cross and Blue Shield Association

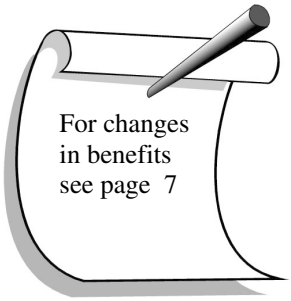
FreeState Health Plan 2001

http://www.carefirst.com

A Health Maintenance Organization with a point of service product

Serving: All of Maryland, Washington, DC, Northeastern West Virginia, and some of Southern Pennsylvania

Enrollment in this Plan is limited; see page 6 for requirements



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

Enrollment codes for this Plan:

LD1 Self Only
LD2 Self and Family

Authorized for distribution by the:

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
HTTP://WWW.OPM.GOV/INSURE

FEHB
Federal Employees Health Benefits Program

RI 73-146

Table of Contents

Introduction

FreeState Health Plan, Inc.
100 S. Charles Street
Baltimore, MD 21201

This brochure describes the benefits of FreeState Health Plan, Inc under our contract (CS 2010) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

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 page 67. 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 FreeState Health Plan, Inc.

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 Insurance Planning and Evaluation Division, P.O. Box 436, Washington, DC 20044-0436.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services.

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

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

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

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

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Who provides my health care?

Since we are an affiliate of CareFirst BlueCross BlueShield, and a mixed model HMO, you can receive your health care services through numerous medical centers and physicians, 24-hours a day, seven days a week within the service area, and on an emergency basis if you are away.

Upon joining our Plan, you select a participating medical center or physician to provide health care to you and your family. Each family member may select a different medical center or physician to provide health services. You then will choose a primary care doctor at the center for yourself and each member of your family.

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, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- We are in compliance with Federal and State licensing and certification requirements. We received the Maryland Certificate of Authority as an HMO on April 24, 1981. We became a Federally Qualified HMO in 1984.
- We have been in existence since 1980
- We are a for profit corporation

If you want more information about us, call 800/445-6036, 410/654-8670, 410/998-5768(TDD), 800/828-3196(TDD), or write to CareFirst BlueCross BlueShield/FreeState Health Plan, 10455 Mill Run Circle, 01-780, Owings Mills MD 21117. You may also contact us by fax at 410/998-5809 or visit our website at www.carefirst.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area.

Our service area is: Maryland; Washington, DC; Northeastern West Virginia and Some of Southern Pennsylvania.

The service area for this Plan includes the following areas:

Baltimore City

Maryland Counties

Allegany	Howard
Anne Arundel	Kent
Baltimore	Montgomery
Calvert	Prince George's
Caroline	Queen Anne's
Carroll	St. Mary's
Cecil	Somerset
Charles	Talbot
Dorchester	Washington
Frederick	Wicomico
Garrett	Worcester
Harford	

Pennsylvania—Zip Codes Listed

15545	17250	17272	17321	17340	17361
17225	17256	17302	17325	17343	17363
17235	17268	17314	17329	17349	
17236	17270	17320	17331	17352	

West Virginia—Zip Codes Listed

25401	25427
25419	25443

Section 2. How we change for 2001

Program-wide changes

- The plain language team reorganized the brochure and the way we describe our benefits. We hope this will make it easier for you to compare plans.
- This year, the Federal Employees Health Benefits Program is implementing network mental health and substance abuse parity. This means that your coverage for mental health, substance abuse, medical, surgical, and hospital services from providers in our plan network will be the same with regard to deductibles, coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed higher patient cost sharing on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many healthcare organizations have turned their attention this past year to improving healthcare 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 800/445-6036, **or** checking our website www.carefirst.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, 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 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.

Changes to this Plan

- Your share of the non-Postal premium will decrease by 28.8% for Self Only or 29.9% for Self and Family.
- We have expanded habilative services for children 18 years old and under. See page 19.
- You are now covered for hair prostheses following chemotherapy/radiation therapy. See page 21.
- Infertility services now include IVF and fertility drug benefits. See page 17.
- You now pay $10 for generic prescriptions, $20 for prescriptions on the Plan's formulary brand name list, and $35 for all other prescriptions. Previously, you paid a copay of $10 for generic prescriptions and $20 for brand name prescriptions. This applies to our point-of-service benefits as well. See page 37 and 44.
- You now pay two copays for a 90-day supply of prescriptions on the Plan's Maintenance List. Previously, you paid one copay for a 90-day supply. See page 37.
- We are now using a new dental vendor. See page 40 for the new customer service phone number. Also see the updated FreeState provider directory for a list of dental providers.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800/445-6036 or 410/654-8670.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and you will not have to file claims. If you use our point-of-service program, you can also get care from non-Plan providers, or from participating providers without a required referral, but it will cost you more.

• Plan providers

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

•Plan facilities

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website.

What you must do

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. Each member may choose his or her own primary care doctor from our Provider Directory.

•Primary care

Your primary care physician can be a family practitioner, general practitioner, internist, or pediatrician. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

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

• Specialty care

Your primary care physician will refer you to a specialist for needed care. However, you may see your Plan gynecologist without a referral.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, your primary care physician will work with the Plan to develop a treatment plan that allows you to see your specialist for a certain number of visits without additional referrals. Your primary care physician will use our criteria when

creating your treatment plan (the physician may have to get an authorization or approval beforehand).

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

- If you have a chronic or disabling condition and lose access to your specialist because we:

  •• terminate our contract with your specialist for other than cause; or

  •• drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or

  •• reduce our service area and you enroll in another FEHB Plan,

  you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us.

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 800/445-6036 or 410/654-8670. If you are new to the FEHB Program, we will arrange for you to receive care.

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

- You are discharged, not merely moved to an alternative care center; or

- The day your benefits from your former plan run out; or

- The 92nd day after you become a member of this Plan, whichever happens first.

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

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process pre-authorization. Your physician must obtain pre-authorization for the following non-emergency services such as:

- Inpatient procedures
- Outpatient procedures
- Home health services
- Prosthetic devices
- Orthopedic devices
- Infertility procedures
- Growth Hormone therapy
- Mental Health/Substance Abuse

Your primary care physician will contact us for pre-authorization or an extension of a pre-authorized service. Your in-network service may be denied if pre-authorization is not obtained.

With point of service benefits we must authorize the following services before you receive them, when not an emergency, such as:

- Surgical procedures
- Home health services
- DME
- Prosthetic devices
- Orthopedic devices
- Infertility surgery
- Inpatient admissions
- Hospice care
- Ambulance services
- Mental health and substance abuse services

Otherwise, your coinsurance will increase to 40% of our allowed benefit if these services are not pre-authorized, but determined to be medically necessary. If we determined the services were not medically necessary, they will not be covered. Please see pages 43-45.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

- **Copayments**

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

Example: When you see your primary care physician you pay a copayment of $10 per office visit.

- **Deductible**

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. Deductibles only apply when you use our point-of-service benefits.

- The calendar year deductible for point-of-service benefits is $200 per person. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $400.

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

- **Coinsurance**

Coinsurance is the percentage of our negotiated fee that you must pay for your care. Coinsurance doesn't begin until you meet your deductible. We do not have coinsurance unless you are using our point-of-service benefits.

Example: In our Plan, you pay 20% of our allowance for infertility services and durable medical equipment if you use our point-of-service benefits.

Your out-of-pocket maximum

When using the point-of-service benefits, after your coinsurance and deductible total $2000 per person or $4000 per family enrollment in any calendar year, we will pay 100% of the our allowed benefit. You will be responsible for any charges over our allowed benefit or charges as a result of penalties for not receiving pre-authorization where needed. However, coinsurance amounts for the following services do not count toward your out-of-pocket maximum, and you must continue to pay coinsurance for these services:

- Services for which you fail to obtain pre-authorization
- Prescription drugs
- Dental services

Be sure to keep accurate records of your coinsurance since you are responsible for informing us when you reach the maximum.

Section 5. Benefits – OVERVIEW

(See page 7 for how our benefits changed this year and page 67 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 claims forms, claims filing advice, or more information about our benefits, contact us at 800/445-6036 or 410/654-8670 or at our website at www.carefirst.com.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for in-network services.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office	$10 per visit
Professional services of physicians • In a Plan urgent care center • Office medical consultations • Second surgical opinion	$10 per visit
• Initial examination of a newborn child covered under a family enrollment (well visit)	Nothing
• During a hospital stay • At home • In a skilled nursing facility (up to the annual maximum)	Nothing

Diagnostic and treatment services -- Continued on next page

Diagnostic and treatment services *(Continued)*	**You pay**
Not covered: • *Tests and/or services not medically necessary; or experimental* • *Test required for marriage; employment; foreign travel; or governmental licensing*	*All charges*
Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • Cat Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing
Preventive care, adult	
Routine screenings, such as: [at a minimum as determined by your PCP] Blood lead level – One annually • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including ••Fecal occult blood test	Nothing
••Sigmoidoscopy, screening [at a minimum as determined by your PCP] every five years starting at age 50	Nothing
Prostate Specific Antigen (PSA test) [at a minimum as determined by your PCP]-one annually for men age 40 and older	Nothing
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnosis and Treatment*, above.	Nothing

Preventive Care, Adult---Continued next page

Preventive care, adult *(Continued)*	**You pay**
Routine mammogram –covered for women age 35 and older, as follows: [at a minimum as determined by your PCP] • From ages 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, travel, or marriage	*All charges*
Routine Immunizations, limited to: [at a minimum as determined by your PCP] • Tetanus-diphtheria (Td) booster – once every 10 years, ages19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	Nothing
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing for children under 5 years of age. Otherwise, $10 per visit.
• Examinations, such as: ••Eye exams through age 17 to determine the need for vision correction. ••Ear exams through age 17 to determine the need for hearing correction ••Examinations done on the day of immunizations (through age 22) • Well-child care charges for routine examinations, immunizations and care (through age 22)	Nothing for children under 5 years of age. Otherwise, $10 per visit.

Maternity care	You pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 10 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 extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b).	Nothing
Not covered: • *Routine sonograms to determine fetal age, size or sex* • *Maternity and routine nursery charges for surrogate motherhood situations*	*All charges*
Family planning	
• Voluntary sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs) Note: Implanted or injectable contraceptives are covered as a prescription drug benefit.	$10 per visit
Not covered: reversal of voluntary surgical sterilization, genetic counseling,	*All charges*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: ••*intracervical insemination (ICI)* ••in vitro fertilization (IVF) – covered up to 3 attempts for each live birth and up to a $100,000 lifetime maximum when you meet Plan medical criteria • Fertility drugs Note: We cover fertility drugs under the prescription drug benefit. Fertility drugs are limited to $100,000 fertility benefit lifetime maximum	$10 per visit
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* ••*embryo transfer and GIFT* ••*intrauterine insemination (IUI)* ••*intravaginal inseminatin (IVI)* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm*	*All charges*
Allergy care	
Testing and treatment Allergy injection	Nothing
Allergy serum	Nothing
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 27.	$10 per visit if combined with a physician office visit. Covered in full otherwise.
• Respiratory and inhalation therapy	$10 copay
• Dialysis – Hemodialysis and peritoneal dialysis	Nothing
• Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy	Nothing
• Growth hormone therapy (GHT) Note: – We will only cover GHT when we preauthorize the treatment. Call Advance Secure at 800/294-5979 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3. Note: - GHT is covered under our prescription drug benefits.	

Rehabilitative therapies	You pay
Physical therapy, occupational therapy and speech therapy -- • 90 combined visits per condition for the services of each of the following: ••qualified physical therapists and ••occupational therapists • 90 visits per condition for the services of the following: ••speech therapists Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury.	$10 per visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs* • *cardiac rehabilitation* • *chiropractic services* • *acupuncture services*	*All charges*
Hearing services (testing, treatment, and supplies)	
• Hearing testing for children through age 17 (see *Preventive care, children*) • Hearing testing for adults	$10 per visit
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges*
Habilitation services	
Coverage is limited to: • children 18 years old and under with a congenital and genetic birth defect • occupational, physical, and speech therapy when medically necessary and enhances the child's ability to function	$10 per visit
Not covered: • *services through early intervention* • *school services*	*All charges*

Vision services (testing, treatment, and supplies)	You pay
• Eye exam to determine the need for vision correction for children and adults provided by a MEC HealthCare participating provider • Annual eye refractions	$10 per visit
• For each 24 month period, one pair of prescription lenses (standard single vision, bifocal or trifocal) and frames that you select from the designated frame display at a MEC Health Care participating provider	Nothing for standard single vision or bifocal lenses; $45 for trifocal lenses Note: Additional copays exist for lens enhancements Note: If frames and lenses are not selected from designated display you will receive a $40 credit toward the frames you choose. You will pay nothing for standard single vision or bifocal lenses and $45 for trifocal lenses.
• Per 24 month period, one pair of replacement soft daily wear contact lenses instead of glasses Note: You may purchase either contacts or eyeglasses per 24 month benefit period.	Nothing Note: There is a $50 copay if you are a new contact lens wearer Note: Contact lenses other than standard soft daily wear are available for additional copays which vary depending on whether you are or are not a current contact lens wearer.
Not covered: • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery*	*All charges*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	$10 per visit

Foot Care—Continued on next page

Foot Care (continued)	You pay
Not covered: • *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* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*
Orthopedic and prosthetic devices	
• Artificial limbs and eyes • Externally worn breast prostheses and surgical bras (once per year), including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device. • Hair prosthesis (limited to $350 per contract year) for hair loss due to chemotherapy or radiation treatment for cancer. Your oncologist must prescribe both the therapy and the prosthesis. • Foot orthotics • corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome.	Nothing
Not covered: • *Orthopedic and corrective shoes* • *arch supports* • *heel pads and heel cups* • *corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges.*

Durable medical equipment (DME)	You pay
Rental or purchase, at our option, including repair and adjustment, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • hospital beds; • wheelchairs; • crutches; • walkers; • transcutaneous electronic nerve stimulators (TENS unit); • blood glucose monitors; and • insulin pumps. • frames and lenses after surgery as medically necessary Note: Only one wheelchair will be covered at a time Note: Only one motorized type of equipment (e.g. wheelchair) per Lifetime through this Plan or other affiliates of this Plan.	Nothing
Not covered: • *hearing aids* • *environmental control products* • *replacement batteries for DME* • *replacement of DME equipment not due to normal wear and tear* • *computer equipment* • *food products* • *oral appliances* • *comfort and convenience items* • *exercise equipment*	*All charges*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	Nothing
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Nursing care primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication.*	*All charges*

Educational classes and programs	You Pay
Coverage is limited to:	$10 per visit
• Smoking Cessation – Up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs.	Nothing
• Diabetes self-management	Nothing
• Maternity classes-childbirth; infant care	Nothing
• Weight loss programs	$35 per seven week program
Alternative treatments	
No benefit	No benefit

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for in-network services
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- 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 PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over • Insertion of internal prostethic devices. See 5(a) – Orthopedic braces and prosthetic devices for device coverage information.	$10 per office or outpatient visit; nothing for inpatient visits

Surgical procedures continued on next page.

Surgical procedures *(Continued)*	**You pay**
• Voluntary sterilization • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under 5(a); Norplant covered under 5(f). • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$10 per office or outpatient visit; nothing for inpatient visits
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.* • *Surgery of the purposes of human reproduction beyond those specifically listed in the infertility section* • *Surgery for cosmetic purposes*	*All charges*
Reconstructive surgery	
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery • Surgery to correct 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; webbed fingers; and webbed toes.	$10 per office or outpatient visits; nothing for inpatient visits

Reconstructive Surgery---Continued on next page

Reconstructive surgery *(Continued)*	**You pay**
• 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; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may chose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	See previous page
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$10 per office or outpatient visit; nothing for inpatient visits
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Surgery primarily for cosmetic purposes* • *Surgery to shorten the mandible or maxillae for cosmetic purposes, correction of malocclusion, and any dental care involved in treatment of temoromandibular joint pain dysfunction syndrome*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors Limited Benefits – Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient subject to office copays.	$10 for office or outpatient visit; nothing for inpatient visits
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs or non-human organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

General anesthesia and associated hospital ambulatory facility charges received with dental care	You Pay
Your general anesthesia and associated hospital ambulatory facility care, when received with dental are covered, if you or your covered family member: • is seven years old or younger or is developmentally disabled; • cannot expect a successful result from dental care that uses local anesthesia because of a physical, intellectual, or other medically compromising condition, and • can expect a superior result from general anesthesia <u>Or if the member is:</u> • extremely uncooperative, fearful, or an uncommunicative child 17 years of age or younger with such urgent dental needs that they require immediate treatment; and • can expect that oral pain, infection, loss of teeth, or other serious dental problems will result if you do not treat it.	$10 per visit
Clinical trials	
You will be covered for the patient costs required by clinical trials that relate to the treatment provided for a life threatening condition, or prevention, early detection and treatment studies on cancer if: • Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer; or any other life threatening condition; and • clinical trial approved by one of the National Institutes of Health, an NIH Cooperative Group or NIH Center, the FDA in the form of an investigational new drug application, the Federal Department of Veterans Affairs, or an institutional review board of an institution in the State that has a multiple project assurance contract approved by the Office of Protection From Research Risks of the NIH. • There is no clearly superior noninvestigational treatment alternative	$10 per visit

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing

Inpatient hospital continued on next page.

Inpatient hospital *(Continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Appliances and any covered items billed by a hospital for use at home	Nothing
Not covered: • *Custodial care, domiciliary or convalescent care, or rest cures* • *Non-covered facilities, such as nursing homes, extended care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$10 per visit
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.* • *Surgery of the purposes of human reproduction beyond those specifically listed in the infertility section* • *Surgery for cosmetic purposes* • Surgery related to sex transformations • *Transplant surgery not listed in Transplant section*	*All charges*

Extended care benefits/skilled nursing care facility benefits	You pay
Extended care benefit: You receive a comprehensive range of benefits for up to 100 days each calendar year when a Plan doctor determines that you need full-time skilled nursing care or must stay in a skilled nursing facility. All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor	Nothing
Not covered: custodial care	*All charges*
Hospice care	
If terminally ill, you are covered for supportive and palliative care in your home or at a hospice. This includes inpatient and outpatient care and family counseling. A Plan doctor, who certifies that you are in the terminal stages of illness, with a life expectancy of approximately six months or less, will direct these services.	Nothing
Not covered: • *Independent or private duty nursing services* • *House maker services* • *Any services other than palliative treatment* • *Domestic services* • *"Meals on Wheels" or similar food services* • *Rental or purchase of renal dialysis equipment and supplies*	*All charges*
Ambulance	
• Local professional ambulance service when medically appropriate	Nothing

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.
- We have no calendar year deductible for in-network services.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area:
In an emergency, please call your primary care doctor. In extreme emergencies where your life or limbs are in jeopardy, and you cannot reach your doctor, contact the local emergency system (911, for example) or go to the nearest hospital emergency room. Be sure to tell the workers in the emergency room that you are a Plan member so they can notify the Plan. You are responsible for ensuring that you or a member of your family notifies the Plan within 48 hours unless not reasonably possible to do so.

If you need to stay in a hospital, you must notify the Plan within 48 hours or on the first working day following your admission, unless not reasonably possible to do so. If you stay in non-Plan facilities and Plan doctors believe a Plan hospital can give you better care, the facility will transfer you when medically feasible. We will fully cover any ambulance charges.

You can receive benefits for care from non-Plan providers in a medical emergency only if you could become disabled, significantly jeopardize your condition, or die if you did not reach the non-Plan provider in time.

To receive coverage we must approve any follow-up care from non-Plan providers or Plan providers must administer it, except as POS benefits cover.

Emergencies outside our service area:
You can receive benefits for any medically necessary health service that you immediately require because of injury or unforeseen illness.

If you need to stay in a hospital, you must notify the Plan within 48 hours or on the first working day following your admission, unless not reasonably possible to do so. If a Plan doctor believes a Plan hospital can give you better care, the facility will transfer you when medically feasible. We will fully cover any ambulance charges.

So you can receive coverage, we must approve any follow-up care from non-Plan providers or you must get this care from a Plan provider. The exception is when Point of Service benefits cover this care.

Emergency Services continued on next page

Emergency Services (continued)	
Benefit Description	**You pay**
Emergency within our service area	
• Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$25 per hospital emergency room or urgent care center visit Note: Copay is waived if admitted into the hospital
Not covered: Elective care or non-emergency care	*All charges*
Emergency outside our service area	
• Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$25 per hospital emergency room or urgent care center visit Note: Copay is waived if admitted into the hospital
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area*	*All charges*
Ambulance	
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	Nothing
Not covered: • *Air ambulance, unless transported to a regional shock trauma unit from the scene of an accident* • *air or sea transportation needed while traveling outside the U.S.*	*All charges*

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

IMPORTANT

Parity

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.

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan 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:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible for in-network services.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
Diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per visit

Network mental health and substance abuse benefits -- Continued on next page.

Mental health and substance abuse benefits *(Continued)*	**You pay**
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility (inpatient services) • Services in approved alternative care settings such as partial hospitalization.	Nothing $10 per visit
Not covered: Services we have not approved. *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*

Preauthorization

To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes:

Treatment for mental health conditions and substance abuse may be obtained by calling Magellan Behavioral Health (or other vendor we determine) at 800/245-7013.

Special transitional benefit

If a mental health or substance abuse professional provider is treating you under our plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following condition:

- If your mental health or substance abuse professional provider with whom you are currently in treatment leaves the plan at our request for other than cause.

If this condition applies to you, we will allow you reasonable time to transfer your care to a Plan mental health or substance abuse professional provider. During the transitional period, you may continue to see your treating provider and will not pay any more out-of-pocket than you did in the year 2000 for services. This transitional period will begin with our notice to you of the change in coverage and will end 90 days after you receive our notice. If we write to you before October 1, 2000, the 90-day period ends before January 1 and this transitional benefit does not apply.

Limitation

We may limit your benefits if you do not follow your treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, 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.
- We have no calendar year deductibles for in-network prescription services
- Certain drugs require clinical prior authorization. Contact the Plan for a listing of which drugs are subject to the prior authorization policy. Prior authorization may be initiated by the Prescriber or the Pharmacy by calling Advance Secure at 1-800-294-5979. If prior authorization is not obtained or denied the drug will not be covered.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A plan physician or licensed dentist must write the prescription
- **Where you can obtain them.** You must fill the prescription at a plan pharmacy or by mail
- **We use a formulary.** A formulary is a preferred list of drugs that we selected to meet patient needs at a lower cost The formulary includes both generic and brand name drugs. You will be responsible for higher charges if your doctors prescribe a drug not on our formulary list.
- **These are the dispensing limitations.** You can receive up to 34 days worth of medication for each fill of non-maintenance prescriptions. In addition, you can receive up to 90 days of maintenance medications. Maintenance medications are those medications taken on a daily basis to treat a chronic condition and are expected to be used 6 months or more. Your copay will be $10, $20, or $35 for a 34-day supply or less, and twice that amount for 35-day supply or greater up to 90 days. The prescription benefit for mail order service is the same as that from your community pharmacy. In most cases, you can get a refill once you have taken 75% of the medication. Your prescription will not be refilled prior to the 75% usage guidelines.
- **When you have to file a claim.** Call our prescription drug vendor, Advance Paradigm, at 800/241-3371to order prescription drug claim forms. You will send the prescription drug claim form to: Advance Paradigm, PO Box 853901, Richardson, TX 75085-3901.

Prescription drug benefits continued on the next page.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. • Insulin • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (subject to dosage limitations- Contact the Plan for these limitations) • Contraceptive drugs and devices • Dental prescriptions when written by a Plan dentist • Smoking cessation drugs and medications Note: You may be required to use pharmacies associated with your medical center. Call your center or primary care physician to determine which pharmacy must be used to fill your prescription. Note: Injectible coverage will be limited to those medications that are self-injected.	$ 10 per unit or refill for generic prescriptions $ 20 per unit or refill for prescriptions on the Plan's formulary brand name list $ 35 per unit or refill for all other prescriptions Note: For drugs on our Plan's Maintenance Drug List, you pay two copayments for a 90-day supply.
• Diabetic supplies including acetone test, alcohol swabs, blood glucose control regents, blood glucose test kit, glucose monitoring test supplies, insulin injection devices, lancets, swabs and testing strips	Nothing

Prescription drugs continued on next page

Covered medications and supplies *(continued)*	**You pay**
Here are some things to keep in mind about our prescription drug program: • We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 800/241-3371.	
Not covered: • Drugs and supplies for cosmetic purposes • Vitamins, nutrients and food supplements which can be purchased without a prescription • Nonprescription medicines • Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies or through our POS benefits (see page 44) • Medical supplies such as dressing and antiseptics • Drugs to enhance athletic performance • Diet agents	*All Charges*

Section 5 (g). Special Features

Feature	Description
Travel benefits	Away From Home Care provides traveling members with medical care through participating Blue Cross Blue Shield plans in most states across the country. Urgent care appointments, guest memberships for students or business travelers, and pre-authorized follow-up care can be arranged. You will receive the benefits of the Host HMO when you qualify for guest membership coverage. For more information call our Away From Home Care coordinators at 888/452-6403. For out of area urgent care appointments call the Away From Home Care national referral service at 800/446-6872.

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.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- You may transfer participating provider sites if there is no outstanding balance at the site.
- You must be referred to participating specialist sites by your participating provider site.
- You must verify provider participation by calling The Dental Network before seeking care at any new provider site.

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	$10 per visit

Dental benefits

You can receive your benefits through The Dental Network, Inc., (or other vendor as determined by the Plan). The following list summarizes the dental services that you can receive from participating dentists and indicates copayments where they apply. The Dental Network covers other services at varying copayment levels that are not listed. For further information regarding these services and copayment, please call The Dental Network at 888/833-8464 or 410/847-9060.

Dental benefits continued on the next page

Dental Benefits (continued)	
Service	You pay
Clinical Oral Examinations	
00120 Periodic Oral Evaluation	$5
00140 Limited Oral Evaluation - Problem Focused	$5
00150 Comprehensive Oral Evaluation	$6
Radiographs	
00210 Intraoral – Complete Series (incl. Bitewings)	$11
00272 Bitewings - 2 Films	$ 5
00330 Panoramic X-Rays	$11
Dental Prophylaxis	
01110 Prophylaxis (Cleaning) - Adult (two per year)	$8
01120 Prophylaxis (Cleaning) - Child (two per year)	$6
Topical Fluoride Treatment	
01203 Topical App. Of Fluoride Tx - Child (exclude prophy)	$3
01204 Topical App. Of Fluoride Tx - Adult (exclude prophy)	$3
01351 Sealant - Per Tooth	$3
Amalgam Restorations (Including Local Anesthesia & Polishing)	
02110 Amalgam – one surface, primary	$27
02120 Amalgam – two surfaces, primary	$36
02130 Amalgam – three surfaces, primary	$49
02140 Amalgam – one surface, permanent	$27
02150 Amalgam – two surfaces, permanent	$36
02160 Amalgam – three surfaces, permanent	$49

Dental benefits continued on the next page

Dental Benefits (continued)	
Service	You pay
Resin Restoration (Including Local Anesthesia)	
02330 Resin - one surface, anterior	$31
02331 Resin - two surfaces, anterior	$44
02332 Resin – three surfaces, anterior	$58
Complete Dentures (Including Routine Post-Del Care)	
05110 Complete maxillary denture	$399
05120 Complete mandibular denture	$399
05130 Immediate maxillary denture	$422
05140 Immediate mandibular denture	$422
Partial Denture (Including Routine Post-Del Care)	
05213 Max part dent resin base (incl. any conv. Clasp/rests/teeth)	$482
05214 Mand part dent resin base (incl. any conv. Clasps/rests/teeth)	$482
Adjustments to Removable Prosthesis	
05410 Adjust complete denture - maxillary	$14
05411 Adjust complete denture – mandibular	$15
05421 Adjust partial denture - maxillary	$18
05422 Adjust partial denture - mandibular	$18
Repairs to Partial Dentures	
05510 Repair broken complete denture base	$60
Extractions (Including Local Anesthesia and Routine Postoperative Care)	
07110 Single tooth	$ 31
07210 Surgical removal of erupted tooth requiring elevation of mucoperisteal flap	$ 44
07220 Removal of impacted tooth - soft tissue	$ 79
07230 Removal of impacted tooth - partially bony	$ 95
07240 Removal of impacted tooth - completely	$140
Orthodontics	
08070 Comprehensive – transitional	$2,025
08080 Comprehensive – adolescent	$2,025
08090 Comprehensive – adult	$2,025

Section 5 (i). Point of service 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 is: $200 per person ($400 per family).
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- You must get pre-authorization for some procedures as identified below.

IMPORTANT

Facts about this Plan's POS option

You may choose to receive the benefits this Plan covers from non-Plan doctors and hospitals whenever you need care, except for the benefits under the "What is not covered" section in this brochure. To receive the benefits listed in the "Exceptions" section, a Plan doctor must provide or arrange them. If you receive medical treatment that is covered by this plan, from a non-Plan doctor without a referral from a Plan doctor, you will be responsible for the deductibles, coinsurance and maximum benefits stated below.

What POS covers

Medical and surgical benefits

You can refer yourself to the following services instead of going through your primary care physician.

- Physician office, home or hospital visits
- Specialist care and consultation
- Allergy testing and treatment
- Maternity, annual pap smears and pelvic exams
- Diagnostic laboratory and x-ray tests
- Surgical procedures (pre-authorization required)
- Periodic physical exams, immunizations and well child care
- Physical, speech or occupational therapy
- Home health care (pre-authorization required)
- Durable medical equipment, prosthetics and orthopedic devices (pre-authorization required)
- Hearing and vision exams
- Family planning and sterilizations (sterilization surgery requires pre-authorization)
- Dialysis, chemotherapy, radiation therapy and inhalation therapy
- Infertility services (pre-authorization required)

You pay 20% of the allowed benefit after paying the deductible and any charges greater than the allowed benefit.

Exceptions

Your primary care physician, the Plan, or specialists must provide the following services:

- Health education services
- Dental care benefits
- Emergency and urgent care benefits

Hospital/extended care benefits

You can choose the hospital for your inpatient stay. But, you must notify us and receive our authorization before being admitted. You pay 20% of our allowed benefit and any charges above the allowed benefit after paying the $200 deductible. If we do not authorize your stay in advance and the services were medically necessary, you pay 40% of the allowed benefit after paying the deductible. To obtain pre-authorization call (410) 528-7029 or 800/898-9903. In addition to the services noted above, you must receive our authorization before receiving the following services:

- Inpatient hospitalization
- Skilled nursing facility
- Hospice care
- Non-emergency ambulance
- Mental health and substance abuse

Mental conditions/substance abuse benefits

You can choose an inpatient hospital and outpatient care. You must call us to obtain our authorization before receiving these services. You pay 20% of our allowed benefit and any charges above the allowed benefit, after the deductible, for all covered services except outpatient care. We will cover outpatient care, after the deductible. You pay the following portion of the allowed benefit and any additional charges above the allowed benefit for each visit:

- 20% for visits 1 through 5;
- 35% for visits 6 through 30;
- 50% thereafter for the remainder of the calendar year

If we do not authorize inpatient or outpatient care, you pay 40% of the allowed charges and any charges over the allowed benefit, after the deductible. If the services are not medically necessary, you pay 100% of the charges. To request authorization for inpatient or outpatient care call 1-800-245-7013.

Emergency care

We will treat emergency services as a standard HMO benefit and only provide them through the HMO delivery system. Please refer to the section in this brochure covering emergency benefits.

Other benefits

Prescriptions a doctor writes on a self referral are eligible for a:

$10 generic copayment,
$20 formulary brand copayment, and
$35 for all other prescriptions for a 34-day supply as long as they are filled at a Plan participating pharmacy.

Please note: If you use a non-participating pharmacy, you pay 20% of the allowed benefit after deductible.

Call the Client Services Department at 410/654-8670 or 800/445-6036 for claim forms and submit your claims to:

CFS Health Group, Inc.
FEP New Choice Claims
P.O. Box 308
Owings Mills, MD 21117-0308

Note:

- Once a non-Plan doctor is engaged, all charges related to that doctor's services are paid out-of-network.
- You may obtain services in or out of our service area under the POS benefits.
- POS benefits apply to non-Plan doctors and hospitals

Pre-authorization
We must authorize certain services before you receive them, as shown in this brochure, except for emergencies. To request this authorization, you or your physician must call the Plan. Otherwise, you risk having to pay 40% of the allowed benefit after the deductible and take the chance that the procedure is not covered.

Deductible
If you refer yourself, you pay a $200 calendar year deductible for you and $400 for your family, before the Plan pays any benefits.

Coinsurance
When you have met the calendar year deductible, the Plan pays 80% of the allowable benefit; you pay 20%, except for outpatient mental health/substance abuse services which have a different coinsurance. If the actual charge is more than the allowed benefit, you must also pay the difference. Expenses from the last month of the calendar year, which you use to satisfy the deductible, will apply to the deductible of the following calendar year.

Maximum benefit
There is no maximum lifetime benefit under the POS plan.

Out-of-pocket maximum
Once you have paid $2,000 for yourself or $4,000 for your family in deductibles and coinsurance, the Plan will pay 100% of the allowed benefit for the remainder of the calendar year. You are still responsible for charges above the allowed benefit. Please note, you cannot apply the amount you paid because you didn't receive our authorization before receiving the service, toward the out-of-pocket maximum. Furthermore, you cannot apply charges related to prescription drugs or dental services toward your out-of-pocket maximum.

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

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

CareFirst Options

As a member of a CareFirst BlueCross BlueShield HMO, you can receive 25% discounts on alternative therapies including acupuncture, massage therapy and chiropractic care. You also receive discounts for fitness centers including personal trainers, spas and yoga classes. There are no claim forms, referrals or other paperwork for you to fill out. Just show your FreeState ID card at the time you receive service and you get the discount. Please call CareFirst Options Member Services at 888/999/4140 for additional information and a list of practitioners in your area.

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *What Services Require Our Prior Approval* on page 10.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits); or eligible self-referred services (see Point of Service benefits)
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; or
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 800/445-6036 or 410/654-8670

When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

Submit your claims to:

FreeState Health Plan Inc, PO Box 308, Owings Mills MD 21117-0308

Prescription drugs

Submit your claims to:

Advance Paradigm Inc, PO Box 853901, Richardson TX 75085-3901

Deadline for filing your claim

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

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 preauthorization:

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: FreeState Health Plan, Inc, Correspondence Unit 02-640, 10455 Mill Run Circle, Owings Mills MD 21117; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or if applicable arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division III, P.O. Box 436, Washington, D.C. 20044-0436.

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 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 claim 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 haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800/445-6036 or 410/654-8670 and we will expedite our review; or

(b) We denied your initial request for care or preauthorization/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 III at 202/606-0755 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 have 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.

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.

•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 managed care 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 Original Medicare, like prescription drugs.

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PCP, or precertified *as* required.

We will not waive any of our copayments, coinsurance, and deductibles.

(Primary payer chart begins on next page.)

The following chart illustrates whether Original Medicare 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 reemployed 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……	……..	……⎤

Please note, if your Plan physician does not participate in Medicare, you will have to file a claim with Medicare

Claims process -- You probably will never have to file a claim form when you are using your in-network benefits and have both our Plan and Medicare.

- When we are the primary payer, we process the claim first.
- When Original Medicare 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 covered charges and all applicable copays will be your responsibility. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 800/445-6036.

We waive some costs when you have Medicare -- When Medicare is the primary payer, we will waive some out-of-pocket costs, as follows: In this case we do not waive any out-of-pocket costs.

•Medicare managed care plan

If you are eligible for Medicare, you may choose to enroll 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, specialist, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and 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 (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles.

Suspended FEHB coverage and a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to 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** service area.

• Enrollment in Medicare Part B

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

TRICARE

TRICARE is the health care program for members, 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 similar agency pays its maximum benefits for your treatment, we will cover your benefits. You must use our providers.

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

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 11.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See page 11.

Covered services

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

Custodial care

Treatment or services that could be rendered safely or reasonably by a person not medically skilled to provide such services

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 those services. See page 11.

Experimental or Investigational services

To decide whether a service is experimental or investigational, the Plan considers the following questions:

1. Can this service be legally used in testing or other studies on human patients?
2. According to generally accepted medical standards, is this service recognized as safe and effective for the treatment of this condition?
3. When this service was rendered, was it approved by any governmental authority whose approval is required?
4. In the case of a drug, therapeutic regimen, or device: has it been approved for human use by the Federal Food and Drug Administration?

Group health coverage

Health coverage made available through employment or membership with a particular organization or group.

Medical necessity

Services or supplies that*:*

- are proper and needed for the diagnosis or treatment of your medical condition;
- are provided for the diagnosis, direct care, and treatment of your medical condition;
- meet the standards of good practice in the medical community of your local area; and,
- are not mainly for the convenience of your or your doctor.

Plan allowance

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. We determine our allowance as follows: the allowance is based on a Resource Based Relative Value Scale (RBRVS). This scale determines the relationship between services and was first developed by the Health Care Financing Administration. A conversion factor is applied to the value of each code or service to determine the actual allowed amount.

Us/We	Us and we refer to FreeState Health Plan, Inc.
You	You refers to the enrollee 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 is 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.

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.

•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 800/445-6036 or 410/654-8670 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--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/FEHBP Demonstration Project.

The demonstration areas

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

When you can join

You may enroll under the FEHB/DoD 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 does not explain your benefit coverage.

Summary of benefits for FreeState Health Plan - 2001

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and 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.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office.....	Office visit copay: $10 primary care; $10 specialist	13
Services provided by a hospital: • Inpatient ..... • Outpatient.....	Nothing $10 copay per visit	29 30
Emergency benefits: • In-area ..... • Out-of-area.....	$25 per emergency room visit $25 per emergency room visit	33 33
Mental health and substance abuse treatment.....	Regular cost sharing.	34
Prescription drugs.....	$10 generic copay; $20 formulary brand copay; $35 copay for all other	37
Dental Care.....	Variable copays for most services	41
Vision Care.....	One refraction annually- $10 copay	20
Special features: Travel Benefits		39
Protection against catastrophic costs (your out-of-pocket maximum).....	Nothing after $2,000/Self Only or $4,000/Family enrollment per year (applies to NewChoice POS benefits only) Some costs do not count toward this protection	45

2001 Rate Information for
Free State Health 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
All of Maryland, Washington, DC, Northeastern West Virginia, and Some of Southern Pennsylvania							
Self Only	LD1	$86.59	$32.79	$187.61	$71.05	$102.22	$17.16
Self and Family	LD2	$195.82	$76.32	$424.28	$165.36	$231.17	$40.97