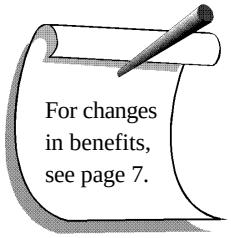
Blue Shield of California

Access+ 2001

http://www.blueshieldca.com

A Health Maintenance Organization



Serving: Most of California

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

Enrollment codes for this Plan:

SJ1 Self Only
SJ2 Self and Family

Authorized for distribution by the:

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

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Table of Contents

Introduction

Blue Shield of California
Access+
50 Beale Street
San Francisco, CA 94105

This brochure describes the benefits of Blue Shield of California Access+ under our contract (CS2639) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

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

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 7. 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 Blue Shield of California Access+.

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 except for your annual eye exam. You only pay the copayments and coinsurance described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

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

How we pay providers

We contract with 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.

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

Corporate Form – Blue Shield of California is a not-for-profit corporation that was founded in 1939.

Fiscal Solvency – Blue Shield of California meets or exceeds California Department of Managed Health Care standards for fiscal solvency, confidentiality of medical records and transfer of medical records.

"Gag Clauses" – A "gag clause" is when a physician does not disclose all treatment options based on cost considerations. You have the right to have a clear understanding of the medical condition and any proposed appropriate necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before receiving treatment.

Medical Records – Access+ members have the right, both under State law and Blue Shield of California policy, to review, summarize and copy their own medical records. Members can request and will receive amendments to their medical records as they are made.

State Licensing – Access+ has been licensed by the State of California since 1978.

If you want more information about us, call us at 800/334-5847, or write to Blue Shield of California Access+, P.O. Box 7168, San Francisco, CA 94120-7168. You may also contact us by fax at 916/350-8780 or visit our website at http://www.blueshieldca.com.

What is this Plan's service area?

To enroll with us, you must live or work in our service area. This is where our providers practice. Our service area is:

County Name	Excluded ZIP Codes
Alameda	None
Butte	None
Contra Costa	None
El Dorado	95613, 95619, 95623, 95633, 95636, 95643, 95651, 95656, 95667, 95672, 95682, 95684, 95709, 95720, 95721, 95726, 95735, and 96150 to 96158
	None
Fresno	93501, 93502, 93504, 93505, 93516, 93519, 93527, 93528, 93554 to 93556, 93560 and 93596
Kern	None
	None
Kings	90704
Los Angeles	None
Madera	None
Marin	None
Merced	None
Napa	95724, 95728, 96111 and 96160 to 96162
Nevada	None
Orange	95701, 95714, 95715, 95717, 96140 to 96143, 96145, 96146 and 96148
Placer	92225-26
	None
Riverside	92242, 92280, 92304, 92319, 92338 and 92363
Sacramento	91905, 91906, 91934, 91948, 91963, 91980, 91987, 91990 to 91995,
San Bernardino	92004 and 92086
San Diego	None
	None
San Francisco	None
San Joaquin	None
San Luis Obispo	None
San Mateo	None
Santa Barbara	None
Santa Clara	None
Santa Cruz	None
Shasta	None
Solano	None
Sonoma	None
Stanislaus	None
Tulare	None
Ventura	
Yolo	

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will normally pay only for emergency or urgent care. We will not pay for any other health care service, except those that are specifically on page 33 under the heading "Medical Care for Vacations, Business Travel and College Students."

If you or a covered family member move outside the service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO like ours that has agreements with affiliates in other states. See page 33 for details about our HMO Medical care available for vacations, business travel and college students coverage. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. 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 coinsurance, copays, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed higher patient cost sharing and shorter day or visit limitations on mental health and 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 800/334-5847, or checking our website www.blueshieldca.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 and concerns.
  - Keep a list of all medicines you take.
  - Make sure you get the results of any test 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 increase by 10% for Self Only or 10% for Self and Family.
- Second opinions: If there is a question about your diagnosis or if additional information concerning your condition would be helpful in determining the most appropriate plan of treatment, your primary care physician will, upon request, refer you to another physician for a second medical opinion. If you are requesting a second opinion about care you received from your primary care physician, a physician within the same Medical Group\IPA as your primary care physician will provide the second opinion. If you are requesting a second opinion about care received from a specialist, any Plan specialist of the same equivalent specialty may provide the second opinion. All second consultations must be authorized by the Plan. **You pay** a $10 copay for a second opinion.
- Mental Health: Blue Shield of California has a contract with U.S. Behavioral Health Plan (USBHPC) to provide your covered mental health and substance abuse services. You must receive all mental health and substance abuse services from USBHPC providers, except for urgent or emergency services or for counseling provided by your Personal Care Physician. Mental health and substance abuse providers affiliated with your Personal Care Physician's IPA or Medical Group may not be USBHPC providers. You or your Personal Care Physician must contact USBHPC directly at 877/263-8827 to obtain approval for mental health and substance abuse services and a referral to USBHPC 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 800/334-5847.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments and/or coinsurance, and you will not have to file claims, except for your annual eye examination.

· **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. All Plan providers are credentialed, 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. You must complete a Primary Care Physician Selection Form.

· **Primary care**

Your primary care physician can be a general practitioner, family practitioner, internist, pediatrician, or an OB/GYN. 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. The exceptions to this are:

1. for true medical emergencies;
2. when another physician is on call for your physician;
3. when you self refer to an Access+ participating specialist (not applicable to mental health care, infertility, urgent care and allergy services); and
4. OB/GYN services provided by an obstetrician/gynecologist or family practitioner within the same IPA/Medical Group as your primary care physician.
5. Mental Health services which must be authorized by USBHPC.

In all other instances, referral to a specialist is done at the primary care physician's direction; if non-Plan specialists or consultants are required, the primary care physician will arrange appropriate referrals.

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 conditions, your primary care physician will develop a treatment plan with you that allows an adequate number of direct access visits with that specialist. Your primary care physician will use our criteria when creating your treatment plan.

- 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. We will not pay for you to see a specialist who does not participate with our Plan, unless your primary care physician refers you to a non-plan specialist for a second opinion.

- 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;

  - 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 or when clinically appropriate after you receive notice of the change. Contact us or, if we drop out of the program, contact your new plan.

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

- **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 800/334-5847. 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;

- 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.

Your personal care physician must obtain a preauthorization from us for; (1) prescription drugs that are not on our drug formulary, (2) organ transplants and (3) bone marrow transplants.

If you request a brand name drug, when a generic drug is available and your personal care physician did not obtain a preauthorization, you will pay your prescription drug copay and the difference between the price of generic and brand name drugs.

See page 22 in Section 5(b) for the preauthorization process for organ and bone marrow transplants.

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.

· **Coinsurance**

Coinsurance is the percentage of our allowable fee that you must pay for your care.

Example: In our Plan, you pay 50% of our allowance for infertility services or durable medical equipment.

Your out-of-pocket maximum for coinsurance and copayments

After your copayments and your percentage of allowable charges for medical and surgical services total $1,000 per person or $2,000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services:

1. your prescription drugs
2. infertility services
3. the Access+ self-referral specialty visit copayments.

For mental health and substance abuse benefits you pay $1,000 in copayments or coinsurance for a Self Only enrollment or $2,000 for a Self and Family enrollment. After that you do not have to make any further payments the rest of the year for authorized treatment or services. However, you must continue to pay co-payments for prescription drugs.

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

Section 5. Benefits -- OVERVIEW

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 for annual eye exams, or more information about our benefits, contact us at 800/334-5847 or at our website at http://www.blueshieldca.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.
- 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	
• During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Vaccines for pediatric and adult immunizations • Inpatient non-dental treatment of temporomandibular joint(TMJ) syndrome	Nothing
• Office visits • Office medical consultations • Second opinions	$10 per office visit
• Home visit by physician	$25
• Self referral to a Plan specialist under Access+ option	$30 per office visit
• In an urgent care center	$50 per office visit
• Home visit by nurse or health aide	$5 per office visit

Lab, X-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Pathology • X-rays • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing
• Non-routine Pap tests • Non-routine mammograms	$10 per test
Preventive care, adult	
Routine screenings, such as: • Total Blood Cholesterol – once every three years, ages 19 through 64 • Colorectal Cancer Screening, including ••Fecal occult blood test ••Sigmoidoscopy, screening – every five years starting at age 50	Nothing
• Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	Nothing
• Routine Pap test	Nothing
Routine mammogram –covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 49, one every one or two years • From age 50 through 64, one every year • At age 65 and older, one every two years	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges.*
Routine immunizations as recommended by the United States Public Health Service. • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccines, annually, age 50 and older • Pneumococcal vaccine for adults 65 and older • Recommended travel immunizations • Hepatitis A, hepatitis B and lyme disease immunization for individuals at high risk.	Nothing

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
• Examinations, such as: •• Eye screenings through age 17 to determine the need for vision correction. •• Ear screenings through age 17 to determine the need for hearing correction •• Examinations done on the day of immunizations (through age 17) • Well-child care charges for routine examinations, immunizations and care (through age 17)	Nothing
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 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	*All charges*
Family planning	
• Physician office visit for fitting a diaphragm.	Nothing
• Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per item
• Voluntary Sterilization •• Vasectomy •• Tubal ligation	 $75 $100
Not covered: reversal of voluntary surgical sterilization	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, such as: • Artificial insemination: •• *intravaginal insemination (IVI)* •• *intracervical insemination (ICI)* •• *intrauterine insemination (IUI)* • Covered injectable fertility drugs	50% of allowable charges
• Oral fertility drugs	$6 at plan pharmacies
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* • ••*in vitro fertilization* • ••*embryo transfer and GIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm, eggs and frozen embryos and their collection and storage.*	*All charges.*
Allergy care	
Allergy serum	Nothing
Testing and treatment Allergy injection	$10 per office visit
Customized antigens	50% of allowable charges
Not covered: provocative food testing and sublingual allergy desensitization	*All charges.*
Treatment therapies	**You pay**
• Growth hormone therapy (GHT) Note: We will only cover GHT for medically necessary conditions when we have preauthorized the treatment. Such authorization must be obtained through your primary care physician. Growth hormone therapy is authorized for medically necessary conditions. Your physician should get pre-authorization before you begin treatment. • 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 22. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy and antibiotic therapy	$10 per office visit $10 per office visit

Rehabilitative therapies	You pay
Physical therapy, occupational therapy and speech therapy -- • These are covered benefits when determined by the plan to be medically necessary and it is demonstrated that the member's condition will significantly improve as a result of the services. ••qualified physical therapists; ••speech therapists; and ••occupational therapists. Note: Speech therapy is limited to treatment of certain speech impairments of organic origin. Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided at a plan facility, if medically necessary with the appropriate treatment plan.	$10 per visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*
Hearing services (testing, treatment, and supplies)	
• Hearing testing for children through age 17 (see *Preventive care, children*)	Nothing
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges.*
Vision services (testing, treatment, and supplies)	
• Eye screenings to determine the need for vision correction for children through age 17 (see preventive care)	Nothing
• Contact lenses, if medically necessary to treat eye conditions such as keratoconus and keratitis sicca or when required as a result of cataract surgery when no intraocular lens has been implanted, are covered. • Annual eye refractions In addition to the medical and surgical benefits provided for diagnosis and treatment of disease of the eye, annual eye refractions (to provide a written lens prescription) may be obtained from Medical Eye Services (MES) providers. MES directories can be ordered by calling 800/334-5847.	$10 per office visit
Not covered: • *Eyeglasses or contact lenses (See page 33 for details about eyewear discounts)* • *Eye exercises and orthoptics* • *Radial keratotomy, refractive keratoplasty and other refractive surgery*	*All charges.*

Foot care	You pay
Not covered: • *Routine foot care*	*All charges.*
Orthopedic and prosthetic devices	
• Surgically implanted breast implant following mastectomy	Nothing

• Surgically implanted prosthetic devices, such as artificial joints, pacemakers.
  • Inpatient Hospital
  • Outpatient Hospital
	
	Nothing
	$50 per surgery

• Orthopedic devices (and their repair) such as braces and functional foot orthoses. • Prosthetic services (and their repair) such as artificial limbs and contact lenses necessary to treat certain medical eye conditions. Contact the plan for details. • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy	50% of allowable charges
Not covered: • *orthopedic and corrective shoes* • *arch supports* • *heel pads and heel cups* • *lumbosacral supports* • *corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Penile prostheses*	*All charges.*
Durable medical equipment (DME)	**You pay**
Purchase or rental up to the purchase price, including repair and adjustment, of durable medical equipment prescribed by your Plan physician. Under this benefit, we cover: • Colostomy/ostomy supplies; • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Canes; • Traction equipment; • Peak flow monitor for self-management of asthma; • Glucose monitor for self-management of diabetes; and • Apnea monitor for management of newborns. Note: Call us at 800/334-5847 as soon as your Plan physician prescribes this equipment. We have contracted with health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	50% of allowable charges

Not covered: • *Exercise equipment* • *Disposable medical supplies for home use* • *Speech/language assistance devices* • *Self-monitoring equipment, except as listed in the covered section* • *Wigs*	*All charges.*
Home health services	
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (ST), Respiratory Therapist (RT), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	$5 per visit
• Home visit by physician	$25 per visit
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.*
Alternative treatments	
Chiropractic Services (with an annual limit of 20 visits per year) Each member is allowed a pre-authorized appliance benefit of up to $50 per year. Examples of covered appliances are elbow supports, back supports (thoracic) and cervical collars. Unlimited chiropractic discounts are also available, see mylifepath features on page 33.	$10 per visit
Not covered: • *naturopathic services* • *hypnotherapy* • *services for or related to acupuncture (see page 33 for Non-FEHB discount information.)* • *All charges after the 20 visit annual maximum*	*All charges*
Appliance benefits that are pre-authorized such as • Elbow supports • Back supports (Thoracic) • Cervical collars	All charges above $50 per year
Educational classes and programs	
Coverage is limited to: • Quarterly health education newsletter • List of community educational classes, support groups and seminars • Healthwise Handbooks for new members • First Steps[sm] prenatal education program • Personal health reminders	Nothing

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.
- 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 charge (i.e. hospital, surgical center, etc.).

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, when medically necessary. • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity – for members who meet Blue Shield Medical Policy and clinical criteria for defined procedures and services that have been approved by their Personal Care Physicians. • Treatment of burns	Nothing in hospital
• Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under Section 5(a).	$10 per office visit
• Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic braces and prosthetic devices for device coverage information.	$10 per procedure
• Outpatient hospital surgery and supplies	$50 per surgery
• Voluntary sterilization •• Vasectomy •• Tubal Ligation	 $75 $100
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot.*	*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 congenial anomalies are: protruding ear derformaties, cleft lip, cleft palate, birth marks, webbed fingers, and webbed toes.	Nothing as an inpatient
• All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; Note: If you need a mastectomy, you may choose to have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	See above.
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 • Surgical and anthroscopic treatment of TMJ is covered if prior history shows conservative medical treatment has failed. Splint therapy and physical therapy is covered, see Section 5 (a). • Other surgical procedures that do not involve the teeth or their supporting structures.	Nothing as an inpatient
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges.*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Skin • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double Limited Benefits – Allogenic (donor) bone marrow transplant; autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions when authorized in writing by the Blue Shield Medical Director and performed at approved facilities: acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advance non-Hodgkin's lymphoma, advanced neuroblastoma, and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors. Breast cancer, multiple myeloma and epithelial ovarian cancer are covered only when approved by the Plan's Medical Director. Related medical and hospital expenses of the donor are covered when the recipient is covered by this plan.	Nothing
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered* • *Pancreas only transplants* • *Travel expenses unless authorized by us*	*All charges*
Anesthesia	**You pay**
Professional services provided in – • Hospital (inpatient) • Skilled Nursing Facility	Nothing
Professional services provided in – • Hospital outpatient department • Ambulatory surgical center • Office	$50 outpatient copay per treatment or surgery including necessary supplies

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

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • semiprivate or intensive care accommodations; • general nursing care; • meals and special diets when medically necessary; • Special duty nursing when medically necessary; and • Private rooms when medically necessary. NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing
Other hospital services and supplies, such as: • Operating, recovery, delivery room, newborn nursery, 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 • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home • Radiation therapy, chemotherapy, and renal dialysis	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, convalescent 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.	$50 per treatment or surgery including necessary supplies
Not covered: blood and blood derivatives if replaced by the member	*All charges*
Extended care benefits/skilled nursing care facility benefits	**You pay**
We provide benefits up to 100 days each calendar year when full time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by your Plan physician and approved by us. Admissions to a sub-acute care setting require prior approval and are limited to 100 days each calendar year. 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 physician.	Nothing
Not covered: custodial care, rest cures, domiciliary or convalescent care and comfort items such as a telephone and television. All charges after the 100 day annual maximum.	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. Care received in the home is limited to 100 visits per year. Care received in a hospice facility provides for 100 days of service, applied against the Extended Care Day Limits, without copayment. Services include inpatient and outpatient care, and family counseling; these services provided under the direction of a Plan physician who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing in a hospice facility. $10 copay per home physician visit $5 copay per visit of other health care providers
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
• Local professional ambulance service when ordered or authorized by a Plan physician.	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.
- 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:

If you are in an emergency situation, please call your primary care physician. In extreme emergencies, if you are unable to contact your physician, contact the local emergency system (e.g., the 911 telephone system) or go to the nearest hospital emergency room. Be sure to tell the emergency room personnel that you are a Plan member so they can notify the Plan. You or a family member should notify the Plan within 48 hours. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admission, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and a Plan physician believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-Plan providers in a medical emergency only if delay in reaching a Plan provider would result in death, disability or significant jeopardy to your condition.

Any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers.

The Plan pays reasonable charges for emergency services to the extent the services would have been covered if received from Plan providers.

If the emergency results in admission to a hospital, any applicable copay is waived.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$10 per visit
• Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: If the emergency results in admission to a hospital, the copay is waived.	$50 per visit
Not covered: Elective care or non-emergency care	*All charges.*
Emergency outside our service area	
Benefits are available for any medically necessary health service that is immediately required because of injury or unforeseen illness. If you need to be hospitalized, the Plan must be notified within 48 hours or on the first working day following your admissions, unless it was not reasonably possible to notify the Plan within that time. If you are hospitalized in non-Plan facilities and a Plan physician believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full. Reasonable charges for emergency care services to the extent the services would have been covered if received from Plan providers. Note: If the emergency results in admission to a hospital, the copay is waived.	
• Emergency care at a doctor's office	$10 per visit
• Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 per visit
Not covered: • *Elective care or non-emergency care*	*All charges.*
Ambulance	
Professional ambulance service when medically appropriate. See 5(c) for non-emergency service.	Nothing
Not covered: taxi, wheelchair van, other non-ambulance assisted transportation	*All charges.*

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

Network Benefit

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:

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

IMPORTANT

Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by 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
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services approved in alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing
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: To obtain an authorization, call 877/263-8827. You should continue to identify yourself as a Blue Shield member and use your Blue Shield identification card and identification numbers when contacting USBHPC or its participating providers. *Your health care provider should contact USBHPC at 877/263-9870 to obtain information about joining the USBHPC network, obtaining an authorization for your treatment, or to speak with a member of USBHPC's clinical staff about issues related to this benefit or your care.* If you would like a copy of a provider directory, you can contact the Blue Shield Member Services Department at 800/334-5847.
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 or when clinically appropriate under the following conditions: • 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, or • If changes to this Plan's benefit structure for 2001 cause your-out-of pocket costs for your out-of-network provider to be greater than they were in year 2000. If these conditions apply to you, we will allow you reasonable time to transfer your care to a USBHPC 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 out notice. If we write to you before October 1, 2000, the 90-day period ends before January 1, 2001 and this transitional benefit does not apply.
Limitation	We may limit your benefits if you do not follow your treatment plan.

Out-of-Network Benefit

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.
- See page 27 for In-Network benefits.
- 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.

Description	You pay
Out-of-Network mental health and substance abuse benefits	
Not covered out-of-network	*All charges.*

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 deductible.
- Physicians must document medical necessity for non-formulary drugs during regular business hours by calling the Plan's toll-free pharmacy services prior authorization hotline at 800/535-9481.
- 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 know about your prescription drug benefit. These include:

- **Who can write your prescription.** A licensed physician, or other covered provider acting within the scope of their license.
- **Where can you obtain your prescriptions.** You must fill the prescription at a retail plan pharmacy, or plan mail service pharmacy for a maintenance medication.
- **Mail Order Drug Program.** Prescriptions are available by mail for up to a 90-day supply. Generic drugs will be dispensed in lieu of name brand drugs when substitution is permissible by the physician. Call Member Services at 800/334-5847 to receive a packet for ordering prescriptions through the mail.
- **We use a formulary.** Prescription Drug coverage is based on the use of the prescription Drug Formulary, a copy of which is available to you. Non-formulary drugs will be covered when prescribed by a physician and approved by Blue Shield. Your physician is responsible for obtaining authorizations from the Plan for all non-formulary drugs and selected formulary drugs and drug dosages which require prior authorization for medical necessity. You should not become directly involved with the Plan for this pre-authorization process. Instead, your physicians should document medical necessity. If all necessary documentation is available from your physician, prior authorization approval or denial will be provided to your physician within two working days of the request.
- Medications are selected for inclusion in Blue Shield's Outpatient Prescription Drug Formulary based on safety, efficacy, and FDA bio-equivalency data. The Blue Shield Pharmacy and Therapeutics Committee reviews new drugs and clinical data four times a year.
- Members may call Blue Shield Member Services at 800/334-5847 to find out if a specific drug is included in the Formulary. New members receive a printed copy of the formulary with their welcome kits. Formulary information is also available on Blue Shield's website at http://www.blueshieldca.com.
- In lieu of brand name drugs, generic drugs will be dispensed when substitution is permissable by the physician. If you request a brand name drug when a generic drug is available, you pay the difference between the cost of the brand name drug and its equivalent generic drug, plus the copayment.
- **Prescription Days Supply Covered:** Present your Access+ ID card at the participating pharmacy. A retail Plan pharmacy may dispense up to a 30-day supply for a $6 copay. You will pay $6 per prescription for out-of-state emergencies. Maintenance drugs are available in a 90-day supply with a $6 copay per prescription through the Plan mail service pharmacy.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a retail Plan pharmacy or through our mail service pharmacy: • Diabetic supplies limited to disposable insulin syringes, needles, pen delivery systems and glucose testing tablets and strips. • Formulary drugs for sexual dysfunction or sexual inadequacies will be covered when the dysfunction is caused by medically documented organic disease. Prior Plan approval is required and the maximum dosage dispensed will be limited by the protocols established by the Plan. Certain drugs for these conditions are not available through the Mail Order option. • Formulary 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 • Formulary oral contraceptive drugs and diaphragms.	$ 6 per plan pharmacy prescription $ 6 per mail service prescription
Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If your receive a name brand drug when a Federally-approved generic drug is available and your physician has not specified Dispense as Written for the name brand drug, you will pay the difference in the cost between the name brand drug and the generic plus the copayment.	$6 plus the difference in price of brand name and generic drugs
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available* • *Intravenous fluids and medications for home use and some injectable drugs, such as Depo Provera, are covered under Sections 5(a) or 5(b) Medical or Surgical services, not the Prescription Drug Benefit.* • *Drugs obtained at a non-Plan pharmacy except for out-of-area emergencies* • *Compounded medication with formulary alternatives or those with no FDA approved indications* • *Medical supplies such as dressings and antiseptics* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs for weight loss* • *Smoking cessation drugs* • *Vitamins and nutritional substances that can be purchased without a prescription* *Note: IUDs and Norplant dispensed by your physician are covered under Section 5(b) Surgical Services, not the Prescription Drug Benefit.*	*All Charges*

Section 5 (g). Special Features

Feature	Description
High risk pregnancies	The Plan covers the prenatal diagnosis of genetic disorders of the fetus in high-risk pregnancy cases.
Self-referral to Specialty services	Access+ allows you to arrange office visits with Plan specialists in the same Medical Group or IPA as your personal care physician without a referral. A few physicians are not Access+ providers. You are advised to refer to the *Access+ 2001 Provider Directory for Federal Employees* to determine if your physician participates in the Access+ self-referral option. Members who use this convenient feature are subject to a $30 copayment per specialty office visit. If the medical condition requires follow-up care to the same specialist, you are encouraged to request that the specialist receive prior authorization from your personal care physicians for additional visits at the regular office copayment of $10 per visit. The Access+ specialist includes: • Examinations and consultations; • Conventional x-rays of the chest and abdomen; • X-rays of bones to diagnose suspected fractures; • Laboratory services; • Diagnostic or treatment procedures that would normally be provided with a referral; and • Vaccines and antibiotics. The Access+ specialist visit does not include: • Diagnostic imaging such as CAT Scans, MRI or bone density measurements; • Services that are not covered benefits or that are not medically necessary; • Services of a provider not in the Access+ network; • Allergy testing; • Endoscopic procedures; • Injectables, chemotherapy or other infusion drugs (not listed above); • Infertility services; • Emergency services; • Urgent care services; • Inpatient services or facility charges; and • Mental health and substance abuse.

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 providers 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.

IMPORTANT

Accidental injury benefit

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 commencing within 90 days of the accidental injury or within 90 days of medical appropriateness of treatment and within one year of the injury. You pay a $10 copay per visit.

Dental benefits

We have no other FEHB dental benefits.

Please refer to page 33. For details about a comprehensive, non-FEHB optional Blue Shield Dental Plan.

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

The benefits described on this page are neither offered nor guaranteed under the contract with FEHB, but are made available to all enrollees and family members who are members of this Plan. The cost of the benefits described on this page is not included in the FEHB premium and any charges for these services do not count toward any FEHB deductibles or out-of-pocket maximums. These benefits are not subject to the FEHB disputed claims procedure.

Blue Shield Dental Option -- Comprehensive and Affordable

CAUTION: When shopping for a dental plan, please carefully compare: (1) copayments, (2) waiting periods and (3) dues.

Enroll in Access+ and pay dues directly to Blue Shield to join this DHMO dental plan. Dues can be paid monthly or quarterly (Dues are also shown on a biweekly basis for your convenience in comparing costs.). Call 888/271-4929 for a list of dentists, a summary of benefits and an enrollment form.

	Biweekly Dues	Monthly Dues	Quarterly Dues
Self only	$7.41	$16.05	$48.15
Two party	$14.28	$30.93	$92.79
Family	$21.07	$45.65	$136.95

Care must be received from or arranged by a Blue Shield Dental Option provider. Below are sample copayments:

Office visits	$5	Fillings (per surface)	$15	Root canal (one canal)	$125
Bitewing X-rays	$0	Metal crowns (each)	$250	Full upper or lower denture	$250
Prophylaxis	$0	Single, routine extraction	$20	Orthodontics (children only)	$1,800

Receive Discounts from Vision One Eyecare Program on Frames and Lenses

Federal employees with Access+ coverage can enjoy savings of up to 66.7% on frames and lenses through our Vision One Eyecare Program at almost 250 Cole Vision California locations. Cole Vision services are available in the optical departments of many Sears, Montgomery Ward and JCPenney stores, at Pearle Vision locations and at offices of participating private practice doctors. There is no added premium for this money-saving feature. Simply present your Access+ identification card when you pay for your eyewear and the discounts are automatic.

For coverage of eye refractions see page 17.

Significant Discounts through the mylifepath[sm] Program - Acupuncture, Massage & More

Access+ offers you participation in mylifepath, which entitles you to significant discounts on health and wellness services. When you see a practitioner in the mylifepath network, you'll experience substantial savings on acupuncture, chiropractic, massage, fitness centers, health spas, and wellness programs. You will be responsible for all charges remaining after the discounts. For more details on all features, please call 888/999-9452. Also visit our website, mylifepath.com for health information and news about other value-added features.

Medical Care for Vacations, Business Travel and College Students

You, and your eligible family members are covered for urgent and emergency care in all 50 states while you are on vacation or business travel. There are no additional premiums for this coverage. "Guest membership" is also available on a temporary basis for members and dependents who will be living away from home and who need a local primary care provider. You pay office copayments, which vary from state to state ($5 to $25) for guest visits and $50 for urgent care visits. For additional information on these coverages, call 800/334-5487.

Blue Shield 65 Plus, A Medicare+Choice Prepaid Plan

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 40, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan if one is available in their area. They may then later reenroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will have to pay for hospital coverage in certain instances in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 888/713-0000 for information on the Medicare prepaid plan and the cost of that enrollment. Blue Shield 65 Plus is now available in Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Ventura counties.

Benefits on this page are not part of the FEHB Contract

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 physician determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury or condition.**

We do not cover the following:

- Care by non-Plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or mental health 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;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs or supplies related to sexual dysfunction or sexual inadequacies (including penile prostheses) except as provided for medically documented treatment of organically based conditions; or
- Services performed by a close relative (the spouse, child, brother, sister, or parent of a member) or a person who ordinarily resides in the member's home.

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 except for your annual eye examination. Just present your identification card and pay your copayment or coinsurance.

You will also 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, hospital and drug 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 800/334-5847

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

Submit your claims to: **Blue Shield of California**
Access+ Member Services
P.O. Box 272550 Chico, CA 95927

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: Blue Shield of California, Administrative review, PO Box 272540, Chico, CA 95927-2540. You may call our MSD at 800/334-5847 and request an initial appeal form, C-4456. We will mail or fax the form to you. (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 II, P.O. Box 436 Washington, D.C. 20044-0436.

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 800/334-5847 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 II at 202/606-3818 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 personal care physician.

We will not waive any of our copayments or coinsurances.

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

· **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed plans, you can only go to doctors, specialists, or hospitals that are part of the Plan. Medicare managed care plans cover all Medicare Plan 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+Choice 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 or coinsurance.

Suspended FEHB coverage and a Medicare+Choice 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.) Medicare 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+Choice 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 eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related disease or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your benefits. 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 at 530/666-2238 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.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care.
Covered services	Care we provide benefits for, as described in this brochure.
Experimental or investigational services	Access+ covers drugs, devices that are medically indicated and biological products no longer considers to be investigational by the Food and Drug Administration. Coverage for other procedures are reviewed by and decided by the Blue Shield of California Medical Policy Committee. The primary criteria are that the proposed new procedures are safe and effective.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. These are negotiated lower provider rates and savings are passed on to you.
Us/We	Us and we refer to *Blue Shield of California Access+ or USBHPC for mental health and substance abuse coverage.*
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 for which your employing or retirement office authorizes coverage. 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 800/334-5847 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 they try to obtain services for a person who is not an eligible family member, or are no longer enrolled in the Plan and try 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 area
- Commonwealth of Puerto Rico
- Greensboro/Winston Salem/High Point, NC
- Humboldt County, CA area
- Naval Hospital, Camp Pendleton, CA
- Coffee County, GA area

When you can join

You may enroll under the 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 877/DOD-FEHB (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 the Access+ 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: • Preventive diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $10 specialist; $30 Access+ self referral	13
Services provided by a hospital: • Inpatient • Outpatient	 Nothing $50 per treatment or surgery	23
Emergency benefits: • In-area or out-of-area	 $50 copay per visit	25
Mental health and substance abuse treatment • In-Network • Out-of-Network	 Regular cost sharing No benefit	27
Prescription Drugs	$6 per Plan pharmacy prescription $6 per Mail service prescription	29
Dental Care Accidental injury benefit Optional Dental Plan	 $10 per office visit You Pay total premiums plus various copays	32
Vision Care	$10 per office visit	17
Special Features: High risk pregnancy program, Access+ self referral		31
Protection against catastrophic costs • Surgical and medical • Mental health and substance abuse Note: There are separate catastrophic cost for mental health and substance abuse services.	 Nothing after $1,000/Self Only or $2,000/Family enrollment per year Some costs do not count toward this protection	11

2001 Rate Information for
Blue Shield of California Access+

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 most career U.S. Postal Service employees. If you are a Postal Service nurse or tool and die employee, the rates that apply to you are different. Refer to the FEHB Guide (for Postal Service nurses and tool and die employees), RI 70-2B. If you are a career employee who is not a member of a special postal employment class, refer to the category definitions in The FEHB Guide for United States Postal Service Employees, RI 70-2 to determine which rate applies to you.

Postal rates do not apply to non-career postal employees, postal retirees, certain special postal employment classes or associate members of any postal employee organization. Such persons not subject to postal rates must 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
Most of California							
High Option Self Only	SJ1	$67.62	$22.54	$146.51	$48.84	$80.02	$10.14
High Option Self and Family	SJ2	$167.75	$55.91	$363.45	$121.15	$198.50	$25.16