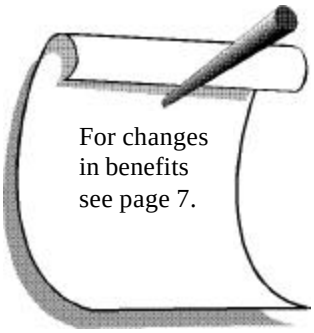
QualChoice Health Plan of North Carolina, Inc.

http://www.qualchoicenc.com

QUALCHOICE OF NORTH CAROLINA, INC.

2001

A Health Maintenance Organization with a point of service product



Serving: Northwestern North Carolina

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

Enrollment codes for this Plan:

7Q1 Self Only
7Q2 Self and Family

Authorized for distribution by the:

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

FEHB
Federal Employees
Health Benefits Program

RI 73-767

Table of Contents

Introduction

QualChoice of North Carolina, Inc.
P.O. Box 340
Winston-Salem, North Carolina 27102-0340

This brochure describes the benefits of QualChoice Health Plan of North Carolina, Inc. under our contract (CS 2822) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

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

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2001, and are summarized on page 58. 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 QualChoice Health Plan of North Carolina, Inc.

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

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

Section 1. Facts about this HMO Plan

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

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

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

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

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

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

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayment 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 us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Our company was established in 1994 as a Health Maintenance Organization and is a for-profit corporation operating under the laws of the State of North Carolina.
- We have, since our inception in 1994, maintained compliance with all state and federal licensing, certification and fiscal solvency requirements.
- We also comply with all state and federal standards to assure confidentiality of your medical and personal information, and the orderly transfer of such information to caregivers as appropriate to manage your care and administer your benefits under this Plan.
- As a means of measuring the satisfaction of our members, we conduct an annual customer satisfaction survey in accordance with the specifications of the Health Plan Employer and Data Information Set (HEDIS).
- We will forward any of the following information about our Plan to you upon request:
    - information about our provider network, individual providers and facilities
    - compensation arrangements that exist with our providers
    - formulary drug inclusion and exception process
    - experimental/investigational determination process

- preauthorization and utilization review procedures used to approve care
- clinical protocols, practice guidelines and utilization review standards being used to direct your care
- mandatory or voluntary disease management programs
- credentials of the person(s) involved in reviewing appeals

If you want more information about us, call 336/716-0911, or write to P.O. Box 340, Winston-Salem, NC 27102-0340. You may also contact us by fax at 333/716-0920 or visit our website at www.qualchoicenc.com

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: Alamance, Alexander, Alleghany, Ashe, Burke, Caldwell, Catawba, Davidson, Davie, Forsyth, Guilford, Iredell, Randolph, Rockingham, Rowan, Stokes, Surry, Watauga, Wilkes and Yadkin Counties.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care or point-of-service benefits. We will not pay for any other health care services.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. 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 deductibles, coinsurance, copayments, and day and visit limitations when you follow a treatment plan that we approve. Previously, we placed higher patient cost sharing and/or shorter day or visit limitations on mental health and substance abuse services than we did on services to treat physical illness, injury, or disease.
- Many 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 336/716-0911 (ask for our Patient Safety Coordinator in the Healthcare Management Department), **or** checking our website, www.qualchoicenc.com. You can find out more about patient safety on the OPM website, www.opm.gov/insure. To improve your healthcare, take these five steps:
  - Speak up if you have questions or concerns.
  - Keep a list of all the medicines you take.
  - Make sure you get the results of any test or procedure.
  - Talk with your doctor and health care team about your options if you need hospital care.
  - Make sure you understand what will happen if you need surgery.
- We clarified the language to show that anyone who needs a mastectomy may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure. Previously, the language referenced only women.

Changes to this Plan

- Your share of the non-Postal premium will increase/decrease by __% for Self Only or __% for Self and Family.
- Your copayment for a mental health or substance abuse outpatient visit will decrease to $15.
- You will have no day/visit limits for inpatient or outpatient mental health or substance abuse services, except when receiving out-of-network benefit. See Section 5(e).
- Your coverage for out-of-network inpatient and outpatient mental health or substance abuse services will decrease to 70%. Day/visit limits remain in effect. See Section 5(e).
- Your annual deductible for out-of-network inpatient and outpatient mental health or substance abuse services has been eliminated.
- Your annual and lifetime dollar limits for inpatient and outpatient chemical dependency services have been eliminated, except when receiving out-of-network services. See Section 5(e).
- Your coverage for accidental dental injury will have a limit of $3,000 per occurrence.
- You will have a new benefit that covers dental anesthesia for certain individuals, See Section 5(j).
- Your prescription drug benefit will change to a three-tier open drug formulary, and your copayment may increase. Your copayment will be $6 for generic drugs, $12 for brand-name preferred drugs, and $22 for brand-name non-preferred drugs. See Section 5(f).
- You will now be required to pay a $10 copayment per visit for outpatient physical, occupational and speech therapy services.
- Chiropractic services are no longer covered.

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 336/716-0911 or 800/816-0911.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will pay copayments, coinsurance and/or deductibles, and normally you will not have to file claims. If you use our point-of-service program (POS), you can also get care from non-Plan providers, or from participating providers without a required referral, but it will cost you more. You will be required to submit a claim to us if you receive services from a provider who doesn't contract with us.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to criteria that has been approved by our Medical Quality Improvement Committee, and which also meets nationally recognized standards.

Our network includes physicians on the faculty of Wake Forest University School of Medicine as well as community physicians and other health care providers.

We list Plan providers in our provider directory as primary care physicians (family practitioners, pediatricians, OB/GYNs and internists), with their locations and phone numbers, and note whether or not the doctor is accepting new patients. We also list specialists with their locations and phone numbers. Directories are updated monthly and are available at the time of enrollment or upon request by calling our Customer Service department at 336/716-0911 or 800/816-0911; you can also find out if your physician participates with this Plan by calling this number. If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients. Important note: When you enroll in this Plan, services (except for emergency or POS benefits) are provided through the Plan's delivery system.

- **Plan facilities**

Plan facilities include Wake Forest University Baptist Medical Center and other area hospitals and allied/ancillary providers in our service area that we contract with to provide covered services to our members.

We list hospitals and allied/ancillary providers in the provider directory with their locations and phone numbers. Directories are updated monthly and are available at the time of enrollment or upon request by calling our Customer Service department at 336/716-0911 or 800/816-0911.

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.

It is the responsibility of your primary care physician to obtain any necessary referrals from the Plan before referring you to a specialist or making arrangements for hospitalization. Services of other providers are covered only when you have been referred by your primary care physician or when you use POS benefits, with the following exception: females age 13 years or older may see an obstetrics and gynecology PCP for obstetrical and gynecological care. Female enrollees must select an OB/GYN physician. If your medical PCP provides your OB/GYN care, you may select that physician as your OB/GYN PCP as well as your medical PCP.

If you enroll, you will be asked to let the Plan know which primary care physician(s) you've selected for you and each member of your family by sending a selection form to the Plan. If you need help choosing a physician, call the Plan. Members may change their physician selection by notifying the Plan 30 days in advance and your new primary care physician will be available the first day of the following month.

If you are interested in receiving care from a specific provider who is listed in the directory, call the provider to verify that he or she still participates with the Plan and is accepting new patients.

· **Primary care**

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

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

· **Specialty care**

Your primary care physician will refer you to a specialist for needed care; however, you may see any doctor without a referral under the POS benefit. Females age 13 years or older may see an obstetrics and gynecology PCP for obstetrical and gynecological care without a referral.

Here are other things you should know about specialty care:

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

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

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another

specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

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

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

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

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

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

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

- **Hospital care**

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

If you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 336/716-0911 or 800/816-0911. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

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

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

Circumstances beyond our control

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

Services requiring our prior approval

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

We call this review and approval process precertification. Your physician must obtain our approval prior to performing activities, such as: sending you to a hospital or skilled nursing facility, referring you to a

specialist, arranging home health care, or prescribing certain types of durable medical equipment.

Your physician is required to obtain prior authorization from our precertification department for non-emergent medical services such as those listed above. We use InterQual medical review criteria to confirm medical necessity prior to authorization of requested medical services.

Your physician may also need to obtain our approval for certain point-of-service benefits, such as hospital admissions and certain outpatient services. See Section 5(i).

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 $15 per office visit. When you go to any of our physicians without being referred by your PCP, you will pay a copayment of $25 and 20% of your total bill for certain services (Option 2).

· **Deductible**

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. We do not have a deductible for Option 1 and Option 2 benefits. We do have a deductible for Option 3 (POS) benefits as stated below.

- The calendar year deductible is $300 per person under Option 3. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $750 under Option 3.

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

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

· **Coinsurance**

Coinsurance is the percentage of our Plan allowance that you must pay for your care. We do not have coinsurance for Option 1 benefits. We do have coinsurance for Option 2 and Option 3 benefits as stated below.

- You pay 20% of the charges for certain services under Option 2; and 30% of the Plan allowance under Option 3, after you have paid the applicable deductible. You may be billed by the provider for the difference between the actual charges and the Plan allowance.

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

Your out-of-pocket expenses for benefits under this Plan are limited to the stated copayments required for a few benefits, except for the POS options. After your coinsurance under Option 2 totals $800 per person or $2,000 per family, and coinsurance and deductible under Option 3 totals $900 per person or $2,250 per family enrollment in any calendar year, you do not have to pay any more for covered services. Copayments under Option 1 and Option 2 do not count toward your out-of-pocket maximum.

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

Section 5. Benefits -- OVERVIEW

(See page 7 for how our benefits changed this year and page 58 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 336/716-0911 or 800/816-0911 or at our website at www.qualchoicenc.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 under this Option 1.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians • In physician's office	$10 per office visit to your primary care physician. $15 per office visit to a specialist
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion	$10 per office visit to your primary care physician $15 per office visit to a specialist
At home	$10 per office visit to your primary care physician $15 per office visit to a specialist

Lab, X-ray and other diagnostic tests	You Pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing when ordered by your physician.
Preventive care, adult	**You Pay**
Routine screenings, such as: • Blood lead level – One annually • 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	$10 per office visit to your primary care physician $15 per office visit to a specialist
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	$10 per office visit to your primary care physician $15 per office visit to a specialist
Routine pap test Note: The office visit is covered if pap test is received on the same day; see *Diagnosis and Treatment*, above. 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 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	$10 per office visit to your primary care physician $15 per office visit to a specialist
Not covered: • *Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.*	*All charges.*
Routine Immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, when recommended by your physician	$10 per office visit to your primary care physician $15 per office visit to a specialist No charge for immunizations; charge for office visit only.

Preventive care, children	You pay
• Childhood immunizations recommended by the American Academy of Pediatrics	$10 per office visit to your primary care physician $15 per office visit to a specialist No charge for immunizations; charge for office visit only
• Examinations, such as: •• Eye exams through age 17 to determine the need for vision correction. •• Ear exams through age 17 to determine the need for hearing correction •• Examinations done on the day of immunizations (through age 22) • Well-child care charges for routine examinations, immunizations and care (through age 22)	$10 per office visit to your primary care physician $15 per office visit to a specialist
Maternity care	**You pay**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see Section 3 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits, Section 5(c) and Surgery benefits, Section 5(b).	Nothing. Copayments are waived for maternity care.
Not covered: • *Routine sonograms to determine fetal age, size or sex*	*All charges*

Family planning	You pay
• Voluntary sterilization, for you and your spouse • Surgically implanted contraceptives • Injectable contraceptive drugs • Intrauterine devices (IUDs)	$10 per office visit to your primary care physician $15 per office visit to a specialist
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling* • *Voluntary abortion*	*All charges.*
Infertility services	**You pay**
Diagnosis and treatment of infertility, such as: • Artificial insemination: •• *intravaginal insemination (IVI)* •• *intracervical insemination (ICI)* •• *intrauterine insemination (IUI)* Artificial insemination procedures are limited to a total of 6 attempts per lifetime. Note: Injectable fertility drugs used as part of an artificial insemination procedure are covered.	$10 per office visit to your primary care physician $15 per office visit to a specialist
Not covered: • *Fertility drugs, except as noted above* • *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*	*All charges.*
Allergy care	**You pay**
Testing and treatment Allergy injection	$10 per office visit to your primary care physician $15 per office visit to a specialist
Allergy serum	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges.*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants in Section 5(b). • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: – We will only cover GHT when we preauthorize the treatment. Call 336/716-0911 or 800/816-0911 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See *Services requiring our prior approval* in Section 3.	$10 per office visit to your primary care physician $15 per office visit to a specialist
Rehabilitative therapies	**You pay**
• Physical therapy, occupational therapy and speech therapy -- Two consecutive months per condition for the services of each of the following: •• licensed physical therapists; •• licensed speech therapists; and •• licensed occupational therapists. Note: We only cover therapy to restore bodily function or speech when there has been a total or partial loss of bodily function or functional speech due to illness or injury. • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided for up to 12 sessions	$10 per visit
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges.*

Hearing services (testing, treatment, and supplies)	You pay
• First hearing aid and testing only when necessitated by accidental injury • Hearing testing for children through age 17 (see *Preventive care, children*)	$10 per office visit to your primary care physician $15 per office visit to a specialist
Not covered: • *All other hearing testing* • *Hearing aids, testing and examinations for them*	*All charges.*
Vision services (testing, treatment, and supplies)	**You pay**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	$10 per visit to your primary care physician $15 per visit to a specialist
• Eye exam to determine the need for vision correction for children through age 17 (see preventive care)	$10 per office visit to your primary care physician $15 per office visit to a specialist
Not covered: • *Eyeglasses or contact lenses and, after age 17, examinations for them* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Annual eye refractions*	*All charges.*
Foot care	**You pay**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.	$10 per office visit to your primary care physician $15 per office visit to a specialist
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges.*

Orthopedic and prosthetic devices	You pay
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See Section 5(b) for coverage of the surgery to insert the device.	$10 per office visit to your primary care physician $15 per office visit to a specialist
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges.*
Durable medical equipment (DME)	**You pay**
Rental or purchase, at our option, including repair and adjustment, of medically necessary durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds; • Wheelchairs; • Crutches; • Walkers; • Blood glucose monitors; and • Insulin pumps. Note: Certain DME requires precertification. Call us at 336/716-0911 or 800/816-0911 as soon as your Plan physician prescribes this equipment. We will arrange with a 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.	Nothing

Home health services	You pay
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications.	$15 per visit
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;*	*All charges.*

Educational classes and programs	You pay
Coverage includes: • Disease Management - Diabetes - Congestive Heart Failure - Chronic Obstructive Pulmonary Disease - Multiple Sclerosis - Rheumatoid Arthritis - Cystic Fibrosis - Parkinson's Disease - Mysathenia Gravis - Lupus - ALS - Gauchers Disease • Health Screenings (blood pressure, glucose, cholesterol) • Smoking Cessation Program • Stress Management Program • Prenatal Wellness Program • Fitness Center Membership Discounts • Health Seminars • Wellness News Articles (included in quarterly "Quality Life" magazine) • Health on Call - 24-Hour Nurse Triage Phone Line	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 under this Option 1.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.)
- YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to Section 3 to learn more about services requiring our prior approval.

IMPORTANT

Benefit Description	You pay
Surgical procedures	
• Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedure • Biopsy procedure • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. All surgical treatment for morbid obesity must receive prior approval by the Plan's Medical Director. • Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic braces and prosthetic devices, for device coverage information.	Copayment for office visits only: $10 per office visit to your primary care physician $15 per office visit to a specialist
• Voluntary sterilization, for you and your spouse • Norplant (a surgically implanted contraceptive) and intrauterine devices (IUDs) Note: Devices are covered under Section 5(a). • Treatment of burns Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.	$10 per office visit to your primary care physician $15 per office visit to a specialist
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot; see Foot care.*	*All charges.*

Reconstructive surgery	You pay
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: •• the condition produced a major effect on the member's appearance and •• the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers, and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: •• surgery to produce a symmetrical appearance on the other breast; •• treatment of any physical complications, such as lymphedemas; •• breast prostheses and surgical bras and replacements (see Prosthetic devices) Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	$10 per office visit to your primary care physician $15 per office visit to a specialist
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	You pay
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures.	$10 per office visit to your primary care physician $15 per office visit to a specialist
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 • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • National Transplant Program (NTP) – All transplants are coordinated through the United Resource Network. Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. All requests for organ/tissue transplants that are in the clinical trial phase require prior approval from the Plan's Medical Director. Note: We cover related medical and hospital expenses of the donor when we cover the recipient**.**	$10 per office visit to your primary care physician $15 per office visit to a specialist
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*	*All charges*
Anesthesia	**You pay**
Professional services provided in – • Hospital (inpatient)	Nothing
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing

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 under this Option 1.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Section 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS.** Please refer to Section 3 to learn more about services requiring our prior approval.

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home	Nothing

Inpatient hospital – Continued on next page

Inpatient hospital *(Continued)*	**You pay**
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, extended care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*
Outpatient hospital or ambulatory surgical center	**You pay**
• 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 • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia services 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.	Nothing
Not covered: • *Blood and blood derivatives not replaced by the member*	*All charges*
Extended care benefits/skilled nursing care facility benefits	**You pay**
Extended care benefit: We will pay for care in a nursing home, skilled nursing facility, or rehabilitation facility if daily skilled care is medically necessary. We will pay for a total of 90 days of care per member, per benefit year. We will also pay for prescription drugs while you are receiving treatment at the facility. We will not pay for "custodial care," that is, care that is primarily for meeting personal needs. This is care that can be given by persons without professional skills or training. For example, "custodial care" includes assistance with activities of daily living, such as walking, getting in and out of bed, bathing, dressing, eating and taking medicine.	Nothing
Not covered: • *Custodial care*	*All charges*

Hospice care	You pay
We will pay for hospice care provided by a hospice that possesses all licenses, certifications, permits and approvals required by state and local law. A hospice provides a centralized program of palliative and supportive services to terminally ill persons and their families in the form of physical, psychological, social and spiritual care. We will pay for hospice care authorized by your physician during the period when you are admitted to the hospice program. We will pay for the following hospice services: **A.** Inpatient care in a freestanding hospice, a hospice unit within a hospital or skilled nursing facility, or in a regular hospital bed. **B.** Home care services either directly or by agreement with other licensed providers, including: • Intermittent nursing care by registered nurses, licensed practical nurses, or home health aides; • Physical therapy; • Respiratory therapy; • Social services; • Laboratory examinations, x-rays, chemotherapy and radiation therapy when required for control of symptoms; • Medical supplies; • Drugs and medications prescribed by a physician. (We will not pay when the drug or medication is of an experimental or investigative nature); or • Medical care by your own attending physician or the hospice physician.	Nothing
Not covered: • *Independent nursing, homemaker services*	*All charges*
Ambulance	**You pay**
• Local professional ambulance service, ground or air, when medically appropriate	$50 per trip
Not covered: • *Non-emergency ambulance services for home to routine outpatient medical treatment such as but not limited to physician visits, radiation, chemotherapy, or physical therapy, unless ordered or authorized by a plan provider.*	*All charges*

Section 5 (d). Emergency services/accidents

IMPORTANT		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 under this Option 1.
- 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.

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 doctor, 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 must notify the Plan within 48 hours, unless it was not reasonably possible to do so. It is your responsibility to ensure that the Plan has been timely notified.

If you need to be hospitalized in a non-Plan facility, 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 doctor 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.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers except as covered under POS benefits.

Emergencies 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 admission, unless it was not reasonably possible to notify the Plan within that time. If a Plan doctor believes care can be better provided in a Plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

To be covered by this Plan, any follow-up care recommended by non-Plan providers must be approved by the Plan or provided by Plan providers except as covered under POS benefits.

With your authorization, the Plan will pay benefits directly to the providers of your emergency care upon receipt of their claims. Physician claims should be submitted on the HCFA 1500 claim form. If you are required to pay for the services, submit itemized bills and your receipts to the Plan along with an explanation of the services and the identification information from your ID card. Payment will be sent to you (or the provider if you did not pay the bill), unless the claim is denied. If it is denied, you will receive notice of the decision, including the reasons for the denial and the provisions of the contract on which denial was based. If you disagree with the Plan's decision, you may request reconsideration in accordance with the disputed claims procedure in Section 8.

Benefit Description	You pay
Emergency within our service area	
• Emergency care at a doctor's office	$10 per office visit to your primary care physician $15 per office visit to a specialist
• Emergency care at an urgent care center	$50 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 per visit. (Copayment waived if admitted to hospital.)
Not covered: • *Elective care or non-emergency care, except as covered under POS benefits*	*All charges.*
Emergency outside our service area	**You pay**
• Emergency care at a doctor's office	$15 per visit
• Emergency care at an urgent care center	$50 per visit
• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	$50 per visit (Copayment waived if admitted to hospital.)
Not covered: • *Elective care or non-emergency care* • *Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area, except as covered under POS benefits* • *Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area.*	*All charges.*
Ambulance	**You pay**
Professional ambulance service, ground or air, when medically appropriate and ordered or authorized by Plan doctor. See Section 5(c) for non-emergency services.	$50 per trip
Not covered: • *Non-emergency ambulance services for home to routine outpatient medical treatment such as but not limited to physician visits, radiation, chemotherapy, or physical therapy, unless ordered or authorized by a Plan provider.*	*All charges.*

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

IMPORTANT

Parity

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

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible under this Option 1.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits description below.

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a network 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	$15 per visit

Mental health and substance abuse benefits - Continued on next page

Mental health and substance abuse benefits *(Continued)*	**You pay**
• Diagnostic tests	$15 per (visit or test)
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment (when recommended by a network provider and contained in a treatment plan we approve.	Nothing
Services such as the following are 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 enhanced mental health and substance abuse benefits you must follow your treatment plan and all of our network authorization processes. These include:

A network of mental health and chemical dependency providers is available to you. This network includes psychiatrists, licensed clinical psychologists, certified social workers, and certified chemical dependency counselors. These providers are referred to as "network providers" in this Section. To obtain care from these network providers, you may choose from Option 1 (In-Network benefits) or Option 3 (Out-of-Network benefits). You cannot receive services from network providers under Option 3. See page 41 for Out-of-Network benefits.

Under Option 1, the first step in obtaining care from the mental health and chemical dependency network providers is to call 1-800-475-7900. A trained and licensed mental health and chemical dependency professional will answer your call. He or she will discuss your problem and make a referral for evaluation, counseling or treatment to a network provider. Referrals are based on your needs and the network provider's availability and experience with your kind of problem.

We will pay for the "appropriate level of treatment" considering the following criteria:

- The intensity and scope of care; and
- The least restrictive environment that will provide adequate care with the least disruption to you, your family, work, school, etc. The level of treatment should offer the best opportunity for independent or community assisted functioning.

Special transitional benefit	If a mental health or substance abuse professional provider is treating you under our Plan as of January 1, 2001, you will be eligible for continued coverage with your provider for up to 90 days under the following 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. If this condition applies to you, we will allow you reasonable time to transfer your care to a network 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. The transitional period will last for up to 90 days from the date you receive notice of the change. You may receive this notice prior to January 1, 2001, and the 90-day period begins with receipt of the notice.
Limitation	We may limit your benefits if you do not follow your treatment plan.

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- There is no deductible for prescription drug benefits; you pay only the applicable copayment.
- 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.
- Prior authorization means the process of obtaining a certification of coverage for certain prescription drug products or quantities of certain prescription drug products before they are dispensed using guidelines approved by us. The list of prescription drug products requiring prior authorization is subject to periodic review and modification by us. Upon request, you may obtain a list of prescription drug products requiring prior authorization by contacting us. Your physician or pharmacist obtains the prior authorization. If prior authorization is not obtained for a prescription drug product requiring prior authorization, a paper claim with information documenting the need for the product must be submitted to us. We will then determine the level of coverage for the product. We may delegate the prior authorization function, but retain the final discretionary authority regarding coverage

IMPORTANT

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

- **Who can write your prescription.** Your prescription must be written by a duly licensed health care provider whose scope of practice permits issuing such a directive.
- **Where you can obtain them.** You may fill the prescription at a participating pharmacy, a non-network pharmacy or by mail
  - Participating pharmacy**.** You must pay the applicable copayment, listed on page 36, to the participating pharmacy. The pharmacy will submit the claim for reimbursement.
  - Non-participating pharmacy. The pharmacy network extends beyond our service area. Coverage may be provided for formulary products when there is no access to a participating pharmacy, or when you have an emergency, as defined in this brochure. We do not coordinate pharmacy benefit payments with other drug plans. A list of participating pharmacies outside the service area is available from us.

  A list of our participating retail and mail order pharmacies is provided at enrollment, and can also be obtained by contacting us.
- **We use a formulary.** An open drug formulary is a continually updated list of recommended prescription medicines that are covered at some level of cost sharing; cost sharing means that a copayment is required. Our three-tier prescription drug benefit plan is designed to help you get the medicines you need at a reasonable cost. It is a three-tier benefit plan that brings you the prescriptions you need and the choice you want. We make sure physicians and pharmacists can choose from the full range of available medications when treating patients. You'll almost always have a choice of using brand-name or generic drugs. You'll have the lowest copayment for generic preferred drugs (Tier 1) (see Definitions below), a higher copayment for brand-name preferred drugs (Tier 2) (see Definitions below), and the highest copayment for brand-name non-preferred drugs (Tier 3) (see Definitions below). You'll want to discuss your options with your primary care physician (PCP) when you receive your prescription.

Definitions:

A. **Prescription drug** means any drug, product or device approved by the U.S. Food and Drug Administration, and required by law to be dispensed only by prescription. Prescription drugs will include injectable insulin, and compound prescriptions when the compound contains at least one prescription drug.

B. **Brand name drug** means any prescription drug that is manufactured and marketed under a trade name by a specific drug manufacturer and identified as a brand name drug by the Plan. For example, "Naprosyn" is dispensed as a brand name drug while "Naproxen," its chemical equivalent, is dispensed as a generic drug.

C. **Generic drug** means any prescription drug that is dispensed under a nonproprietary name and is identified as a generic drug by the Plan. See the example in (B) above.

D. **Prescription order or refill** means the directive to dispense a prescription drug product issued by a duly licensed health care provider whose scope of practice permits issuing such a directive.

E. **Copayment** means the specified charges that you must pay each time you have a prescription drug filled or refilled. Refer to the summary of benefits for applicable copayment amounts.

F. **Drug formulary or preferred drug list** means a list that identifies those prescription drug products that are preferred by the Plan for dispensing to you when medically necessary. This list is subject to periodic review and modification by the Plan. Upon request, you may obtain a copy of the drug formulary by contacting us.

G. **Formulary product or preferred drug** means a prescription drug product identified on the drug formulary as a formulary drug.

H. **Maintenance drug** means any drug that is used to treat long lasting or chronic conditions and is included on the maintenance drug list. Refer to page 36 for the copayment amount.

I. **Participating pharmacy** means a pharmacy that has contracted with Us or our designated drug program administrator to provide prescription services to you.

J. **Prior authorization** means the process of obtaining a certification of coverage for certain prescription drug products or quantities of certain prescription drug products before they are dispensed using guidelines approved by us. The list of prescription drug products requiring prior authorization is subject to periodic review and modification by us. Upon request, you may obtain a list of prescription drug products requiring prior authorization by contacting us.

- **These are the dispensing limitations.** The Plan will pay for a prescription drug product if all of these conditions are met: (1) it is medically necessary; (2) it appears in the drug formulary; (3) it is obtained through a participating pharmacy, except in an emergency situation; (4) it is prescribed by a participating provider, except in an emergency situation; (5) it is provided while you are enrolled in the Plan; (6) it is not excluded under the exclusions section.

  If a generic drug is available it will be dispensed and covered by the Plan subject to the copayment that applies to the requested generic drug. If the requested prescription drug product is available only as a brand name drug, or if a physician orders that the prescription drug product be "dispensed as written," the brand name drug will be covered. You must pay the copayment that applies to the requested brand name drug. If you ask for a brand name drug when a generic drug exists, and your physician has not indicated "dispensed as written", you must pay the copayment that applies to the requested brand name drug plus the difference in price between the brand name drug and the generic drug.

	• **When you have to file a claim.** When you have your prescription filled at a non-participating pharmacy (emergency situations), you will need to file a claim as follows: - obtain a claim form from us or your employer - submit your receipt for the prescription with the claim form to the drug administrator whose address is printed on the claim form

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy or through our mail order program: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except as excluded below. • Insulin; a copayment charge applies to each vial • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction • Contraceptive drugs and devices • Diabetic supplies, including insulin syringes, needles, glucose test tablets and test tape, Benedict's solution or equivalent, glucose monitors and acetone test tablets	Tier 1 (generic) Prescription Drug • $6 per prescription order or refill/34-day supply • $18 per prescription order or refill/102-day supply (maintenance drugs only) Tier 2 (brand-name preferred) Prescription Drug • $12 prescription order or refill/34-day supply • $36 per prescription order or refill/102-day supply (maintenance drugs only) Tier 3 (brand-name non-preferred) Prescription Drug • $22 per prescription order or refill/34-day supply • $66 per prescription order or refill/102-day supply (maintenance drugs only) Note: If there is no generic equivalent available, you will still have to pay the brand name copayment.
Limitations: • Zyban: one course of treatment (normally 7-12 weeks, but at physician's discretion) will be covered per calendar year. Any treatment extending beyond the 12-week period must be prior approved by us	Applicable Tier copayment applies.

Not covered: • *Drugs, supplies, and prescription drug products prescribed for cosmetic purposes only;* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them;* • *Over the counter medications, including vitamins, except prenatal vitamins when prescribed by a physician;* • *Retin A for anyone over age thirty-five (35) unless accompanied by a diagnosis of Acne Vulgaris, malignant skin lesion, or premalignant skin lesion;* • *Weight loss medications or appetite suppressants;* • *Prescription drugs purchased at non-participating pharmacies (except in emergencies);* • *Prescription drug products that are prescribed, dispensed or intended for use while you are an inpatient in a hospital or other facility;* • *Compounded drugs not containing at least one ingredient requiring a prescription order;* • *Injectable drugs except when subcutaneously self-administered or when determined by the Plan to be included as part of the drug formulary;* • *Drugs for the treatment of infertility;* • *Nonprescription medications.*	*All Charges*

Section 5 (g). Special Features

Feature	Description
Health on Call (24 hour nurse line)	For any of your health concerns, 24 hours a day, 7 days a week, you may call 800/443-9480 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	We have a special line for the hearing impaired. You may call our TDD/TTY number at 1-800-735-2962
BabyWatch	If you are pregnant, you may participate in our BabyWatch program. You will receive an assessment, education, and support from a team of registered nurses who are experienced in the care of pregnant women. The BabyWatch goal is to help you deliver a healthy, full-term baby. If you have a high-risk pregnancy, you will be referred to our Case Management Department for education, monitoring, and assistance in receiving appropriate care.
Centers of excellence for transplants	All transplants are performed at Centers of Excellence as identified by the United Resources Network.

Section 5 (h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible under this Option 1.
- 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	**You Pay**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	$10 per office visit to your primary care physician $15 per office visit to a specialist Your total benefit payable for dental accidents shall be limited to $3,000 per occurrence.
Dental benefits	
Dental Anesthesia We will pay for anesthesia and hospital or facility charges for services performed in a hospital or ambulatory surgical facility in connection with dental procedures for (a) children below the age of 9 years, (b) persons with serious mental or physical conditions, and (c) persons with significant behavioral problems, when the provider treating the patient involved certifies that anesthesia is required in order to safely and effectively perform the procedures. Plan rules relating to network providers must be followed with respect to appropriate notification to the plan.	Payment shall be subject to Plan rules regarding services performed in network facilities . Refer to Section 3 "How you get care."
We have no other dental benefits.	

Section 5 (i). Point of service benefits

Point of Service (POS) Benefits

Facts about this Plan's POS option

With the Plan's Triple Option feature you decide, each and every time, how you want to obtain care.

Option 1: You see your Primary Care Physician (PCP), who treats you and/or refers you to a specialist or other provider. You simply pay a copayment and there is no deductible or coinsurance under Option 1. These are In-Network benefits and are described in detail by category in Sections 5(a)-5(h).

Option 2: You go directly to any of our network physicians, without being referred by your PCP. You will pay a $25 copayment plus 20% of your total bill for certain services. There is no deductible for Option 2.

Option 3: You go to any doctor or hospital outside our network. Option 3 requires you to obtain precertification for hospital admissions and certain outpatient services. You must satisfy an annual deductible and then pay 30% of your total medical bill.

At your option, you may choose to obtain benefits covered by this Plan from non-Plan doctors and hospitals whenever you need care. Benefits not covered under Point of Service must either be received from or arranged by Plan doctors to be covered. When you obtain covered non-emergency treatment from a non-Plan doctor without a referral from a Plan doctor, you are subject to the deductibles, coinsurance and/or maximum benefit stated below.

Using Our POS Option for Medical Benefits

What is covered	You may receive the same benefits under POS that you receive under Option 1 (In-Network). However, deductibles, coinsurance, and limitations apply.
Precertification	You are required to obtain precertification for hospital admissions and certain outpatient services under Option 3. For non-emergency admissions, you must call us at 336/716-0911 or 800/816-0911 for preadmission approval. If you fail to call, a $500 non-notification penalty will apply, unless you are physically unable to make the call.
Deductible	There is no deductible for Option 1 or Option 2 of the Plan. Option 3 has a $300 deductible per year for individuals and a $750 deductible per year for family.
Coinsurance	Once the applicable deductible is paid, the Plan will pay 80% of certain services charged under Option 2; and 70% of charges up to the Plan allowance under Option 3. You may be billed by the provider for the difference between the actual charges and the Plan allowance.
Maximum benefit	There are no annual or lifetime limits for benefits.
Out-of-pocket maximum	When the accumulated paid coinsurance reaches the annual out-of-pocket maximum, the Plan will pay 100% of all charges up to the Plan allowance for the remainder of the calendar year. You may be billed by the provider for the difference between the actual charges and the Plan allowance. The deductible paid and the copayments are not included in the out-of-pocket maximum. The out-of-pocket maximum for Option 2 is $800 for an individual and $2,000 for a family. The out-of-pocket maximum for Option 3 is $900 for an individual, and $2,250 for a family.
Hospital/extended care	You go directly to a network specialist or hospital without a referral from your PCP; the Plan will apply the appropriate coinsurance and pay under Option 2. You go directly to a non-network specialist or hospital without a referral from your PCP; the Plan will apply the appropriate deductible and coinsurance and pay under Option 3. (Hospital admissions under Option 3 require precertification.)

Emergency benefits	Emergency room visits are covered with a $50 copayment, which is waived if you are admitted to the hospital.
How to obtain benefits	The three options are available to you at the point of service - you decide, each and every time, how you want to obtain care and how much you pay for services

Using Our POS Option for Mental Health/Substance Abuse Benefits

There are no Option 2 benefits for mental health and substance abuse since these specialists are covered under Option 1. See Section 5(e) for information about In-Network services.

What is covered	You may receive the same benefits under POS that you receive under Option 1 (In-Network), however, coinsurance and limitations apply.
Precertification	You are required to obtain precertification for hospital admissions. For non-emergency admissions, you must call us at 800/475-7900 prior to your admission to a hospital or inpatient facility, or for a partial hospitalization treatment. You must pay a $500 penalty if you fail to notify us within 48 hours or by close of the next business day following admission of inpatient care unless your medical condition renders you unable to call within this time frame.
Deductible	There is no deductible for mental health or substance abuse services.
Coinsurance	You pay 30% coinsurance for up to 20 outpatient visits and/or 30 inpatient days per year; all charges thereafter.
Maximum benefit	There are no annual or lifetime limits for mental health benefits. Your substance abuse benefits are limited to a maximum of $8,000 per year and $16,000 per lifetime.
Out-of-pocket maximum	There is no out-of-pocket maximum for mental health and substance abuse benefits under Option 3 (Out-of-Network).
How to submit Out-of-Network claims	When you receive services from an out-of-network provider and file a claim with us, please forward us all of the documents for your claim as soon as possible. You must submit claims by December 31 of the year after the year you received the service. Either OPM or we can extend this deadline if you show that circumstances beyond your control prevented you from filing on time. Claims should be sent to: Carolina Behavioral Health Alliance, LLC P. O. Box 571137 Winston-Salem, NC 27157-1137

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

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

Medicare prepaid plan enrollment

This Plan offers Medicare recipients the opportunity to enroll in the Plan through Medicare. As indicated on page 49, 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 when one is available in their area. They may then later re-enroll in the FEHB Program. Most Federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will probably have to pay for hospital coverage 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 336-716-0660 or 800-273-4115 for information on the Medicare prepaid plan and the cost of that enrollment. If you are Medicare eligible and are interested in enrolling in a Medicare HMO sponsored by this Plan without dropping your enrollment in this Plan's FEHB plan, call 336-716-0660 or 800-273-4115 for information on the benefits available under the Medicare HMO.

The following services are available to Plan Members at no additional cost:

Complementary Care Alternative Health Program

As a member of our Plan, you have access to an extensive network of complementary health care providers, including chiropractors, acupuncturists and massage therapists. You may receive services from approved providers at a 25% discount off usual and customary charges. Under this program, you are also eligible for discounts and one-week introductory membership certificates at fitness clubs in all 50 states, and can access a website and mail-order catalog that offers high quality health products such as vitamins, herbal supplements, books, tapes and other products. This program is administered by American Speciality Health Network and you can call their Member Services Department toll free at 877/327-2746 for more information. Hearing impaired members may call the TDD/TTY number at 800/855-2880. Information about this program is also available on our website at www.qualchoicenc.com

Vision Care

As a member of the our Plan, you'll receive special prices and discounts on all eyewear at Visionworks, Eckerd Optical and other fine optical professionals. You'll also receive special prices on eye exams, contact lens exams and contact lenses. Here are some examples of those discounts:

Optometric Benefits	Member Pays
Regular Eye Exam	$35
Regular Price Less 20%	

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

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

See Section 3, *Services Requiring Prior Approval*.

We do not cover the following:

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

Section 7. Filing a claim for covered services

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

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 336/716-0911 or 800/816-0911.

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

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

Submit your claims to: QualChoice of North Carolina, Inc.
Claims Department
P. O. Box 340
Winston-Salem, NC 27102-0340

Prescription drugs

If you have your prescription filled at a non-participating pharmacy (emergency situations), you will need to file a claim as follows:

- obtain a claim form from us or your employer
- submit your receipt for the prescription with the claim form to the drug administrator whose address is printed on the claim form

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: P.O. Box 340, Winston-Salem, NC 27102-0340, Attn: Appeals Specialist; and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial -- go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 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.

The disputed claims process (*continued*)

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 336/716-0911 or 800/816-0911 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 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

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

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

· What is Medicare?

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

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

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

· The Original Medicare Plan

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

When you are enrolled in this Plan and Original Medicare, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your Plan PCP and/or precertified as required. We will not waive any of our copayments, coinsurance and deductibles.

(Primary payer chart begins on next page.)

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

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are an 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		✓

PLEASE NOTE: If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

- **Medicare managed care plan**

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans cover all Medicare Part A and 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 our Medicare+Choice plan: You may enroll in our Medicare+Choice plan and also remain enrolled in our FEHB Plan. In this case, we do/do not waive any of our copayments, coinsurance, or deductibles for your FEHB coverage.

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

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

Workers' Compensation

We do not cover services that:

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

Once OWCP or similar agency pays its maximum benefits for your treatment, we will provide coverage. You must use our providers.

Medicaid

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

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

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

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

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See Section 4.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. See Section 4.

Covered services

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

Custodial care

Care is considered custodial when it is primarily for personal needs and could be provided by persons without professional skills or training. Custodial care includes assisting in activities of daily living such as walking, getting in and out of bed, bathing, dressing, eating and taking medication.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See Section 4.

Experimental or investigational services

A drug, device, medical treatment or procedure that meets any of the following:

- The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished.
- Reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going clinical trials, is the research, experimental, study or investigational arm of on-going clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment of diagnosis.
- Reliable evidence, based on the prevailing opinion of experts and upon authoritative published medical and scientific literature regarding the drug, device, medical treatment or procedure, shows that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with a standard means of treatment or diagnosis.

The Medical Director decides if a drug, device, or procedure is experimental or investigational.

Medical necessity

Covered Services or supplies that are:

- Provided for the diagnosis, treatment, cure or relief of a health condition, illness, injury, or disease;
- Not for experimental, investigational, or cosmetic purposes;

- Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms;
- Within generally accepted standards of medical care in the community; and
- Not solely for the convenience of you, your family, or the provider.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Fee-for-service plans determine their allowances in different ways. Our allowance is based on the rates that we have negotiated with our network providers.

Us/We

Us and we refer to QualChoice Health Plan of North Carolina, Inc.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

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

Your medical and claims records are confidential

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

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

When you retire

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

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

- **TCC**

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

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

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

· **Converting to individual coverage**

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Inspector General Advisory

Stop health care fraud! Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 336/716-0911 or 800/816-0911 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE--202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

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

Index

Do not rely on this page; it is for your convenience and does not explain your benefit coverage.

NOTES:

Summary of benefits for the QualChoice Health Plan - 2001

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- **Option 1 Benefits (In-Network) are described below. See Section 5(i) for POS Benefits (Out-of-Network).**

Benefits	You Pay	Page
Medical services provided by physicians:		
• Diagnostic and treatment services provided in the office	Office visit copay: $10 primary care; $15 specialist	14
Services provided by a hospital:		25
• Inpatient	Nothing	
• Outpatient	Nothing	26
Emergency benefits:		28
• In-area – At doctor's office	$10 copay per visit to your primary care physician; $15 copay per visit to a specialist	
At urgent care center	$50 copay per visit	
At hospital	$50 copay per visit (copay waived if admitted to hospital)	
• Out-of-area At doctor's office	$15 copay per visit	
At urgent care center	$50 copay per visit	
At hospital	$50 copay per visit (copay waived if admitted to hospital)	
Mental health and substance abuse treatment	Regular cost sharing	30
Prescription drugs	$6 copay generic, $12 copay brand-name preferred, $22 copay brand-name non-preferred	33
Dental Care	Accidental injury benefit; limit of $3,000 per occurrence. No current benefit for preventive dental care.	39
Vision Care	No benefit. Discount applies.	42
Special features: • Health on Call (24 hour nurse line) • Services for deaf and hearing impaired • BabyWatch • Centers of excellence for transplants		38
Point of Service benefits -- Yes		40
Protection against catastrophic costs	Nothing	

2001 Rate Information for QualChoice of North Carolina, Inc.

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, but do not apply to non-career Postal employees, Postal retirees, certain special Postal employment categories or associate members of any Postal employee organization. If you are in a special Postal employment category, refer to the FEHB Guide for that category.

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	7Q1	$86.59	$35.53	$187.61	$76.98	$102.22	$19.90
High Option Self & Family	7Q2	$195.82	$101.43	$424.28	$219.76	$231.17	$66.08