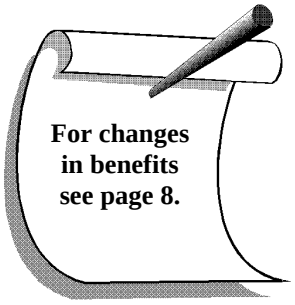
Blue Cross® and Blue Shield® Service Benefit Plan

http://www.fepblue.org

2002

A fee-for-service plan with a preferred provider organization



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

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

Enrollment codes for this Plan:

104 Standard Option - Self Only
105 Standard Option - Self and Family
111 Basic Option - Self Only
112 Basic Option - Self and Family

Authorized for distribution by the:

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

FEHB
Federal Employees
Health Benefits Program

RI 71-005

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Introduction

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

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

This brochure describes the benefits of the **Blue Cross and Blue Shield Service Benefit Plan** under our contract (CS 1039) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits 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, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means the Blue Cross and Blue Shield Service Benefit Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to the Office of Personnel Management, Insurance Planning and Evaluation Division, 1900 E Street, NW, Washington, DC 20415-3650.

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 1-800-FEP-8440 and explain the situation.
- If we do not resolve the issue, call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
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.

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

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

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

We have Preferred Provider Organizations (PPO):

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

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

Under Basic Option, you must use Preferred providers in order to receive benefits. See page 11 for the exceptions to this requirement.

How we pay professional and facility providers:

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

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

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

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

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

You must pay any difference between the amount Non-participating providers charge and our allowance, in addition to any applicable coinsurance amounts, copayment amounts, amounts applied to your calendar year deductible, and amounts for noncovered services. **Important: Under Standard Option, your out-of-pocket costs may be substantially higher when you use Non-participating providers than when you use Preferred or Participating providers.** Under Basic Option, you must use Preferred providers to receive benefits. See page 11 for the exceptions to this requirement.

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

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

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

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

- In Montana, when we pay secondary, Preferred and Participating physicians may collect the difference between the total payments made by us and the primary carrier and the billed amount.

- In South Carolina, except when we pay secondary to other Blue Cross and Blue Shield coverage, Preferred and Participating physicians may collect the difference between the total payments made by us and the primary carrier and the billed amount.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, and providers. You can also find out about care management, including medical practice guidelines, disease management programs, and how we determine if procedures are experimental or investigational. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you.

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

Section 2. How we change for 2002

Do not rely only on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 (Benefits). Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- We clarified the brochure to show why we think you should use generic drugs whenever possible. We moved other language around within the Prescription drugs section but didn't change its meaning. (Section 5(f))
- We changed the address for sending disputed claims to OPM. (Section 8)
- Georgia, Montana, North Dakota, and Texas are added to and Louisiana is deleted from the list of states designated as medically underserved in 2002. (Section 3)

Changes to this Plan

- Your share of the non-Postal Standard Option premium will increase by 20.0% for Self Only or 17.2% for Self and Family.
- We have merged our High Option into Standard Option. High Option is no longer available.
- We have added a new option called **Basic Option**.
  - You pay no deductible under Basic Option.
  - You must use Preferred providers in order to receive benefits (see page 11 for the exceptions to this requirement).
  - Please carefully review this brochure, including Section 5 (Benefits), to understand Basic Option benefits. If you have any questions about Basic Option, please call us at the customer service telephone number on the back of your Service Benefit Plan ID card.
- We have discontinued our Point of Service (POS) pilot program.
- Under Standard Option, your catastrophic protection out-of-pocket limit is now $4,000 per contract when you use only Preferred providers and $6,000 per contract when you use a combination of Preferred and Non-preferred providers. Previously, your catastrophic protection out-of-pocket limit was $3,000 (Preferred only) and $5,000 (Preferred and Non-preferred). (Section 4)
- We now provide benefits at Preferred benefit levels for covered services performed by certain other covered health care professionals (for example, nurse practitioners, audiologists, nurse anesthetists, etc.) that contract with Local Plans. (Section 3)
- We now provide benefits at Preferred benefit levels for covered services performed in Preferred facilities by covered Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, and emergency room physicians. (Sections 5(a) and 5(b))
- We now provide benefits for routine screening for chlamydial infection. (Section 5(a))
- We now provide benefits for organ/tissue transplants to include autologous stem cell support for amyloidosis. (Section 5(b))
- We now provide benefits for organ/tissue transplants in clinical trials to include nonmyeloablative allogeneic stem cell transplants for chronic myelogenous leukemia, acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced forms of myelodysplastic syndromes, multiple myeloma, chronic lymphocytic leukemia, early stage (indolent or non-advanced) small cell lymphocytic lymphoma, and renal cell carcinoma. (Section 5(b))
- Under Standard Option, we now provide benefits in full for ambulance services provided in connection with, and within 72 hours after, an accidental injury. (Section 5(d))
- We now provide benefits for dental accidental injury only when treatment is started promptly and completed within 12 months of the accident. (Section 5(h))
- Under Standard Option, your Mail Service Prescription Drug Program copayments have changed: for generic drugs the copayment has decreased to $10 and for brand-name drugs the copayment has increased to $35. Previously, the Mail Service Prescription Drug Program copayments were $12 for generic drugs and $20 for brand-name drugs. (Section 5(f))
- We now treat smoking cessation services the same as other medical or mental health/substance abuse services. Previously, under Standard Option, smoking cessation services were limited to $100 of coverage per lifetime. In addition, we no longer limit smoking cessation drugs to one course of treatment per year; additional courses of treatment do require prior approval and participation in a smoking cessation program. (Sections 3, 5(a), 5(e), and 5(f))

Section 3. How you receive benefits

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call the Local Plan serving the area where you reside and ask them to assist you, or write to us directly at: FEP Enrollment Services, 550 12th Street, SW, Washington, DC 20065-1463.

Where you get covered care

Under Standard Option, you can get care from any "covered professional provider" or "covered facility provider." How much we pay – and you pay – depends on the type of covered provider you use. If you use our Preferred, Participating, or Member providers, you will pay less.

Under Basic Option, you **must** use those "covered professional providers" or "covered facility providers" that are **Preferred providers** for Basic Option in order to receive benefits. Please refer to page 11 for the exceptions to this requirement. Refer to page 6 for more information about Preferred providers.

- **Covered professional providers**

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

Physicians – Doctors of medicine (M.D.); osteopathy (D.O.); dental surgery (D.D.S.); medical dentistry (D.M.D.); podiatric medicine (D.P.M.); and optometry (O.D.). For Basic Option, the term "primary care provider" includes family practitioners, general practitioners, medical internists, pediatricians, and obstetricians/gynecologists.

Other Covered Health Care Professionals – Professionals who provide additional covered services and meet the state's applicable licensing or certification requirements and the requirements of the Local Plan. Other covered health care professionals include:

- **Clinical Psychologist –** A psychologist who (1) is licensed or certified in the state where the services are performed; (2) has a doctoral degree in psychology (or an allied degree if, in the individual state, the academic licensing/certification requirement for clinical psychologist is met by an allied degree) or is approved by the Local Plan; and (3) has met the clinical psychological experience requirements of the individual State Licensing Board.
- **Clinical Social Worker –** A social worker who (1) has a master's or doctoral degree in social work; (2) has at least two years of clinical social work practice; and (3) if the state requires it, is licensed, certified, or registered as a social worker where the services are performed.
- **Independent Laboratory –** A laboratory that is licensed under state law or, where no licensing requirement exists, that is approved by the Local Plan.
- **Nurse Midwife –** A person who is certified by the American College of Nurse Midwives or, if the state requires it, is licensed or certified as a nurse midwife.
- **Nurse Practitioner/Clinical Specialist –** A person who (1) has an active R.N. license in the United States; (2) has a baccalaureate or higher degree in nursing; and (3) if the state requires it, is licensed or certified as a nurse practitioner or clinical nurse specialist.

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

Medically underserved areas. In states that OPM determines are "medically underserved":

Under Standard Option, we cover any licensed medical practitioner for any covered service performed within the scope of that license.

Under Basic Option, we cover any licensed medical practitioner who is **Preferred** for any covered service performed within the scope of that license.

For 2002, the states are: Alabama, Georgia, Idaho, Kentucky, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Texas, Utah, and Wyoming.

- **Covered facility providers**

Covered facilities include those listed below, when they meet the state's applicable licensing or certification requirements.

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

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

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

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

(1) Provides services in an outpatient setting;
(2) Contains permanent amenities and equipment primarily for the purpose of performing medical, surgical, and/or renal dialysis procedures;

(3) Provides treatment performed or supervised by doctors and/or nurses, and may include other professional services performed at the facility; and
(4) Is not, other than incidentally, an office or clinic for the private practice of a doctor or other professional.

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

– **Cancer Research Facility** – A facility that is:

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

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

What you must do to get covered care

Under Standard Option, you can go to any covered provider you want, but in some circumstances, we must approve your care in advance.

Under Basic Option, you **must** use **Preferred** providers in order to receive benefits, except under the special situations listed below. In addition, we must approve certain types of care in advance. Please refer to Section 4, *Your costs for covered services*, for related benefits information.

(1) Medical emergency or accidental injury care in a hospital emergency room and related ambulance transport as described in Section 5(d), *Emergency services/accidents*;
(2) Professional care provided by certain Non-preferred providers (radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons) at Preferred facilities;
(3) Laboratory and pathology services, X-rays, and diagnostic tests billed by Non-preferred laboratories, radiologists, and outpatient facilities;
(4) Services of assistant surgeons;
(5) Special provider access situations (contact your Local Plan for more information); or
(6) Care received outside the United States and Puerto Rico.

Unless otherwise noted in Section 5, when services of Non-preferred providers are covered in a special exception, benefits will be provided based on the Plan allowance. You are responsible for the applicable coinsurance or copayment, and may also be responsible for any difference between our allowance and the billed amount.

Transitional care:

Specialty Care: If you have a chronic or disabling condition and

- lose access to your specialist because we drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan, or

- lose access to your Preferred specialist because we terminate our contract with your specialist for other than cause,

you may be able to continue seeing your specialist and receiving any Preferred benefits 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 and any Preferred benefits will continue until the end of your postpartum care, even if it is beyond the 90 days.

Hospital care:

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

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

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

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

How to get approval for…

• Your hospital stay

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition. Unless we are misled by the information given to us, we will not change our decision on medical necessity.

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

Warning:

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

How to precertify an admission:

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

Maternity care

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

If your hospital stay needs to be extended:

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

What happens when you do not follow the precertification rules

- When we precertified the admission but you remained in the hospital beyond the number of days we approved and you did not get the additional days precertified, then:
  - for the part of the admission that was medically necessary, we will pay inpatient benefits, but
  - for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and we will not pay inpatient benefits.
- If no one contacted us, we will decide whether the hospital stay was medically necessary.
  - If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty. [See Section 5(c) for payment information.]
  - If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.
- If we denied the precertification request, we will not pay inpatient hospital benefits or inpatient physician care benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

Exceptions:

You do not need precertification in these cases:

- You are admitted to a hospital outside the United States.
- You have another group health insurance policy that is the primary payer for the hospital stay.
- Your Medicare Part A is the primary payer for the hospital stay.

  Note: If you exhaust your Medicare hospital benefits and do not want to use your Medicare lifetime reserve days, then we will become the primary payer and you **do** need precertification.

• Other services

These services require prior approval under both Standard and Basic Option:

- **Home hospice care –** Contact us at the customer service number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination and advise you which home hospice care agencies we have approved.
- **Partial hospitalization or intensive outpatient treatment for mental health/substance abuse –** Contact us at the mental health and substance abuse number listed on the back of your ID card before obtaining services for intensive outpatient treatment or partial hospitalization. We will request the medical evidence we need to make our coverage determination. We will also consider the necessary duration of either of these services.

- **Organ/tissue transplants –** Contact us at the customer service number listed on the back of your ID card before obtaining services. We will request the medical evidence we need to make our coverage determination. We will consider whether the facility is approved for the procedure and whether you meet the facility's criteria.
- **Clinical trials for certain organ/tissue transplants –** Contact our Clinical Trials Information Unit at 1-800-225-2268 for information or to request prior approval before obtaining services. We will request the medical evidence we need to make our coverage determination. Use this number **only** for prior approval of clinical trials for bone marrow and peripheral blood stem cell transplant support procedures for those conditions shown on page 52 as covered only in clinical trials.
- **Cardiac rehabilitation –** Contact us at the customer service number listed on the back of your ID card prior to starting treatment. We will request the information we need to make our coverage determination.
- **Prescription drugs –** Certain prescription drugs require prior approval. Contact our Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077 for the hearing impaired) to request prior approval, or to obtain an updated list of prescription drugs that require prior approval. We will request the information we need to make our coverage determination. You must periodically renew prior approval for certain drugs. See page 83 for more about our prescription drug prior approval program, which is part of our Patient Safety and Quality Monitoring (PSQM) program.

  Note: Benefits for drugs to aid smoking cessation that require a prescription by Federal law are limited to one course of treatment per calendar year. Prior approval is required before benefits will be provided for additional medication. To obtain approval, the physician must certify the patient is participating in a smoking cessation program that provides clinical treatment, including counseling and behavioral therapies.

  Note: Until we approve them, you must pay for these drugs in full when you purchase them – even if you purchase them at a Preferred retail pharmacy or through an internet pharmacy – and submit the expense(s) to us on a claim form. Preferred pharmacies will not file these claims for you.

  Under **Standard Option,** members may use our Mail Service Prescription Drug Program to fill their prescriptions. However, the Mail Service Prescription Drug Program also will not fill your prescription until you have obtained prior approval. Merck-Medco Rx Services, the administrator of the Mail Service Prescription Drug Program, will return your prescription to you along with a Prior Approval Request Form and a letter explaining the prior approval procedures.

  The Mail Service Prescription Drug Program is not available under **Basic Option**.

In addition to the types of care listed above, these services also require prior approval under Basic Option:

- **Outpatient mental health and substance abuse treatment – You must call us** at the number listed on the back of your ID card for mental health and substance abuse **before receiving any outpatient professional or facility care**. We will then provide you with the names and phone numbers of several Preferred providers to choose from and tell you how many visits we are initially approving.

Section 4. Your costs for covered services

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

- **Copayments**

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

Example: Under Standard Option, when you see your Preferred physician, you pay a copayment of $15 per visit and when you go in a Preferred hospital, you pay $100 per admission. We then pay the remainder of the bill for covered services.

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

- **Deductible**

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

Under Standard Option, the calendar year deductible is $250 per person. Under a family enrollment, the calendar year deductible for each family member is satisfied and benefits are payable for all family members when the combined covered expenses of the family reach $500.

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

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

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

Under Basic Option, there is **no calendar year deductible**.

- **Coinsurance**

Coinsurance is the percentage of the Plan allowance that you must pay for your care. Your coinsurance is based on the Plan allowance, or billed amount, whichever is less. **Under Standard Option only,** coinsurance does not begin until you meet your deductible.

Example: You pay 10% of the Plan allowance under Standard Option for durable medical equipment obtained from a Preferred provider, after meeting your $250 calendar year deductible.

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

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

- **Waivers**

In some instances, a Preferred, Participating, or Member provider may ask you to sign a "waiver" prior to receiving care. This waiver may state that you accept responsibility for the total charge for any care that is not covered by your health plan. If you sign such a waiver, whether you are responsible for the total charge depends on the content of the contracts that the Local Plan has with its providers. If you are asked to sign this type of waiver, please be aware that, if benefits are denied for the services, you could be legally liable for the related expenses. If you would like more information about waivers, please contact us at the customer service number on the back of your ID card.

- **Differences between our allowance and the bill**

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

Often, the provider's bill is more than a fee-for-service plan's allowance. Whether or not you have to pay the difference between our allowance and the bill will depend on the type of provider you use. In this Plan, we have the following types of providers:

- **Preferred providers.** These types of providers have agreements with the Local Plan to limit what they bill our members**.** Because of that, when you use a Preferred provider, your share of the provider's bill for covered care is limited.

  Under Standard Option, your share consists only of your deductible and coinsurance or copayment. Here is an example of coinsurance: You see a Preferred physician who charges $150, but our allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 10% of our $100 allowance ($10). Because of the agreement, your Preferred physician will not bill you for the $50 difference between our allowance and his/her bill. See page 7 for exceptions.

  Under Basic Option, your share consists only of your copayment or coinsurance amount, since there is no calendar year deductible. Here is an example involving a copayment: You see a Preferred physician who charges $150 for covered services subject to a $20 copayment. Even though our allowance may be $100, you still pay just the $20 copayment. Because of the agreement, your Preferred physician will not bill you for the $130 difference between your copayment and his/her bill.

  Remember, under Basic Option, you must use Preferred providers in order to receive benefits. See page 11 for the exceptions to this requirement.

- **Participating providers.** These types of **Non-preferred providers** have agreements with the Local Plan to limit what they bill our **Standard Option** members.

  Under Standard Option, when you use a Participating provider, your share of covered charges consists only of your deductible and coinsurance or copayment. Here is an example: You see a Participating physician who charges $150, but the Plan allowance is $100. If you have met your deductible, you are only responsible for your coinsurance. That is, under Standard Option, you pay just 25% of our $100 allowance ($25). Because of the agreement, your Participating physician will not bill you for the $50 difference between our allowance and his/her bill. See page 7 for exceptions.

  Under Basic Option, there are no benefits for care performed by Participating providers; you pay all charges. See page 11 for the exceptions to this requirement.

- **Non-participating providers.** These Non-preferred providers have no agreement to limit what they will bill you.

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

  Under Basic Option, there are no benefits for care performed by Non-participating providers; you pay all charges. See page 11 for the exceptions to this requirement.

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

EXAMPLE	Preferred physician Standard Option	Preferred physician Basic Option	Participating physician (Standard Option*)	Non-participating physician (Standard Option*)
Physician's charge	$150	$150	$150	$150
Our allowance	We set it at: 100	We set it at: 100	We set it at: 100	We set it at: 100
We pay	90% of our allowance: 90	Our allowance less copay: 80	75% of our allowance: 75	75% of our allowance: 75
You owe: Coinsurance	10% of our allowance: 10	Not applicable	25% of our allowance: 25	25% of our allowance: 25
You owe: Copayment	Not applicable	20	Not applicable	Not applicable
+Difference up to charge?	No: 0	No: 0	No: 0	Yes: 50
TOTAL YOU PAY	$10	$20	$25	$75

***Under Basic Option, there are no benefits for care performed by Participating and Non-participating physicians. You must use Preferred providers in order to receive benefits.** See page 11 for the exceptions to this requirement.

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

- **Overseas providers.** We pay overseas claims at Preferred benefit levels, using an Overseas Fee Schedule as our Plan allowance. Most overseas professional providers are under no obligation to accept our allowance, and you must pay any difference between our payment and the provider's bill. For facility care you receive overseas, we provide benefits in full after you pay the applicable copayment or coinsurance. See Section 5(g) for more information about our overseas benefits.

- **Dental care. Under Standard Option,** we pay scheduled amounts for routine dental services and you pay any balance. **Under Basic Option,** you pay $20 for any covered evaluation and we pay the balance for covered services. See Section 5(h) for a listing of covered dental services.
- **Hospital care.** You pay the coinsurance or copayment amounts listed in Section 5(c). **Under Standard Option,** you must meet your deductible before we begin providing benefits for certain hospital-billed services. **Under Basic Option,** you must use **Preferred** facilities in order to receive benefits. See page 11 for the exceptions to this requirement.

Your catastrophic protection out-of-pocket maximum

If the total amount of out-of-pocket expenses in a calendar year for you and your covered family members for deductibles (Standard Option only), coinsurance, and copayments (other than those listed below) exceeds $6,000 under Standard Option, or $5,000 under Basic Option, then you and any covered family members will not have to continue paying them for the remainder of the calendar year.

Standard Option Preferred maximum: If the total amount of these out-of-pocket expenses from using Preferred providers for you and your covered family members exceeds $4,000 in a calendar year under Standard Option, then you and any covered family members will not have to pay these expenses for the remainder of the calendar year when you continue to use Preferred providers. You will, however, have to pay them when you use Non-preferred providers, until your out-of-pocket expenses (for the services of both Preferred and Non-preferred providers) reach $6,000 under Standard Option, as shown above.

Basic Option maximum: If the total amount of these out-of-pocket expenses from using Preferred providers for you and your covered family members exceeds $5,000 in a calendar year under Basic Option, then you and any covered family members will not have to pay these expenses for the remainder of the calendar year.

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

- The difference between the Plan allowance and the billed amount. See pages 16-17;
- Expenses for services, drugs, and supplies in excess of our maximum benefit limitations;
- Under Standard Option, your 30% coinsurance for inpatient care in a Non-member hospital;
- Under Standard Option, your 25% coinsurance for outpatient care by a Non-member facility;
- Your expenses for mental conditions and substance abuse care by a Non-preferred professional or facility provider;
- Your expenses for dental services in excess of our fee schedule payments under Standard Option. See Section 5(h);
- The $500 penalty for failing to obtain precertification, and any other amounts you pay because we reduce benefits for not complying with our cost containment requirements;
- Under Basic Option, coinsurance you pay for non-formulary brand-name drugs; and
- Under Basic Option, your expenses for care received from Participating/Non-participating professional providers or Member/Non-member facilities, except for coinsurance and copayments you pay in those special situations where we do pay for care provided by Non-preferred providers. Please see page 11 for the exceptions to the requirement to use Preferred providers.

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

- If you had already paid the out-of-pocket maximum, we will continue to provide benefits as described on page 18 until the effective date of your new plan.
- If you had not yet paid the out-of-pocket maximum, we will apply any expenses you incur in January (before the effective date of your new plan) to our prior year's out-of-pocket maximum. Once you reach the maximum, you don't need to pay our deductibles, copayments or coinsurance amounts (except as shown on page 18) from that point until the effective date of your new plan.

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

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

When government facilities bill us

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from us for certain services and supplies they provide to you or a family member. They may not seek more than their governing laws allow.

If we overpay you

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

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

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

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

If you…

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

Then, for your inpatient hospital care,

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

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

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

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

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

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

When you have the Original Medicare Plan (Part A, Part B, or both)

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

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

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

- If your physician accepts Medicare assignment, then you pay nothing for covered charges.

- If your physician does not accept Medicare assignment, then you pay the difference between our payment combined with Medicare's payment, and the charge.

Note: **Under Basic Option,** you must see **Preferred** providers in order to receive benefits. See page 11 for the exceptions to this requirement.

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

When you have a Medicare Private Contract

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

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

Section 5. Benefits -- OVERVIEW

(See page 8 for how our benefits changed this year and pages 118-119 for a benefits summary.)

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

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option,** the calendar year deductible is $250 per person ($500 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- **Under Basic Option,** there is **no calendar year deductible**.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See page 11 for the exceptions to this requirement.**
- Please refer to Section 3, *How you receive benefits*, for a list of providers we consider to be primary care providers (under Basic Option) and other health care professionals.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.
- The amounts listed below are for the charges billed by a physician or other health care professional for your medical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital or other outpatient facility, etc.).
- The non-PPO benefits are the standard benefits for Standard Option. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

IMPORTANT

Benefit Description	You Pay	
NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Diagnostic and treatment services	**You Pay – Standard Option**	**You Pay – Basic Option**
Professional services of physicians and other health care professionals: • Outpatient consultations • Outpatient second surgical opinions • Office visits • Home visits • Initial examination of a newborn needing definitive treatment when covered under a family enrollment	Preferred: $15 copayment for the office visit charge (No deductible) Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges

Diagnostic and treatment services – *continued on next page*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Diagnostic and treatment services *(continued)*	**You Pay – Standard Option**	**You Pay – Basic Option**
Outpatient professional services: • Pharmacotherapy [see Section 5(f) for prescription drug coverage] • Neurological testing	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges
Inpatient professional services: • During a hospital stay • Services for nonsurgical procedures when ordered, provided, and billed by a physician during a covered inpatient hospital admission • Medical care by the attending physician (the physician who is primarily responsible for your care when you are hospitalized) on days we pay inpatient hospital benefits ***Note:*** A consulting physician employed by the hospital is not the attending physician. • Consultations when requested by the attending physician • Concurrent care – hospital inpatient care by a physician other than the attending physician for a condition not related to your primary diagnosis, or because the medical complexity of your condition requires this additional medical care • Physical therapy by a physician other than the attending physician • Initial examination of a newborn needing definitive treatment when covered under a family enrollment • Pharmacotherapy [see Section 5(c) for prescription drug coverage] • Neurological testing • Second surgical opinion	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** We provide benefits at 90% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, and emergency room physicians. You are responsible for any difference between our allowance and the billed amount.	Preferred: Nothing Participating/Non-participating: You pay all charges ***Note:*** We provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons. You are responsible for any difference between our allowance and the billed amount.

Diagnostic and treatment services – *continued on next page*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Diagnostic and treatment services *(continued)*	**You Pay – Standard Option**	**You Pay – Basic Option**
Not covered: • *Routine services except for those Preventive care services described on pages 27-30* • *Inpatient private duty nursing* • *Standby physicians* • *Routine radiological and staff consultations required by hospital rules and regulations* • *Inpatient physician care when your hospital admission or portion of an admission is not covered [see Section 5(c)]* ***Note:*** *If we determine that a hospital admission is not covered, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.*	*All charges*	*All charges*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Lab, X-ray, and other diagnostic tests	**You Pay – Standard Option**	**You Pay – Basic Option**
Diagnostic tests provided, or ordered and billed by a physician, such as: • Blood tests • CT scans/MRIs • EKGs and EEGs • Laboratory tests • Pathology services • Ultrasounds • Urinalysis • X-rays Laboratory and pathology services billed by an independent laboratory ***Note:*** See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note*:** If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay a separate $20 copayment, plus any difference between our allowance and the billed amount.
Other diagnostic tests provided, or ordered and billed by a physician, such as: • Fecal occult blood tests • Non-routine mammograms • Non-routine Pap tests • Prostate Specific Antigen (PSA) tests • Sigmoidoscopies ***Note:*** See Section 5(c) for services billed for by a facility, such as the outpatient department of a hospital.	Preferred: $15 copayment for associated office visits (No deductible); nothing for services or tests Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note*:** If your Preferred provider uses a Non-preferred laboratory or radiologist, we will pay Non-preferred benefits for any laboratory and X-ray charges.	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay a separate $20 copayment, plus any difference between our allowance and the billed amount.

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Preventive care, adult	**You Pay – Standard Option**	**You Pay – Basic Option**
Home and office visits for routine (screening) physical examinations **Under Standard Option,** benefits are limited to the following services when performed as part of a routine physical examination: • History and risk assessment • Chest X-ray • EKG • Urinalysis • Basic or comprehensive metabolic panel test • CBC • Cholesterol tests (may be done by any independent laboratory) • Chlamydial infection test **Under Basic Option,** benefits are provided for all of the services listed above and for other appropriate screening tests and services. ***Note:*** These benefits do not apply to children up to age 22. (See benefits under *Preventive care, children*, this section.)	Preferred: $15 copayment for the examination (No deductible); nothing for services or tests ***Note:*** We cover one routine physical examination every three calendar years for members under age 65 and one each calendar year for members age 65 and older. ***Note:*** We provide benefits for adult routine physical examinations only when you receive these services from a **Preferred provider.** Participating: You pay all charges Non-participating: You pay all charges ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay a separate $20 copayment, plus any difference between our allowance and the billed amount. ***Note:*** See Section 5(c) for our payment levels for these services when billed for by a facility, such as the outpatient department of a hospital.

Preventive care, adult – *continued on next page*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Preventive care, adult *(continued)*	**You Pay – Standard Option**	**You Pay – Basic Option**
Cancer screening • Colorectal cancer screening, including: – Fecal occult blood test – Sigmoidoscopy • Prostate cancer screening – Prostate Specific Antigen (PSA) test • Cervical cancer screening • Breast cancer screening (routine mammograms)	Preferred: $15 copayment for associated office visits (No deductible); nothing for services or tests ***Note*:** We provide benefits in full for preventive (screening) tests and immunizations only when you receive these services from a **Preferred provider** on an outpatient basis. If these services are billed separately from the routine physical examination, you may be responsible for paying an additional copayment for each office visit billed. Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay a separate $20 copayment, plus any difference between our allowance and the billed amount. ***Note:*** See Section 5(c) for our payment levels for these services when billed for by a facility, such as the outpatient department of a hospital.

Preventive care, adult – *continued on next page*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Preventive care, adult *(continued)*	**You Pay – Standard Option**	**You Pay – Basic Option**
Cancer screening *(continued)*	***Note:*** If you go to a Participating or Non-participating provider for these services, the following limits apply: • Fecal occult blood test – one annually starting at age 40 • Sigmoidoscopy – one every five years starting at age 50 • Prostate Specific Antigen (PSA) test – one annually for males age 40 and older • Cervical cancer screening – one routine Pap test annually for females of any age • Breast cancer screening – routine mammograms for females age 35 and older, as follows –From age 35 through 39, one during this five-year period –From age 40 through 64, one annually –At age 65 and older, one every two consecutive calendar years ***Note*:** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	See page 28

Preventive care, adult – *continued on next page*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Preventive care, adult *(continued)*	**You Pay – Standard Option**	**You Pay – Basic Option**
Routine immunizations without regard to age, limited to: • Hepatitis immunizations (Types A and B) for patients with increased risk or family history • Influenza and pneumococcal vaccines, annually • Lyme disease vaccine • Tetanus-diphtheria (Td) booster – once every 10 years	Preferred: $15 copayment for associated office visits (No deductible); nothing for immunizations Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $20 copayment for associated office visits; nothing for immunizations Preferred specialist: $30 copayment for associated office visits; nothing for immunizations Participating/Non-participating: You pay all charges
Not covered: Office visit charges associated with preventive services and routine immunizations performed by Participating and Non-participating providers	*All charges*	*All charges*
Preventive care, children		
We provide benefits for the following services: • All healthy newborn visits including routine screening (inpatient or outpatient) • The following routine services as recommended by the American Academy of Pediatrics for children up to the age of 22, including children living, traveling, or adopted from outside the United States: – Routine physical examinations – Routine hearing tests – Laboratory tests – Immunizations – Related office visits	Preferred: Nothing (No deductible) Participating: Nothing (No deductible) Non-participating: Nothing (No deductible) up to the Plan allowance. You are responsible only for any difference between our allowance and the billed amount. ***Note:*** When billed by a facility, such as the outpatient department of a hospital, we provide benefits as shown here, according to the contracting status of the facility.	Preferred primary care provider or other health care professional: $20 copayment per visit; you pay nothing for inpatient visits Preferred specialist: $30 copayment per visit; you pay nothing for inpatient visits Participating/Non-participating: You pay all charges ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay a separate $20 copayment, plus any difference between our allowance and the billed amount. ***Note:*** See Section 5(c) for our payment levels for these services when billed for by a facility, such as the outpatient department of a hospital.

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.

Maternity care	You Pay – Standard Option	You Pay – Basic Option
Complete maternity (obstetrical) care including related conditions resulting in childbirth or miscarriage when provided, or ordered and billed by a physician or nurse midwife, such as: • Prenatal care • Delivery • Postpartum care ***Note*:** Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay, if medically necessary, but you, your representative, your doctor, or your hospital must precertify the extended stay. See Section 3 for information on requesting additional days. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay, or if the child is covered under the father's Self and Family enrollment. ***Note:*** When a newborn requires definitive treatment including incubation charges by reason of prematurity or evaluation for medical or surgical reasons during or after the mother's confinement, the newborn is considered a patient in his or her own right. Expenses of the newborn including circumcision are eligible for benefits only if the child is covered by a Self and Family enrollment. ***Note:*** We pay assistant surgeon services (delivery) and anesthesia the same as for illness or injury. **See Surgical and anesthesia benefits in Section 5(b).**	Preferred: Nothing (No deductible) ***Note:*** For facility care related to maternity, including care at birthing facilities, we waive the per admission copayment and pay for covered services in full when you use Preferred providers. Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment for the delivery; nothing for prenatal and postpartum care ***Note:*** For facility care related to maternity, including care at birthing facilities, see Section 5(c). Participating/Non-participating: You pay all charges ***Note:*** For services billed by Participating and Non-participating laboratories and radiologists, you are responsible only for any difference between our allowance and the billed amount.
Not covered: Procedures, services, drugs, and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest	*All charges*	*All charges*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Family planning	**You Pay – Standard Option**	**You Pay – Basic Option**
A broad range of voluntary family planning services, limited to: • Depo-Provera • Diaphragms • Intrauterine devices (IUDs) • Norplant • Oral contraceptives • Voluntary sterilization ***Note:*** See Section 5(f) for prescription drug coverage.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay $100 for related surgical procedures. See Section 5(b) for our coverage for related surgical procedures. Participating/Non-participating: You pay all charges
Not covered: • *Reversal of voluntary surgical sterilization* • *Contraceptive devices not described above*	*All charges*	*All charges*
Infertility services		
Diagnosis and treatment of infertility, except as shown in *Not Covered* ***Note:*** See Section 5(f) for prescription drug coverage.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay a separate $20 copayment, plus any difference between our allowance and the billed amount.

Infertility services – *continued on next page*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Infertility services *(continued)*	**You Pay – Standard Option**	**You Pay – Basic Option**
Not covered: • *Assisted reproductive technology (ART) procedures, such as:* – *artificial insemination (AI)* – *in vitro fertilization (IVF)* – *embryo transfer and Gamete Intrafallopian Transfer (GIFT)* – *intravaginal insemination (IVI)* – *intracervical insemination (ICI)* – *intrauterine insemination (IUI)* • *Services and supplies related to ART procedures, such as sperm banking*	*All charges*	*All charges*
Allergy care		
• Testing and treatment, including materials (such as allergy serum) • Allergy injections	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $20 copayment per visit; nothing for injections Preferred specialist: $30 copayment per visit; nothing for injections Participating/Non-participating: You pay all charges ***Note:*** For services billed by Participating and Non-participating laboratories or radiologists, you pay a separate $20 copayment, plus any difference between our allowance and the billed amount.
Not covered: Provocative food testing and sublingual allergy desensitization	*All charges*	*All charges*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Treatment therapies	**You Pay – Standard Option**	**You Pay – Basic Option**
Outpatient treatment therapies: • Chemotherapy and radiation therapy ***Note*:** We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under Organ/tissue transplants in Section 5(b). See also, *Services requiring our prior approval*, in Section 3. • Renal dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/infusion therapy – Home IV or infusion therapy ***Note:*** Home nursing visits associated with Home IV/infusion therapy are covered as shown under Home health services on page 41. • Pharmacotherapy [see Section 5(f) for prescription drug coverage] • Outpatient cardiac rehabilitation (Prior approval is required. See Section 3.) ***Note:*** See Section 5(c) for our payment levels for treatment therapies billed for by the outpatient department of a hospital.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges ***Note:*** You pay 30% of the Plan allowance for drugs and supplies related to outpatient treatment therapies.
Inpatient treatment therapies: • Chemotherapy and radiation therapy ***Note*:** We cover high dose chemotherapy and/or radiation therapy in connection with bone marrow transplants, and drugs or medications to stimulate or mobilize stem cells for transplant procedures, only for those conditions listed as covered under Organ/tissue transplants in Section 5(b). See also, *Services requiring our prior approval*, in Section 3. • Renal dialysis – Hemodialysis and peritoneal dialysis • Pharmacotherapy [see Section 5(f) for prescription drug coverage]	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** We provide benefits at 90% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, and emergency room physicians. You are responsible for any difference between our allowance and the billed amount.	Preferred: Nothing Participating/Non-participating: You pay all charges ***Note:*** We provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons. You are responsible for any difference between our allowance and the billed amount.

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Physical therapy	**You Pay – Standard Option**	**You Pay – Basic Option**
When performed by a physical therapist or physician: • Physical therapy • Acupuncture as a physical therapy modality and for pain management ***Note:*** See Section 5(c) for our payment levels for physical therapy performed in and billed by the outpatient department of a hospital. ***Note:*** When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for professional care, according to the contracting status of the therapist.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** Benefits are limited to 50 visits per person, per calendar year. ***Note*:** Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** Benefits are limited to 50 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three. Participating/Non-participating: You pay all charges
Not covered: • *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay* • *Maintenance or palliative rehabilitative therapy* • *Exercise programs* • *Hippotherapy (exercise on horseback)*	*All charges*	*All charges*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Occupational and speech therapies	**You Pay – Standard Option**	**You Pay – Basic Option**
Occupational and speech therapy when performed by an occupational therapist, speech therapist, or physician ***Note:*** See Section 5(c) for our payment levels for occupational and speech therapy performed in and billed by the outpatient department of a hospital. ***Note:*** When billed by a skilled nursing facility, nursing home, or extended care facility, we pay benefits as shown here for professional care, according to the contracting status of the therapist.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** Benefits are limited to 25 visits per person, per calendar year for occupational therapy or speech therapy, or a combination of both. ***Note*:** Visits that you pay for while meeting your calendar year deductible count toward the limit cited above.	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** Benefits are limited to 50 visits per person, per calendar year for physical, occupational, or speech therapy, or a combination of all three. Participating/Non-participating: You pay all charges
Not covered: • *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay* • *Maintenance or palliative rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Hearing services (testing, treatment, and supplies)	**You Pay – Standard Option**	**You Pay – Basic Option**
Hearing tests related to illness or injury	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges
Not covered: • *Routine hearing tests (except as indicated under Preventive care, children)* • *Hearing aids (including implanted bone conduction hearing aids)* • *Testing and examinations for the prescribing or fitting of hearing aids*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)		
• One pair of eyeglasses, replacement lenses, or contact lenses to correct an impairment directly caused by a single instance of accidental ocular injury or intraocular surgery ***Note:*** This benefit may also be used to obtain one pair of eyeglasses or lenses prescribed in lieu of surgery when the condition can be corrected by surgery, but surgery is precluded because of age or medical condition.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
• Eye examinations related to a specific medical condition • Nonsurgical treatment for amblyopia and strabismus, for children from birth through age 12 ***Note:*** See Section 5(b), *Surgical procedures*, for coverage for surgical treatment of amblyopia and strabismus.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges

Vision services (testing, treatment, and supplies) – *continued on next page*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Vision services (testing, treatment, and supplies) *(continued)*	**You Pay – Standard Option**	**You Pay – Basic Option**
Not covered: • *Eyeglasses, contact lenses, routine eye examinations, or vision testing for the prescribing or fitting of eyeglasses or contact lenses, except as described on page 37* • *Eye exercises, visual training, or orthoptics, except for nonsurgical treatment of amblyopia and strabismus as described on page 37* • *LASIK, radial keratotomy, and other refractive services*	*All charges*	*All charges*
Foot care		
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes ***Note*:** See orthopedic and prosthetic devices for information on podiatric shoe inserts. ***Note:*** See Section 5(b) for our coverage for surgical procedures.	Preferred: $15 copayment for the office visit (No deductible); 10% of the Plan allowance for all other services (deductible applies) Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges
Not covered: Routine foot care, such as cutting, trimming, or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above	*All charges*	*All charges*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Orthopedic and prosthetic devices	**You Pay – Standard Option**	**You Pay – Basic Option**
Orthopedic braces and prosthetic appliances such as: • Artificial limbs and eyes • Functional foot orthotics when prescribed by a physician • Rigid devices attached to the foot or a brace, or placed in a shoe • Replacement, repair, and adjustment of covered devices • Following a mastectomy, breast prostheses and surgical bras, including necessary replacements ***Note*: A **prosthetic appliance** is a device that is surgically inserted or physically attached to the body to restore a bodily function or replace a physical portion of the body. We provide hospital benefits for internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implants following mastectomy; see Section 5(c) for payment information. Insertion of the device is paid as surgery; see Section 5(b).	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
Not covered: • *Shoes and over-the-counter orthotics* • *Arch supports* • *Heel pads and heel cups* • *Penile implants* • *Wigs* • *Implanted bone conduction hearing aids*	*All charges*	*All charges*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Durable medical equipment (DME)	**You Pay – Standard Option**	**You Pay – Basic Option**
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment. Under this benefit, we cover: • Home dialysis equipment • Oxygen equipment • Hospital beds • Wheelchairs • Crutches • Walkers • Other items that we determine to be DME	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
Not covered: • *Exercise and bathroom equipment* • *Lifts, such as seat, chair, or van lifts* • *Car seats* • *Air conditioners, humidifiers, dehumidifiers, and purifiers* • *Breast pumps* • *Computer "story boards" or "light talkers" for communication-impaired individuals* • *Equipment for cosmetic purposes*	*All charges*	*All charges*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Medical supplies	**You Pay – Standard Option**	**You Pay – Basic Option**
• Medical foods for children with inborn errors of amino acid metabolism • Medical foods and nutritional supplements when administered by catheter or nasogastric tubes • Ostomy and catheter supplies • Oxygen, regardless of the provider • Blood and blood plasma except when donated or replaced, and blood plasma expanders	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Non-participating: You pay all charges
Home health services		
Home nursing care for two (2) hours per day, up to 25 visits per calendar year, when: • A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; and • A physician orders the care	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note*:** Visits that you pay for while meeting your calendar year deductible count toward the annual visit limit.	Preferred: $20 copayment per visit Participating/Non-participating: You pay all charges
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for bathing, feeding, exercising, moving the patient, homemaking, giving medication, or acting as a companion or sitter*	*All charges*	*All charges*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Chiropractic	**You Pay – Standard Option**	**You Pay – Basic Option**
• Initial office visit • Spinal manipulations • Initial set of X-rays	*All charges* ***Note:*** Benefits may be available for covered services you receive from chiropractors in medically underserved areas. See page 10 for additional information.	Preferred: $20 copayment per visit, up to 20 manipulations per calendar year Participating/Non-participating: You pay all charges
Alternative treatments		
Acupuncture – when performed and billed by a physician or physical therapist, for: • pain relief, and • as a modality of physical therapy ***Note:*** See page 35 for limitations. ***Note:*** We may also cover services of certain alternative treatment providers in medically underserved areas. See page 10 for additional information.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges
Not covered: • *Services you receive from non-covered providers such as:* – *naturopaths* – *hypnotherapists* • *Biofeedback (or other forms of self-care or self-help training)*	*All charges*	*All charges*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Educational classes and programs	**You Pay – Standard Option**	**You Pay – Basic Option**
• Smoking cessation ***Note:*** See Section 5(e) for our coverage of individual and group psychotherapy for smoking cessation and Section 5(f) for our coverage of smoking cessation drugs.	Preferred: $15 copayment for the office visit charge (No deductible); 10% of the Plan allowance for all other services (deductible applies) Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges
• Diabetic education when billed by a covered provider ***Note:*** We cover diabetic educators, dieticians, and nutritionists who bill independently only as part of a covered diabetic education program.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit Participating/Non-participating: You pay all charges
Not covered: • *Marital, family, educational, or other counseling or training services when performed as part of an educational class or program* • *Premenstrual (PMS), lactation, headache, eating disorder, and other educational clinics* • *Recreational or educational therapy, and any related diagnostic testing except as provided by a hospital as part of a covered inpatient stay* • *Services performed or billed by a school or halfway house or a member of its staff*	*All charges*	*All charges*

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under **Standard Option,** the calendar year deductible is $250 per person ($500 per family). The calendar year deductible applies to almost all **Standard Option** benefits in this Section. We say "(No deductible)" to show when the calendar year deductible does not apply.
- **Under Basic Option,** there is **no calendar year deductible.**
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See page 11 for the exceptions to this requirement.**
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- We base payment on whether a facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRIOR APPROVAL for all organ transplant surgical procedures;** and if your surgical procedure requires an inpatient admission, **YOU MUST GET PRECERTIFICATION. Please refer to the prior approval and precertification information shown in Section 3 to be sure which services require prior approval or precertification.**
- The non-PPO benefits are the standard benefits for Standard Option. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

IMPORTANT

Benefit Description	You pay	
NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Surgical procedures	**You pay – Standard Option**	**You pay – Basic Option**
A comprehensive range of services provided, or ordered and billed by a physician, such as: • Operative procedures • Treatment of fractures and dislocations, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery on page 46) • Treatment of burns	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges

Surgical procedures – *continued on next page*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Surgical procedures *(continued)*	**You pay – Standard Option**	**You pay – Basic Option**
• Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic and prosthetic devices, and Section 5(c) – Other hospital services and supplies – for our coverage for the device. • Voluntary sterilization, Norplant (a surgically implanted contraceptive), and intrauterine devices (IUDs) • Assistant surgeons/surgical assistance by a physician if required because of the complexity of the surgical procedures • Gastric bypass surgery or gastric stapling procedures for morbid obesity – a condition in which an individual weighs 100 pounds over, or 100% over, his or her normal weight according to current underwriting standards; eligible members must be age 18 or over ***Note:*** When multiple surgical procedures that add time or complexity to patient care are performed during the same operative session, the Local Plan determines our allowance for the combination of multiple, bilateral, or incidental surgical procedures. Generally, we will allow a reduced amount for procedures other than the primary procedure. ***Note:*** We do not pay extra for "incidental" procedures (those that do not add time or complexity to patient care). ***Note:*** When unusual circumstances require the removal of casts or sutures by a physician other than the one who applied them, the Local Plan may determine that a separate allowance is payable.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** We provide benefits at 90% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, and emergency room physicians. You are responsible for any difference between our allowance and the billed amount.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges ***Note:*** We provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby physician* • *Routine surgical treatment of conditions of the foot [see Section 5(a) – Foot care]* • *Cosmetic surgery* • *LASIK, radial keratotomy, and other refractive surgery*	*All charges*	*All charges*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Reconstructive surgery	**You pay – Standard Option**	**You pay – Basic Option**
• Surgery to correct a functional defect • Surgery to correct a congenital anomaly – a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. ***Note:*** Congenital anomalies do not include conditions related to the teeth or intra-oral structures supporting the teeth. • Treatment to restore the mouth to a pre-cancer state • All stages of breast reconstruction surgery following a mastectomy, such as: – surgery to produce a symmetrical appearance on the other breast – treatment of any physical complications, such as lymphedemas ***Note:*** Internal breast prostheses are paid as Medical services and supplies [see Section 5(a)], or Other hospital services and supplies [see Section 5(c)]. ***Note:*** If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** We provide benefits at 90% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, and emergency room physicians. You are responsible for any difference between our allowance and the billed amount.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges ***Note:*** We provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
Not covered: • *Cosmetic surgery – any operative procedure or any portion of a procedure performed primarily to improve physical appearance through change in bodily form – unless required for a congenital anomaly or to restore or correct a part of the body that has been altered as a result of accidental injury, disease, or surgery (does not include anomalies related to the teeth or structures supporting the teeth)* • *Surgeries related to sex transformation, sexual dysfunction, or sexual inadequacy*	*All charges*	*All charges*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Oral and maxillofacial surgery	**You pay – Standard Option**	**You pay – Basic Option**
Oral surgical procedures, limited to: • Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth when pathological examination is necessary • Surgery needed to correct accidental injuries (see Definitions) to jaws, cheeks, lips, tongue, roof and floor of mouth • Excision of exostoses of jaws and hard palate • External incision and drainage of cellulitis • Incision and surgical treatment of accessory sinuses, salivary glands, or ducts • Reduction of dislocations and excision of temporomandibular joints • Removal of impacted teeth	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** We provide benefits at 90% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, and emergency room physicians. You are responsible for any difference between our allowance and the billed amount.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges ***Note:*** We provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
Not covered: • *Oral implants and transplants* • *Surgical procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone), except as shown above and in Section 5(h)* • *Surgical procedures involving orthodontic care, dental implants, or preparation of the mouth for the fitting or the continued use of dentures, except as specifically shown above and in Section 5(h)*	*All charges*	*All charges*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.

Organ/tissue transplants	You pay – Standard Option	You pay – Basic Option
• Cornea • Kidney • Heart • Liver • Heart-lung • Pancreas • Single or double lung: only for the following end-stage pulmonary diseases: pulmonary fibrosis, primary pulmonary hypertension, and emphysema • Double lung: only for patients with end-stage cystic fibrosis • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** We provide benefits at 90% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, and emergency room physicians. You are responsible for any difference between our allowance and the billed amount.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges ***Note:*** We provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.

Organ/tissue transplants – *continued on next page*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.

Organ/tissue transplants *(continued)*	**You pay – Standard Option**	**You pay – Basic Option**
Bone marrow and stem cell transplants, limited to: • Allogeneic bone marrow transplants and allogeneic cord blood stem cell transplants (from related or unrelated donors) for: – Advanced neuroblastoma – Infantile malignant osteopetrosis – Severe combined immunodeficiency – Mucopolysaccharidosis (e.g., Hunter, Hurler's, Sanfilippo, Maroteaux-Lamy variants) – Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) – Severe or very severe aplastic anemia – Thalassemia major (homozygous beta-thalassemia) – Sickle cell anemia – Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** We provide benefits at 90% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, and emergency room physicians. You are responsible for any difference between our allowance and the billed amount.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges ***Note:*** We provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.

Organ/tissue transplants – *continued on next page*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Organ/tissue transplants *(continued)*	**You pay – Standard Option**	**You pay – Basic Option**
Bone marrow and stem cell transplants, limited to: *(continued)* • Allogeneic bone marrow transplants, allogeneic cord blood stem cell transplants (from related or unrelated donors) and allogeneic peripheral blood stem cell transplants for: – Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia – Advanced Hodgkin's lymphoma – Advanced non-Hodgkin's lymphoma – Chronic myelogenous leukemia – Advanced forms of myelodysplastic syndromes • Autologous bone marrow transplants and autologous peripheral blood stem cell transplants (collectively referred to as autologous stem cell support) for: – Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia – Advanced Hodgkin's lymphoma – Advanced non-Hodgkin's lymphoma – Advanced neuroblastoma – Amyloidosis – Testicular, Mediastinal, Retroperitoneal, and Ovarian germ cell tumors – Multiple myeloma	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** We provide benefits at 90% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, and emergency room physicians. You are responsible for any difference between our allowance and the billed amount.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges ***Note:*** We provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.

Organ/tissue transplants – *continued on next page*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.

Organ/tissue transplants *(continued)*	**You pay – Standard Option**	**You pay – Basic Option**
• Extraction or reinfusion of bone marrow, blood stem cells, or cord blood as a source of stem cells as part of a covered allogeneic or autologous bone marrow transplant or blood stem cell transplant support procedure • Marrow harvesting in anticipation of a covered autologous bone marrow transplant, for patients diagnosed at the time of harvesting with one of the conditions listed on page 49 or 50 • Collection, processing, storage, and distribution of cord blood only when performed by a cord blood bank approved by the FDA • Storage of harvested bone marrow, blood stem cells, or cord blood as a source of stem cells, only when a covered transplant has already been scheduled • Related medical and hospital expenses of the donor, as part of a covered transplant procedure • Related services or supplies provided to the recipient ***Note:*** See Section 5(a) for coverage for related services, such as chemotherapy and/or radiation therapy and drugs administered to stimulate or mobilize stem cells for covered transplant procedures.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** We provide benefits at 90% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, and emergency room physicians. You are responsible for any difference between our allowance and the billed amount.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges ***Note:*** We provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
Limitations (1) You must obtain prior approval (see page 14) from the Local Plan, for both the procedure and the facility, for the following transplant procedures: • Bone marrow, cord blood stem cell, and peripheral blood stem cell transplant support procedures • Heart • Heart-lung • Liver • Lung (single/double) • Pancreas • Intestinal transplants (small intestine with or without other organs)		

Organ/tissue transplants – *continued on next page*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.

Organ/tissue transplants *(continued)*	You pay – Standard Option	You pay – Basic Option
(2) For the following procedures, we provide benefits **only** when conducted at a Cancer Research Facility (see page 11) and performed as part of a clinical trial that meets the requirements shown below: • Allogeneic bone marrow transplants, syngeneic bone marrow transplants, and allogeneic peripheral blood stem cell transplants for: – Multiple myeloma – Chronic lymphocytic leukemia – Early stage (indolent or non-advanced) small cell lymphocytic lymphoma • Nonmyeloablative allogeneic stem cell transplants for: – Chronic myelogenous leukemia – Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia – Advanced Hodgkin's lymphoma – Advanced non-Hodgkin's lymphoma – Advanced forms of myelodysplastic syndromes – Multiple myeloma – Chronic lymphocytic leukemia – Early stage (indolent or non-advanced) small cell lymphocytic lymphoma – Renal cell carcinoma • Autologous bone marrow transplants and autologous peripheral blood stem cell transplants (collectively referred to as autologous stem cell support) for: – Breast cancer – Epithelial ovarian cancer – Chronic myelogenous leukemia – Chronic lymphocytic leukemia – Early stage (indolent or non-advanced) small cell lymphocytic lymphoma	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** We provide benefits at 90% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, and emergency room physicians. You are responsible for any difference between our allowance and the billed amount.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges ***Note:*** We provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.

Organ/tissue transplants – *continued on next page*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Organ/tissue transplants *(continued)*	**You pay – Standard Option**	**You pay – Basic Option**
For these bone marrow transplant procedures and related services or supplies covered only through clinical trials: 1. You must contact our Clinical Trials Information Unit at 1-800-225-2268 for prior approval (see page 14); 2. The clinical trial must be reviewed and approved by the Institutional Review Board of the Cancer Research Facility where the procedure is to be delivered; and 3. The patient must be properly and lawfully registered in the clinical trial, meeting all the eligibility requirements of the trial. If a non-randomized clinical trial meeting these requirements is not available at a Cancer Research Facility where you are eligible, we will arrange for the transplant to be provided at another Plan-designated transplant facility.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** We provide benefits at 90% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, and emergency room physicians. You are responsible for any difference between our allowance and the billed amount.	Preferred: $100 copayment per performing surgeon ***Note:*** If you receive the services of a co-surgeon, you pay a second $100 copayment for those services. No additional copayment applies to the services of assistant surgeons. Participating/Non-participating: You pay all charges ***Note:*** We provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons (including assistant surgeons in a physician's office). You are responsible for any difference between our allowance and the billed amount.
Not covered: • *Transplants for any diagnosis not listed as covered* • *Donor screening tests and donor search expenses, except those performed for the actual donor*	*All charges*	*All charges*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Anesthesia	**You pay – Standard Option**	**You pay – Basic Option**
Anesthesia (including acupuncture) for covered surgical services when requested by the attending physician and performed by: • a certified registered nurse anesthetist (CRNA), or • a physician other than the operating physician (surgeon) or the assistant Professional services provided in: • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office Anesthesia services consist of administration by injection or inhalation of a drug or other anesthetic agent (including acupuncture) to obtain muscular relaxation, loss of sensation, or loss of consciousness. ***Note:*** See Section 5(c) for our payment levels for anesthesia services billed by a facility.	Preferred: 10% of the Plan allowance Participating: 25% of the Plan allowance Non-participating: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** We provide benefits at 90% of the Plan allowance for services provided in Preferred facilities by Non-preferred anesthesiologists and certified registered nurse anesthetists (CRNAs). You are responsible for any difference between our allowance and the billed amount.	Preferred: Nothing Participating/Non-participating: You pay all charges ***Note:*** We provide benefits at 100% of the Plan allowance for services provided in Preferred facilities by Non-preferred anesthesiologists and certified registered nurse anesthetists (CRNAs). You are responsible for any difference between our allowance and the billed amount.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Unlike Sections 5(a) and 5(b), in this Section 5(c) the **Standard Option** calendar year deductible applies to only a few benefits. In that case, we added "(calendar year deductible applies)" when it applies. The calendar year deductible is $250 per person ($500 per family) under Standard Option.
- **Under Basic Option,** there is **no calendar year deductible.**
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See page 11 for the exceptions to this requirement.**
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information listed in Section 3 to be sure which services require precertification.
- You should be aware that some PPO hospitals may have non-PPO professional providers on staff.
- We base payment on whether the facility or a health care professional bills for the services or supplies. You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on what type of provider bills for the service. For example, physical therapy is paid differently depending on whether it is billed by an inpatient facility, a doctor, a physical therapist, or an outpatient facility.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your inpatient surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are listed in Sections 5(a) or (b).
- The non-PPO benefits are the standard benefits for Standard Option. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

IMPORTANT

Benefit Description	You pay	
NOTE: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies) ." There is no calendar year deductible under Basic Option.		
Inpatient hospital	**You pay – Standard Option**	**You pay – Basic Option**
Room and board, such as: • semiprivate or intensive care accommodations • general nursing care • meals and special diets ***Note:*** We cover a private room only when you must be isolated to prevent contagion, when your isolation is required by law, or when a Preferred or Member hospital only has private rooms. Otherwise, we will pay the hospital's average daily rate for semiprivate rooms as determined by the Local Plan. If a Non-member hospital only has private rooms, we base our payment on the average daily rate as determined by the Local Plan.	Preferred: $100 per admission copayment for unlimited days Member: $300 per admission copayment for unlimited days Non-member: $300 per admission copayment for unlimited days, plus 30% of the Plan allowance, and any remaining balance after our payment ***Note:*** You pay nothing for facilities outside of the United States and Puerto Rico. See Section 5(g) for more information about benefits for services received overseas. See Section 7, *Filing a claim for covered services*, for instructions on filing claims for overseas care.	Preferred: $100 per day copayment up to $500 per admission for unlimited days Member/Non-member: You pay all charges ***Note:*** You pay a $100 per day copayment up to $500 per admission for facilities outside of the United States and Puerto Rico. See Section 5(g) for more information about benefits for services received overseas. See Section 7, *Filing a claim for covered services*, for instructions on filing claims for overseas care.

Inpatient hospital – *continued on next page*

NOTE: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies) ." There is no calendar year deductible under Basic Option.		
Inpatient hospital *(continued)*	**You pay – Standard Option**	**You pay – Basic Option**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs • Diagnostic laboratory tests, pathology services, MRIs, machine diagnostic tests, and X-rays • Administration of blood or blood plasma • Dressings, splints, casts, and sterile tray services • Internal prosthetic devices • Other medical supplies and equipment, including oxygen • Anesthetics and anesthesia services • Take-home items • Pre-admission testing recognized as part of the hospital admissions process ***Note:*** Here are some things to keep in mind: • You do not need to precertify your normal delivery; see page 13 for other circumstances, such as extended stays for you or your baby. • If you need to stay longer in the hospital than initially planned, we will cover an extended stay if it is medically necessary. However, you must precertify the extended stay. See Section 3 for information on requesting additional days. • We pay inpatient hospital benefits for an admission in connection with dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient. We provide benefits for dental procedures as shown in Section 5(h). ***Note:*** See page 31 for covered maternity services. ***Note:*** See page 41 for coverage of blood and blood products.	Preferred: $100 per admission copayment for unlimited days Member: $300 per admission copayment for unlimited days Non-member: $300 per admission copayment for unlimited days, plus 30% of the Plan allowance, and any remaining balance after our payment ***Note:*** You pay nothing for facilities outside of the United States and Puerto Rico. See Section 5(g) for more information about benefits for services received overseas. See Section 7, *Filing a claim for covered services*, for instructions on filing claims for overseas care.	Preferred: $100 per day copayment up to $500 per admission for unlimited days Member/Non-member: You pay all charges ***Note:*** You pay a $100 per day copayment up to $500 per admission for facilities outside of the United States and Puerto Rico. See Section 5(g) for more information about benefits for services received overseas. See Section 7, *Filing a claim for covered services*, for instructions on filing claims for overseas care.

Inpatient hospital – *continued on next page*

NOTE: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies) ." There is no calendar year deductible under Basic Option.		
Inpatient hospital *(continued)*	**You pay – Standard Option**	**You pay – Basic Option**
Not covered: *Hospital room and board expenses when in our judgement, a hospital admission or portion of an admission is:* • *Custodial care* • *Convalescent care or a rest cure* • *Domiciliary care provided because care in the home is not available or unsuitable* • *Not medically necessary, such as when services did not require the acute/subacute hospital inpatient (overnight) setting but could have been provided safely and adequately in a physician's office, the outpatient department of a hospital, or some other setting, without adversely affecting your condition or the quality of medical care you receive. Some examples are:* – *Admissions for, or consisting primarily of, observation and/or evaluation that could have been provided safely and adequately in some other setting (such as a physician's office)* – *Admissions primarily for diagnostic studies, laboratory and pathology services, X-rays, MRIs, or machine diagnostic tests that could have been provided safely and adequately in some other setting (such as the outpatient department of a hospital or a physician's office)* ***Note:*** *If we determine that a hospital admission is one of the types listed above, we will not provide benefits for inpatient room and board or inpatient physician care. However, we will provide benefits for covered services or supplies other than room and board and inpatient physician care at the level that we would have paid if they had been provided in some other setting.* • *Admission to non-covered facilities, such as nursing homes, extended care facilities, schools, residential treatment centers* • *Personal comfort items, such as guest meals and beds, telephone, television, beauty and barber services* • *Inpatient private duty nursing*	*All charges*	*All charges*

NOTE: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies) ." There is no calendar year deductible under Basic Option.		
Outpatient hospital or ambulatory surgical center	**You pay – Standard Option**	**You pay – Basic Option**
Outpatient **medical services** performed and billed for by a hospital or freestanding ambulatory facility, such as: • Use of special treatment rooms • Diagnostic tests, such as laboratory and pathology services, MRIs, machine diagnostic tests, and X-rays • Administration of blood, blood plasma, and other biologicals • Cardiac rehabilitation (Prior approval is required. See Section 3.) • Renal dialysis ***Note:*** See pages 27-30 for covered preventive services for adults and children.	Preferred facilities: 10% of the Plan allowance (calendar year deductible applies) Member facilities: 25% of the Plan allowance (calendar year deductible applies) Non-member facilities: 25% of the Plan allowance (calendar year deductible applies); plus any difference between our allowance and the billed amount ***Note:*** You pay nothing for facilities outside the United States and Puerto Rico. See Section 5(g) for more information about benefits for services received overseas. See Section 7, *Filing a claim for covered services*, for instructions on filing claims for overseas care.	Preferred: $30 copayment per day per facility Member/Non-member: You pay all charges ***Note:*** For outpatient diagnostic tests billed for by a Member or Non-member facility, you pay a $30 copayment, plus any difference between our allowance and the billed amount. ***Note:*** You pay a $30 per day copayment per facility for outpatient services provided by facilities outside the United States and Puerto Rico. See Section 5(g) for more information about benefits for services received overseas. See Section 7, *Filing a claim for covered services*, for instructions on filing claims for overseas care.

Outpatient hospital or ambulatory surgical center – *continued on next page*

NOTE: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies) ." There is no calendar year deductible under Basic Option.		
Outpatient hospital or ambulatory surgical center *(continued)*	**You pay – Standard Option**	**You pay – Basic Option**
Outpatient **surgery and related services** performed and billed for by a hospital or freestanding ambulatory facility, such as: • Operating, recovery, and other treatment rooms • Pre-surgical testing performed within one business day of the covered surgical services • Facility supplies for hemophilia home care • Diagnostic tests, such as laboratory and pathology services, MRIs, machine diagnostic tests, and X-rays • Administration of blood, blood plasma, and other biologicals ***Note:*** We cover outpatient hospital services and supplies related to dental procedures only when a non-dental physical impairment exists that makes the hospital setting necessary to safeguard the health of the patient. See Section 5(h), *Dental benefits*, for additional benefit information. ***Note:*** See page 31 for covered maternity services.	Preferred facilities: 10% of the Plan allowance Member facilities: 25% of the Plan allowance Non-member facilities: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** You pay nothing for facilities outside the United States and Puerto Rico. See Section 5(g) for more information about benefits for services received overseas. See Section 7, *Filing a claim for covered services*, for instructions on filing claims for overseas care.	Preferred: $30 copayment per day per facility Member/Non-member: You pay all charges ***Note:*** For outpatient diagnostic tests billed for by a Member or Non-member facility, you pay a $30 copayment, plus any difference between our allowance and the billed amount. ***Note:*** You pay a $30 copayment per day per facility for outpatient services provided by facilities outside the United States and Puerto Rico. See Section 5(g) for more information about benefits for services received overseas. See Section 7, *Filing a claim for covered services*, for instructions on filing claims for overseas care.

Outpatient hospital or ambulatory surgical center – *continued on next page*

NOTE: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies) ." There is no calendar year deductible under Basic Option.		
Outpatient hospital or ambulatory surgical center *(continued)*	**You pay – Standard Option**	**You pay – Basic Option**
Outpatient **drugs and supplies** billed for by a hospital or freestanding ambulatory facility, such as: • Prescribed drugs • Blood and blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Other medical supplies, including oxygen	Preferred facilities: 10% of the Plan allowance (calendar year deductible applies) Member facilities: 25% of the Plan allowance (calendar year deductible applies) Non-member facilities: 25% of the Plan allowance (calendar year deductible applies); plus any difference between our allowance and the billed amount ***Note:*** You pay nothing for facilities outside the United States and Puerto Rico. See Section 5(g) for more information about benefits for services received overseas. See Section 7, *Filing a claim for covered services*, for instructions on filing claims for overseas care.	Preferred: 30% of the Plan allowance ***Note:*** You may also be responsible for paying a $30 copayment per day per facility for outpatient services. Member/Non-member: You pay all charges ***Note:*** You pay 30% of the Plan allowance for outpatient drugs and supplies provided by facilities outside the United States and Puerto Rico. See Section 5(g) for more information about benefits for services received overseas. See Section 7, *Filing a claim for covered services*, for instructions on filing claims for overseas care.

NOTE: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies) ." There is no calendar year deductible under Basic Option.		
Extended care benefits/Skilled nursing care facility benefits	**You pay – Standard Option**	**You pay – Basic Option**
Limited to the following benefits for Medicare Part A copayments: When Medicare Part A is the primary payer (meaning that it pays first) and has made payment, **Standard Option** provides limited secondary benefits. We pay the applicable Medicare Part A copayments incurred **in full** during the first through the 30th day of confinement for each benefit period (as defined by Medicare) in a qualified skilled nursing facility. A qualified skilled nursing facility is a facility that specializes in skilled nursing care performed by or under the supervision of licensed nurses, skilled rehabilitation services, and other related care, and meets Medicare's special qualifying criteria, but is not an institution that primarily cares for and treats mental diseases. If Medicare pays the first 20 days in full, Plan benefits will begin on the 21st day (when Medicare Part A copayments begin) and will end on the 30th day. ***Note:*** See pages 35 and 36 for benefits provided for outpatient physical, occupational, and speech therapy when billed by a skilled nursing facility. See Section 5(f) for benefits for prescription drugs. ***Note:*** **If you do not have Medicare Part A, we do not provide benefits for skilled nursing facility care.**	Preferred: Nothing Participating/Member: Nothing Non-participating/Non-member: Nothing ***Note:*** You pay all charges not paid by Medicare after the 30th day.	*All charges*

NOTE: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies) ." There is no calendar year deductible under Basic Option.		
Hospice care	**You pay – Standard Option**	**You pay – Basic Option**
Hospice care is an integrated set of services and supplies designed to provide palliative and supportive care to terminally ill patients in their homes. We provide the following **home hospice care** benefits for members with a life expectancy of six months or less **when prior approval is obtained from the Local Plan** and the home hospice agency is approved by the Local Plan: • Physician visits • Nursing care • Medical social services • Physical therapy • Services of home health aides • Durable medical equipment rental • Prescription drugs • Medical supplies	Nothing	Nothing
Inpatient hospice for members receiving home hospice care benefits: Benefits are provided for up to five (5) consecutive days in a hospital or a freestanding hospice inpatient facility. Each inpatient stay must be separated by at least 21 days. These covered inpatient hospice benefits are available only when inpatient services are necessary to: • control pain and manage the patient's symptoms; or • provide an interval of relief (respite) to the family ***Note:*** **You are responsible for making sure that the home hospice care provider has received prior approval from the Local Plan** (see page 13 for instructions). Please check with your Local Plan and/or your PPO directory for listings of approved agencies.	Preferred: $100 per admission copayment Member: $300 per admission copayment Non-member: $300 per admission copayment plus 30% of the Plan allowance, and any remaining balance after our payment	Preferred: $100 per day copayment up to $500 per admission Member/Non-member: You pay all charges
Not covered: Homemaker or bereavement services	*All charges*	*All charges*

NOTE: The Standard Option calendar year deductible applies ONLY when we say below: "(calendar year deductible applies) ." There is no calendar year deductible under Basic Option.		
Ambulance	**You pay – Standard Option**	**You pay – Basic Option**
Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and: • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care	Preferred: 10% of the Plan allowance (calendar year deductible applies) Participating/Member: 25% of the Plan allowance (calendar year deductible applies) Non-participating/Non-member: 25% of the Plan allowance (calendar year deductible applies); plus any difference between our allowance and the billed amount	Preferred: $50 copayment per trip Participating/Member or Non-participating/Non-member: $50 copayment per trip
Ambulance services related to accidental injury	Preferred: Nothing (No deductible) Participating/Member: Nothing (No deductible) Non-participating/Non-member: Any difference between the Plan allowance and the billed amount (No deductible) ***Note:*** These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.	Preferred: $50 copayment per trip Participating/Member or Non-participating/Non-member: $50 copayment per trip

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Under **Standard Option,** the calendar year deductible is $250 per person ($500 per family). The calendar year deductible applies to almost all **Standard Option** benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- **Under Basic Option,** there is **no calendar year deductible.**
- **Under Basic Option, you must use Preferred providers in order to receive benefits, except in cases of medical emergency or accidental injury. Refer to the guidelines appearing below for additional information.**
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- The non-PPO benefits are the standard benefits for **Standard Option**. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

IMPORTANT

What is an accidental injury?

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

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.

Basic Option benefits for emergency care

Under Basic Option, you are encouraged to seek care from Preferred providers in cases of accidental injury or medical emergency. However, if you need care immediately and cannot access a Preferred provider, we will provide benefits for the **initial** treatment provided in the emergency room of any hospital – even if the hospital is not a Preferred facility. In addition, we will provide benefits for emergency ambulance transportation provided by Preferred or Non-preferred ambulance providers if the transport is due to a medical emergency or accidental injury.

We provide emergency benefits when you have acute symptoms of sufficient severity – including severe pain – such that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the person's health, or with respect to a pregnant woman, the health of the woman and her unborn child.

Benefit Description	You pay	
NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Accidental injury	**You pay – Standard Option**	**You pay – Basic Option**
• **Physician services** in the hospital outpatient department, urgent care center, or physician's office, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests • Related outpatient **hospital services** and supplies, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests ***Note:*** We pay Inpatient hospital benefits if you are admitted [see Section 5(c)]. ***Note:*** See Section 5(h) for dental benefits for accidental injuries.	Preferred: Nothing (No deductible) Participating/Member: Nothing (No deductible) Non-participating/Non-member: Any difference between the Plan allowance and the billed amount (No deductible) ***Note:*** These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, regular medical and outpatient hospital benefits apply. See Section 5(a), Medical services and supplies, Section 5(b), Surgical procedures, and Section 5(c), Outpatient hospital, for the benefits we provide.	Preferred emergency room: $50 copayment per visit Participating/Member emergency room: $50 copayment per visit Non-participating/Non-member emergency room: $50 copayment per visit ***Note:*** You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. ***Note:*** If you are admitted directly to the hospital from the emergency room, you do not have to pay the $50 emergency room copayment. However, the $100 per day copayment for Preferred inpatient care still applies. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.

Accidental injury – *continued on next page*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Accidental injury *(continued)*	**You pay – Standard Option**	**You pay – Basic Option**
		For the following places of service, you **must** receive care from a Preferred provider: **Preferred** urgent care center: $30 copayment per visit **Preferred** primary care provider or other health care professional's office: $20 copayment per visit **Preferred** specialist's office: $30 copayment per visit Participating/Member (for other than emergency room): You pay all charges Non-participating/Non-member (for other than emergency room): You pay all charges
Not covered: • *Oral surgery except as shown in Section 5(b)* • *Injury to the teeth while eating*	*All charges*	*All charges*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.

Medical emergency	You pay – Standard Option	You pay – Basic Option
• **Physician services** in the hospital outpatient department, urgent care center, or physician's office, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests • Related outpatient **hospital services** and supplies, including X-rays, MRIs, laboratory and pathology services, and machine diagnostic tests ***Note:*** We pay Inpatient hospital benefits if you are admitted as a result of a medical emergency [see Section 5(c), Inpatient hospital]. ***Note:*** Please refer to Section 3 for information about precertifying emergency hospital admissions.	Preferred: 10% of the Plan allowance ***Note:*** If you receive services in a Preferred physician's office, you pay a $15 copayment (No deductible) for the office visit, and 10% of the Plan allowance for all other services (deductible applies). Participating/Member: 25% of the Plan allowance Non-participating/Non-member: 25% of the Plan allowance, plus any difference between our allowance and the billed amount ***Note:*** These benefit levels **do not** apply if you receive care in connection with, and within 72 hours after, an accidental injury. See Accidental Injury benefits on pages 65-67 for the benefits we provide.	Preferred emergency room: $50 copayment per visit Participating/Member emergency room: $50 copayment per visit Non-participating/Non-member emergency room: $50 copayment per visit ***Note:*** You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. ***Note:*** If you are admitted directly to the hospital from the emergency room, you do not have to pay the $50 emergency room copayment. However, the $100 per day copayment for Preferred inpatient care still applies. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits. For the following places of service, you **must** receive care from a Preferred provider: **Preferred** urgent care center: $30 copayment per visit **Preferred** primary care provider or other health care professional's office: $20 copayment per visit **Preferred** specialist's office: $30 copayment per visit Participating/Member (for other than emergency room): You pay all charges Non-participating/Non-member (for other than emergency room): You pay all charges

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Ambulance	**You pay – Standard Option**	**You pay – Basic Option**
Local professional ambulance transport services to or from the nearest hospital equipped to adequately treat your condition, when medically appropriate, and: • Associated with covered hospital inpatient care • Related to medical emergency • Associated with covered hospice care ***Note:*** See Section 5(c) for non-emergency ambulance services.	Preferred: 10% of the Plan allowance Participating/Member: 25% of the Plan allowance Non-participating/Non-member: 25% of the Plan allowance, plus any difference between our allowance and the billed amount	Preferred: $50 copayment per trip Participating/Member or Non-participating/Non-member: $50 copayment per trip
Ambulance services related to accidental injury	Preferred: Nothing (No deductible) Participating/Member: Nothing (No deductible) Non-participating/Non-member: Any difference between the Plan allowance and the billed amount (No deductible) ***Note:*** These benefit levels apply only if you receive care in connection with, and within 72 hours after, an accidental injury. For services received after 72 hours, see above.	Preferred: $50 copayment per trip Participating/Member or Non-participating/Non-member: $50 copayment per trip

Section 5 (e). Mental health and substance abuse 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.
- Under **Standard Option**, the calendar year deductible or, for facility care, the inpatient per admission copay, applies to almost all benefits in this Section. We added "(No deductible)" to show when the deductible does not apply.
- **Under Standard Option,** there is a maximum of 25 visits per year for office visits, partial hospitalization, intensive outpatient treatment, and other hospital outpatient treatment. The first 25 visits under Standard Option each calendar year by Preferred providers and Non-preferred providers count toward this maximum. This maximum may be waived for services received from Preferred providers.
- Under **Standard Option**, you may choose to get care Out-of-Network (Non-preferred) or In-Network (Preferred). Preferred benefits are payable when the care is clinically appropriate to treat your condition and when you receive the care as part of a treatment plan that we approve. Cost-sharing and limitations for In-Network (Preferred) mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.
- **Under Basic Option, you must call us for prior approval before receiving care.** We will provide you with the names and phone numbers of several Preferred providers and tell you how many visits we are initially approving. You may then choose which of those providers you would like to see. **You must use Preferred providers in order to receive Basic Option benefits.**
- Under **Basic Option**, there is **no calendar year deductible**.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A $500 PENALTY.** Please refer to the precertification information listed in Section 3. Some other services also require prior approval. See the instructions after the benefits descriptions below.
- **Standard Option and Basic Option benefits** for Preferred (In-Network) mental health and substance abuse care begin below and are continued on the following pages. Standard Option benefits for Non-preferred (Out-of-Network) care begin on page 74.
- The non-PPO benefits are the standard benefits for **Standard Option**. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

IMPORTANT

Benefit Description	You pay	
NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Preferred (In-Network) benefits	**You pay – Standard Option**	**You pay – Basic Option**
All diagnostic and treatment services contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. ***Note:*** Preferred benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care from a Preferred provider as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.

Preferred (In-Network) benefits – *continued on next page*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Preferred (In-Network) benefits *(continued)*	**You pay – Standard Option**	**You pay – Basic Option**
Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, clinical social workers, or psychiatric nurses • Office and home visits • In a hospital outpatient department (except for emergency rooms) • Psychotherapy for smoking cessation ***Note:*** Additional licensed provider types may be available to you for mental health and substance abuse services. Consult your PPO directory or contact your Local Plan at the mental health and substance abuse phone number on the back of your ID card.	$15 copayment for the visit, up to two hours per visit (No deductible)	$20 copayment per visit ***Note:*** You pay a $30 copayment for outpatient services billed for by a facility.
Other services: • Pharmacotherapy (medication management) • Psychological testing ***Note:*** Additional licensed provider types may be available to you for mental health and substance abuse services. Consult your PPO directory or contact your Local Plan at the mental health and substance abuse phone number on the back of your ID card.	10% of the Plan allowance (deductible applies) ***Note:*** Other services are not subject to the two-hour limit.	Preferred primary care provider or other health care professional: $20 copayment per visit Preferred specialist: $30 copayment per visit ***Note:*** You pay a $30 copayment for outpatient services billed for by a facility.
• Inpatient professional visits • Professional charges for facility-based intensive outpatient treatment	10% of the Plan allowance ***Note:*** Intensive outpatient treatment is not limited to two hours per visit but you must obtain prior approval.	Nothing
• Professional charges for intensive outpatient treatment in a provider's office or other professional setting	10% of the Plan allowance ***Note:*** Intensive outpatient treatment is not limited to two hours per visit but you must obtain prior approval.	Preferred: $30 copayment per visit
• Professional charges for outpatient diagnostic tests	10% of the Plan allowance	$20 copayment per visit

Preferred (In-Network) benefits – *continued on next page*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.		
Preferred (In-Network) benefits *(continued)*	**You pay – Standard Option**	**You pay – Basic Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services • Diagnostic tests ***Note:*** You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	$100 per admission copayment (No deductible)	$100 per day copayment up to $500 per admission
Outpatient services provided and billed by a hospital or other covered facility • Diagnostic tests • Services in the following approved treatment programs (must be prior approved): – partial hospitalization – facility-based intensive outpatient treatment	10% of the Plan allowance	$30 copayment per day per facility
Not covered: • *Services we have not approved* • *Educational or training services* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present*	*All charges*	*All charges*

Preferred (In-Network) benefits – *continued on next page*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply. There is no calendar year deductible under Basic Option.

Preferred (In-Network) benefits *(continued)*

Authorization Procedures

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

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

Basic Option: To be eligible to receive mental health and substance abuse benefits, you must call us for prior approval at the mental health and substance abuse phone number on the back of your ID card before you receive care. We will then provide you with the names and phone numbers of several Preferred providers to choose from and tell you how many visits we are initially approving.

Precertification

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

Prior Approval

Standard Option: Prior approval is required for partial hospitalization and intensive outpatient treatment programs.

Basic Option: Prior approval is required for all mental health and substance abuse services.

Prior to starting treatment, you, someone acting on your behalf, your physician, or your hospital must call us at the mental health and substance abuse phone number on the back of your ID card. We will not pay for mental health and substance abuse services under Basic Option or for partial hospitalization or intensive outpatient treatment programs under Standard Option, even at Preferred facilities, until you obtain prior approval.

Treatment Plans

Standard Option: We provide Preferred benefits only when you receive care as part of a treatment plan that we have approved. In order to maximize your benefits, your provider must submit a treatment plan to us **prior to your ninth outpatient visit**. When we approve the treatment plan, we will give your provider authorization for additional visits or services. The services or number of additional visits authorized will depend on the treatment plan. We may need to request updated treatment plans as your treatment progresses. If a treatment plan is not submitted or approved, we will provide only Non-preferred (out-of-network) benefits. If you change providers, a new treatment plan must be submitted. We will be flexible in allowing additional visits while your treatment plan is being prepared or under review.

Basic Option: We will work directly with your provider and may request a treatment plan from your provider.

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.

Preferred Limitation

Under Standard Option, if you do not obtain an approved treatment plan, we will provide only Non-preferred (out-of-network) benefits.

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply.		
Non-preferred (Out-of-Network) benefits	**You pay – Standard Option**	**You Pay – Basic Option**
Professional services, including individual or group therapy, by providers such as psychiatrists, psychologists, clinical social workers, or psychiatric nurses, for: • Office and home visits • In a hospital outpatient department (except for emergency rooms) • Psychotherapy for smoking cessation	40% of the Plan allowance for up to two hours per visit and up to 25 outpatient visits per calendar year; all charges after 25 visits*. You may also be responsible for any difference between the Plan allowance and the billed amount. *The 25-visit limit is a combined maximum for all outpatient professional care, partial hospitalization, intensive outpatient treatment, and outpatient facility care, whether performed by Preferred or Non-preferred providers, or applied to your calendar year deductible.	Participating/Non-participating: You pay all charges
Other services: • Pharmacotherapy (medication management) • Psychological testing	25% of the Plan allowance. You may also be responsible for any difference between the Plan allowance and the billed amount. ***Note:*** Other services are not subject to the 25-visit limitation.	Participating/Non-participating: You pay all charges
Inpatient visits	40% of the Plan allowance up to 100 days per calendar year; all charges after 100 days. You may also be responsible for any difference between the Plan allowance and the billed amount.	Participating/Non-participating: You pay all charges

Non-preferred (Out-of-Network) benefits – *continued on next page*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply.		
Non-preferred (Out-of-Network) benefits *(continued)*	**You pay – Standard Option**	**You Pay – Basic Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services You must get precertification of inpatient hospital stays; failure to do so will result in a $500 penalty.	$400 copayment per day (No deductible) up to 100 days per calendar year; all charges after 100 days	Member/Non-member: You pay all charges
Outpatient services provided and billed by a hospital or other covered facility • Psychological testing	25% of the Plan allowance, plus any difference between the Plan allowance and the billed amount ***Note:*** Psychological testing is not subject to the visit limitations.	Member/Non-member: You pay all charges
Partial hospitalization and intensive outpatient treatment ***Note:*** You must request and receive prior approval for these services. See Section 3 for more information about prior approval.	25% of the Plan allowance, plus any difference between the Plan allowance and the billed amount; all charges after 25 visits* ***Note:*** Visits that you pay for while meeting your deductible count toward the limit cited above. *The 25-visit limit is a combined maximum for all outpatient professional care, partial hospitalization, intensive outpatient treatment, and outpatient facility care, whether performed by Preferred or Non-preferred providers, or applied to your calendar year deductible.	Participating/Member or Non-participating/Non-member: You pay all charges

Non-preferred (Out-of-Network) benefits – *continued on next page*

NOTE: The calendar year deductible applies to almost all Standard Option benefits in this Section. We say "(No deductible)" when the Standard Option deductible does not apply.		
Non-preferred (Out-of-Network) benefits *(continued)*	**You pay – Standard Option**	**You Pay – Basic Option**
Inpatient care to treat substance abuse includes room and board and ancillary charges for confinements in a treatment facility for rehabilitative treatment of alcoholism or substance abuse	Non-preferred facility: $400 copayment per day (No deductible); all charges after 28 days per lifetime Non-preferred professional: 40% of the Plan allowance; all charges after 28 days per lifetime. You may also be responsible for any difference between the Plan allowance and the billed amount. ***Note:*** Non-preferred inpatient care for the treatment of substance abuse is limited to one treatment program (28-day maximum) per lifetime.	Member/Non-member: You pay all charges Participating/Non-participating: You pay all charges
Not covered: • *Marital, family, educational, or other counseling or training services* • *Services performed by a non-covered provider* • *Testing and treatment for learning disabilities and mental retardation* • *Services performed or billed by schools, residential treatment centers, halfway houses, or members of their staffs* • *Psychoanalysis or psychotherapy credited toward earning a degree or furtherance of education or training regardless of diagnosis or symptoms that may be present*	*All charges*	*All charges*

Lifetime maximum	Non-preferred inpatient care for the treatment of substance abuse is limited to one treatment program (28-day maximum) per lifetime under **Standard Option.**
Precertification	You must get precertification of the medical necessity of your admission to a hospital or other covered facility. Report emergency admissions within two business days following the day of admission, even if you have been discharged. Otherwise, we will reduce the benefits payable by $500. See Section 3 for more information on precertification.

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

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

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescription drugs and supplies, as described in the chart beginning on page 79.
- All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under Standard Option,** the calendar year deductible does **not** apply to prescriptions filled through the Retail Pharmacy Program or Mail Service Prescription Drug Program. We added "(calendar year deductible applies)" when it applies.
- **Under Basic Option,** there is **no calendar year deductible.**
- **YOU MUST GET PRIOR APPROVAL FOR CERTAIN DRUGS, and prior approval must be renewed periodically. Please refer to the prior approval information shown on page 83 of this Section and in Section 3.** Prior approval is part of our Patient Safety and Quality Monitoring (PSQM) program. See page 83 of this Section for more information about this important program.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- **Under Standard Option**, non-PPO benefits are the standard benefits. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- **Under Basic Option, you must use Preferred providers in order to receive benefits. See page 11 for the exceptions to this requirement.**
- Please note that retail pharmacies and internet pharmacies that are Preferred under Standard Option are not necessarily Preferred under Basic Option. Refer to page 80 for information about locating Preferred pharmacies.
- **Under Standard Option,** you may use the Mail Service Prescription Drug Program to fill your prescriptions.
- The Mail Service Prescription Drug Program **is not** available under **Basic Option.**

IMPORTANT

We will send each new enrollee a description of our prescription drug program and a combined prescription drug/Plan identification card. Standard Option members are eligible to use the Mail Service Prescription Drug Program and will also receive a mail order form/patient profile and a preaddressed reply envelope.

- **Who can write your prescriptions.** A physician or dentist licensed in the United States or Puerto Rico, or a nurse practitioner in states that permit it, must write your prescriptions.
- **Where you can obtain them.**

  Under Standard Option, you may fill prescriptions at a Preferred retail pharmacy, through a Preferred internet pharmacy, at a Non-preferred retail pharmacy, or through our Mail Service Prescription Drug Program. Under Standard Option, we pay a higher level of benefits when you use a Preferred retail pharmacy, a Preferred internet pharmacy, or our Mail Service Prescription Drug Program.

  Under Basic Option, you must fill prescriptions only at a Preferred retail pharmacy or through a Preferred internet pharmacy in order to receive benefits.
- **We use an open formulary.** This is a list of preferred brand-name drugs selected to meet patient needs at a lower cost to us. If your physician believes a brand-name drug is necessary or there is no generic equivalent available, ask your physician to prescribe a brand-name drug from our formulary list.

  Under Standard Option, we may ask your doctor to substitute a formulary drug in order to help control costs. We cover drugs that require a prescription (whether or not they are on our formulary list). Your cooperation with our cost-savings efforts helps keep your premium affordable.

Under Basic Option, we encourage you to ask your physician to prescribe a brand-name drug from our formulary list when your physician believes a brand-name drug is necessary or when there is no generic equivalent available. If you purchase a drug that is not on our formulary list, your cost will be higher. (We cover drugs that require a prescription whether or not they are on our formulary list.)

You can view our formulary on our website at www.fepblue.org or request a copy by mail by calling 1-800-624-5060 (TDD: 1-800-624-5077). Any savings we receive on the cost of drugs purchased under this Plan from drug manufacturers are credited to the reserves held for this Plan.

- **Generic equivalents.**

  Standard Option: By submitting your prescription (or those of family members covered by the Plan) to your retail pharmacy or the Mail Service Prescription Drug Program, you authorize them to substitute any available Federally approved generic equivalent, unless you or your physician specifically request a brand-name drug.

  Basic Option: By filling your prescriptions (or those of family members covered by the Plan) at a Preferred retail pharmacy or through a Preferred internet pharmacy, you authorize the pharmacist to substitute any available Federally approved generic equivalent, unless you or your physician specifically request a brand-name drug.

- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. In most cases, they must contain the same active ingredients and must be equivalent in strength and dosage to the original brand-name product. Generics cost less than the equivalent brand-name product. The U.S. Food and Drug Administration (FDA) sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.

  You can save money by using generic drugs. However, you and your doctor have the option to request a brand-name if a generic option is available. Using the most cost-effective medication saves money.

- **Disclosure of information.** As part of our administration of prescription drug benefits, we may disclose information about your prescription drug utilization, including the names of your prescribing physicians, to any treating physicians or dispensing pharmacies.

- **These are the dispensing limitations.**

  Standard Option: You may purchase up to a 90-day supply of covered drugs and supplies through the Retail Pharmacy Program. You may purchase a supply of more than 21 days up to 90 days through the Mail Service Prescription Drug Program for a single copayment.

  Basic Option: When you fill a prescription for the first time, you may purchase up to a 34-day supply for a single copayment. For additional copayments, you may purchase up to a 90-day supply for continuing prescriptions and for refills.

Note: Certain drugs such as narcotics may have additional FDA limits on the quantities that a pharmacy may dispense. In addition, pharmacy dispensing practices are regulated by the state where they are located and may also be determined by individual pharmacies. In most cases, refills cannot be obtained until 75% of the prescription has been used. Call us or visit our website if you have any questions about dispensing limits. See the contact information below.

- **Important contact information.**

  Standard Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077); Mail Service Prescription Drug Program: 1-800-262-7890 (TDD: 1-800-446-7292); or www.fepblue.org.

  Basic Option: Retail Pharmacy Program: 1-800-624-5060 (TDD: 1-800-624-5077) or www.fepblue.org.

Covered medications and supplies	You pay – Standard Option	You pay – Basic Option
• Drugs, vitamins and minerals, and nutritional supplements that by Federal law of the United States require a prescription for their purchase • Insulin • Needles and disposable syringes for the administration of covered medications • Drugs to aid smoking cessation that require a prescription by Federal law ***Note:*** Prior approval is required if drug treatment extends beyond the initial course of treatment. See Section 3 for more information. • Contraceptive drugs and devices, limited to: – Depo-Provera* – Diaphragms* – Intrauterine Devices (IUDs) – Norplant* – Oral contraceptives *available only through retail and internet pharmacies ***Note:*** See Family planning in Section 5(a).	See following pages	See following pages

Covered medications and supplies – *continued on next page*

Covered medications and supplies *(continued)*	You pay – Standard Option	You pay – Basic Option
Here is how to obtain your prescription drugs and supplies: **Preferred Retail Pharmacies** • Make sure you have your Plan ID card when you're ready to purchase your prescription • Go to any Preferred retail pharmacy, or • Visit our special website, www.fepblue.org, click on "Pharmacy Programs," and follow the FEP Retail Pharmacy Providers link to fill your prescription and receive home delivery • For a listing of Preferred retail pharmacies, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our website, www.fepblue.org ***Note:*** Please be sure to request the Preferred retail or internet pharmacy listing for your specific option. Retail and internet pharmacies that are Preferred under Standard Option are not necessarily Preferred under Basic Option. ***Note:*** For prescription drugs billed for by a skilled nursing facility, nursing home, or extended care facility, we provide benefits as shown on this page for retail pharmacy-obtained drugs, as long as the pharmacy supplying the drugs to the facility is a Preferred pharmacy. For a list of the Preferred Network Long Term Care pharmacies, call 1-800-624-5060 (TDD: 1-800-624-5077) or visit our website at www.fepblue.org. **For benefit information about drugs supplied by Non-preferred pharmacies, please refer to the next page.** ***Note:*** For coordination of benefits purposes, if you need a statement of Preferred retail pharmacy benefits in order to file claims with your other coverage when this Plan is the primary payer, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077) or visit our website at www.fepblue.org.	25% of the Plan allowance	**First-time purchase of a new prescription** up to a 34-day supply: Generic drug: $10 copayment Formulary brand-name drug: $25 copayment Non-formulary brand-name drug: 50% of Plan allowance ($35 minimum) **Refills or continuing prescriptions** up to a 90-day supply: Generic drug: $10 copayment for each purchase of up to a 34-day supply ($30 copayment for 90-day supply) Formulary brand-name drug: $25 copayment for each purchase of up to a 34-day supply ($75 copayment for 90-day supply) Non-formulary brand-name drug: 50% of Plan allowance ($35 minimum for each purchase of up to a 34-day supply, or $105 minimum for 90-day supply) ***Note:*** If there is no generic equivalent available, you must still pay the brand-name copayment when you receive a brand-name drug. ***Note:*** For generic and brand-name drug purchases, if the cost of your prescription is less than your cost-sharing amount noted above, you pay only the cost of your prescription.

Covered medications and supplies – *continued on next page*

Covered medications and supplies *(continued)*	**You pay – Standard Option**	**You pay – Basic Option**
Non-preferred Retail Pharmacies	45% of the Plan allowance (AWP), plus any difference between our allowance and the billed amount ***Note:*** If you use a Non-preferred retail pharmacy, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims.	*All charges*
Mail Service Prescription Drug Program Under Standard Option, if your doctor orders more than a 21-day supply of covered drugs or supplies, up to a 90-day supply, you can use this service for your prescriptions and refills. Please refer to Section 7 for instructions on how to use the Mail Service Prescription Drug Program. ***Note:*** Not all drugs are available through the Mail Service Prescription Drug Program.	Mail Service Program: $10 generic $35 brand-name ***Note:*** If there is no generic equivalent available, you must still pay the brand-name copayment when you receive a brand-name drug. ***Note:*** If the cost of your prescription is less than your copayment, you pay only the cost of your prescription. The Mail Service Prescription Drug Program will charge you the lesser of the prescription cost or the copayment when you place your order. If you have already sent in your copayment, they will credit your account with any difference.	No benefit ***Note:*** You may request home delivery of your internet prescription drug purchases. See page 80 of this Section for our payment levels for drugs obtained through Preferred retail and internet pharmacies.

Covered medications and supplies – *continued on next page*

Covered medications and supplies *(continued)*	You pay – Standard Option	You pay – Basic Option
Drugs from other sources • Covered prescription drugs and supplies not obtained at a retail pharmacy, through an internet pharmacy, or, for Standard Option only, through the Mail Service Prescription Drug Program ***Note:*** Drugs purchased overseas must be the equivalent to drugs that by Federal law of the United States require a prescription. ***Note:*** For covered prescription drugs and supplies purchased outside of the United States and Puerto Rico, please submit claims on an Overseas Claim Form. See Section 7 for information on how to file claims for overseas services. • Please refer to Sections 5(a) and 5(c) for additional benefit information when you purchase drugs from a: – Physician's office – Home health care agency – Hospital (inpatient or outpatient) – Hospice agency	Preferred: 10% of the Plan allowance (calendar year deductible applies) Participating/Member: 25% of the Plan allowance (calendar year deductible applies) Non-participating/Non-member: 25% of the Plan allowance (calendar year deductible applies); plus any difference between our allowance and the billed amount	Preferred: 30% of the Plan allowance Participating/Member or Non-participating/Non-member: You pay all charges

Covered medications and supplies – *continued on next page*

Covered medications and supplies *(continued)*	You pay – Standard Option	You pay – Basic Option
Prior Approval As part of our Patient Safety and Quality Monitoring (PSQM) program (see below), members must request and receive prior approval for certain prescription drugs and supplies in order to use their prescription drug coverage. Prior approval must be renewed periodically. To obtain a list of these drugs and supplies and to obtain prior approval request forms, call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077). You can also obtain the list through our website at www.fepblue.org. Please read Section 3 for more information about prior approval. ***Note:*** If your prescription requires prior approval and you have not yet obtained prior approval, you must pay the full cost of the drug or supply at the time of purchase and file a claim with the Retail Pharmacy Program to be reimbursed. Please refer to Section 7 for instructions on how to file prescription drug claims. **Patient Safety and Quality Monitoring (PSQM)** We have a special program to promote patient safety and monitor health care quality. Our Patient Safety and Quality Monitoring (PSQM) program features a set of closely aligned programs that are designed to promote the safe and appropriate use of medications. Examples of these programs include: • Prior approval – As described above, this program requires that approval be obtained for certain prescription drugs and supplies before we provide benefits for them. • Safety checks – Before your prescription is filled, we perform quality and safety checks for usage precautions, drug interactions, drug duplication, excessive use, and frequency of refills. • Quantity allowances – Specific allowances for several medications are based on FDA-approved recommendations, clinical studies, and manufacturer guidelines. For more information about our PSQM program, including listings of drugs subject to prior approval or quantity allowances, visit our website at www.fepblue.org or call the Retail Pharmacy Program at 1-800-624-5060 (TDD: 1-800-624-5077).		

Covered medications and supplies – *continued on next page*

Covered medications and supplies *(continued)*	**You pay – Standard Option**	**You pay – Basic Option**
Not covered: • *Medical supplies such as dressings and antiseptics* • *Drugs and supplies for cosmetic purposes* • *Drugs and supplies for weight loss* • *Drugs for orthodontic care, dental implants, and periodontal disease* • *Medication that does not require a prescription under Federal law even if your doctor prescribes it or a prescription is required under your State law* • *Drugs for which prior approval has been denied or not obtained*	*All charges*	*All charges*

Section 5 (g). Special features

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

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.
- **Under Standard Option,** the calendar year deductible applies only to the accidental injury benefit below. We added "(calendar year deductible applies)" when it applies.
- **Under Basic Option,** there is **no calendar year deductible.**
- **Under Basic Option, you must use Preferred providers in order to receive benefits, except in cases of dental care resulting from an accidental injury as described below.**
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including Medicare.
- ***Note:*** We cover hospitalization for dental procedures only when a non-dental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient (even if the dental procedure itself is not covered).

IMPORTANT

Accidental injury benefit	You pay – Standard Option	You pay – Basic Option
We provide benefits for services, supplies, or appliances for dental care necessary to promptly repair injury to sound natural teeth required as a result of, and directly related to, an accidental injury. ***Note:*** An **accidental injury** is an injury caused by an external force or element such as a blow or fall and that requires immediate attention. Injuries to the teeth while eating are not considered accidental injuries. ***Note:*** A **sound natural tooth** is a tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal, or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth. ***Note:*** Treatment must be started promptly and completed within 12 months of the accident.	Preferred: 10% of the Plan allowance (calendar year deductible applies) Participating: 25% of the Plan allowance (calendar year deductible applies) Non-participating: 25% of the Plan allowance (calendar year deductible applies), plus any difference between our allowance and the billed amount ***Note:*** Under Standard Option, we first provide benefits as shown in the Schedule of Dental Allowances on the following pages. We then pay benefits as shown here for any balances.	$20 copayment ***Note:*** **We provide benefits for accidental dental injury care in cases of medical emergency when performed by Preferred or Non-preferred providers.** See Section 5(d) for the criteria we use to determine if emergency care is required. You are responsible for the applicable copayment as shown above. If you use a Non-preferred provider, you may also be responsible for any difference between our allowance and the billed amount. ***Note:*** All follow-up care must be performed and billed for by Preferred providers to be eligible for benefits.

Dental benefits – *continued on next page*

Dental benefits *(continued)*

What is Covered

Standard Option dental benefits are presented in the chart beginning below and continuing on the following pages.

Basic Option dental benefits appear on page 91.

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

Preferred Dental Network

All Local Plans contract with Preferred dentists who are available in most areas. Preferred dentists agree to accept a negotiated, discounted amount called the Maximum Allowable Charge (MAC) as payment in full for the following services. They will also file your dental claims for you. Under Standard Option, you are responsible, as an out-of-pocket expense, for the difference between the amount specified in this Schedule of Dental Allowances and the MAC. To find a Preferred dentist near you or to obtain a copy of the applicable MAC listing, refer to the Preferred provider directory, visit our website at www.fepblue.org, or call us at the customer service number on the back of your ID card.

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

Standard Option dental benefits

Under Standard Option, we pay billed charges for the following services, up to the amounts shown per service as listed in the Schedule of Dental Allowances on the following pages below. This is a complete list of dental services covered under this benefit for Standard Option. There are no deductibles, copayments, or coinsurance. You pay all charges in excess of our listed fee schedule amounts.

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

Dental benefits – *continued on next page*

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

Dental benefits – *continued on next page*

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

Dental benefits – *continued on next page*

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

Dental benefits – *continued on next page*

Basic Option dental benefits

Under Basic Option, we provide benefits for the services listed below. You pay a $20 copayment for each evaluation, and we pay any balances in full. This is a complete list of dental services covered under this benefit for Basic Option. You **must** use a Preferred dentist in order to receive benefits. For a list of Preferred dentists, please refer to the Preferred provider directory, visit our website at www.fepblue.org, or call us at the customer service number on the back of your ID card.

Basic Option dental benefits	Basic Option Only	
Service and ADA Code	**We pay**	**You pay**
Clinical oral evaluations 0120 Periodic oral evaluation 0140 Limited oral evaluation 0150 Comprehensive oral evaluation ***Note:*** Benefits are limited to a combined total of 2 evaluations per person per calendar year for 0120 and 0150.	Preferred: All charges in excess of your $20 copayment Participating/Non-participating: Nothing	Preferred: $20 copayment per evaluation Participating/Non-participating: You pay all charges
Radiographs 0210 Intraoral – complete series including bitewings (*limited to 1 complete series every 3 years*) 0270 Bitewing – single film 0272 Bitewings – two films 0274 Bitewings – four films ***Note:*** Benefits are limited to a combined total of 4 films per person per calendar year for 0270, 0272, and 0274.		
Preventive 1110 Prophylaxis – adult *(up to 2 per calendar year)* 1120 Prophylaxis – child *(up to 2 per calendar year)* 1201 Topical application of fluoride (including prophylaxis) – child *(up to 2 per calendar year)* 1203 Topical application of fluoride (prophylaxis not included) – child *(up to 2 per calendar year)* 1351 Sealant – per tooth, first and second molars only *(once per tooth for children up to age 16 only)* ***Note:*** Benefits are limited to a combined total of 2 visits per person per calendar year for 1120 and 1201.		
Not covered: Any service not specifically listed above	*Nothing*	*All charges*

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

The benefits on this page are not part of the FEHB contract or premium, **and you cannot file an FEHB dispute regarding these benefits**. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums. In addition, these services are not eligible for benefits under the FEHB program. Please do not file a claim with us for these services.

Vision Care Program

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

Service Benefit Plan members may also obtain contact lenses through the Advantage Program. Contact one of the participating optometrists next to a LensCrafters for information on how to enroll in this program. You can also save 15% off the retail price or 5% off promotional pricing on LASIK or PRK vision correction procedures provided by the U.S. Laser Network. Simply call 1-877-552-7376 for the nearest laser facility and to receive authorization for the discount.

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

Complementary and Alternative Medicine

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

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

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

ASH Customer Service hours are from 8:00 a.m. to 9:00 p.m. eastern time, Monday through Friday.

Federal DentalBlue

Federal DentalBlue is an optional dental product with an additional premium that supplements the dental benefits included in your Service Benefit Plan coverage. To apply for Federal DentalBlue, you must be:

1. Enrolled in **Standard Option** and reside in one of the following Plan areas: Alabama, Oklahoma, or Washington State (only counties served by Regence BlueShield); or
2. Enrolled in **Basic Option** and reside in Alabama.

To purchase this additional coverage, complete and sign the Federal DentalBlue enrollment form, which you can obtain from your Local Plan.

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

Medicare Prepaid Plan Enrollment

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

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

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

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

We do not cover the following:

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

Section 7. Filing a claim for covered services

How to claim benefits

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

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

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

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

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

In addition:

- You must send a copy of the explanation of benefits (EOB) form from any primary payer [such as the Medicare Summary Notice (MSN)] with your claim.
- Bills for home nursing care must show that the nurse is a registered or licensed practical nurse.
- Claims for rental or purchase of durable medical equipment, private duty nursing, and physical, occupational, and speech therapy, require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies that are not received from the Retail Pharmacy Program, through a Preferred internet pharmacy, or through the Mail Service Prescription Drug Program must include receipts that include the prescription number, name of drug or supply, prescribing physician's name, date, and charge. (See below for information on how to obtain benefits from the Retail Pharmacy Program, a Preferred internet pharmacy, and the Mail Service Prescription Drug Program.)
- We will provide translation and currency conversion services for claims for overseas (foreign) services.

Prescription drug claims

Preferred Retail/Internet Pharmacies – When you use Preferred retail pharmacies, show your Service Benefit Plan ID card. Preferred retail pharmacies will file your claims for you. To use Preferred internet pharmacies, go to our special website, www.fepblue.org, click on "Pharmacy Programs," and follow the FEP Retail Pharmacy Providers link to fill your prescriptions and receive home delivery. Be sure to have your Service Benefit Plan ID card ready to complete your purchase. We reimburse the Preferred retail or internet pharmacy for your covered drugs and supplies. You pay the applicable coinsurance or copayment.

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

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

See the following paragraph for claim filing instructions.

Non-Preferred Retail/Internet Pharmacies

Standard Option: You must file a paper claim for any covered drugs or supplies you purchase at Non-preferred retail or internet pharmacies. Contact your Local Plan or call 1-800-624-5060 to request a retail prescription drug claim form to claim benefits. Hearing-impaired members with TDD equipment may call 1-800-624-5077. Follow the instructions on the prescription drug claim form and submit the completed form to: Blue Cross and Blue Shield Service Benefit Plan Retail Pharmacy Program, P.O. Box 52057, Phoenix, AZ 85072-2057.

Basic Option: There are **no benefits** for drugs or supplies purchased at Non-preferred retail or internet pharmacies.

Mail Service Prescription Drug Program

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

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1) Complete the initial mail order form;
2) Enclose your prescription and copayment;
3) Mail your order to Merck-Medco Rx Services, P.O. Box 30492, Tampa, FL 33633-0144; and
4) Allow approximately two weeks for delivery.

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

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

Basic Option: The Mail Service Prescription Drug Program **is not** available under Basic Option.

Records

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

Deadline for filing your claim

Send us your claim and appropriate documentation as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided you submitted the claim as soon as reasonably possible. If we return a claim or part of a claim for additional information, you must resubmit it within 90 days, or before the timely filing period expires, whichever is later.

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

Overseas claims

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

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. Write to us at the address shown on your explanation of benefits (EOB) form. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program or Mail Service Prescription Drug Program); and (c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, precertify your hospital stay or grant your request for prior approval for a service, drug, or supply); or (b) Write to you and maintain our denial – go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request – go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information – if we did not send you a decision within 30 days after we received the additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division I, 1900 E Street, NW, Washington, DC 20415-3610.

The disputed claims process *(continued)*

Send OPM the following information:

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

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

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

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

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

6 If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claims decision. This information will become part of the court record.

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

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

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

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

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

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

- If you are an annuitant under our Plan and also are actively employed, any group health insurance you have from your employer will pay primary and we will pay secondary.
- When you are entitled to the payment of health care expenses under automobile insurance, including no-fault insurance and other insurance that pays without regard to fault, your automobile insurance is the primary payer and we are the secondary payer.

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

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

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

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

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

What is Medicare?

Medicare is a health insurance program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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

- **The Original Medicare Plan (Part A or Part B)**

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

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

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

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

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

When Medicare Part A is primary –

- Under **Standard Option**, we will waive our:
  - Inpatient hospital per-admission copayments;
  - Inpatient Non-member hospital coinsurance; and
  - Non-Preferred inpatient per-day copayments for mental conditions/substance abuse care.
- Under **Basic Option,** we will waive our:
  - Inpatient hospital per-day copayments.

***Note*:** Once you have exhausted your Medicare Part A benefits, we become primary.

- Under **Standard Option**, you must then pay any difference between our allowance and the billed amount at Non-member hospitals.
- Under **Basic Option**, you must then pay the inpatient hospital per-day copayments.

When Medicare Part B is primary –

- Under **Standard Option**, we will waive our:
  - Calendar year deductible;
  - Coinsurance for services and supplies provided by physicians and other covered health care professionals (inpatient and outpatient, including mental conditions and substance abuse care);
  - Copayments for office visits to Preferred physicians and other health care professionals;
  - Copayments for routine physical examinations and preventive (screening) services performed by Preferred physicians, other health care professionals, and facilities; and
  - Outpatient facility coinsurance for medical, surgical, preventive, and mental conditions and substance abuse care.
- Under **Basic Option**, we will waive our:
  - Copayments and coinsurance for care received from covered professional and facility providers.

***Note*:** We do not waive benefit limitations, such as the 25-visit limit for home nursing visits. In addition, we do not waive any coinsurance or copayments for prescription drugs.

You must tell us about your or your covered family members' Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

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

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

- **Medicare managed care plan**

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

If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB Plan. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Under Standard Option, we will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area, but we will not waive any of our copayments, coinsurance, or deductibles, if you receive services from providers who do not participate in the Medicare managed care plan.

Under Basic Option, we provide benefits for care received from Preferred providers when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area. However, we will not waive any of our copayments or coinsurance for services you receive from Preferred providers who do not participate in the Medicare managed care plan. Please remember that you must receive care from Preferred providers in order to receive Basic Option benefits. See page 11 for the exceptions to this requirement.

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

- **Private contract with your physician**

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

- **If you do not enroll in Medicare Part A or Part B**

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE

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

Workers' Compensation

We do not cover services that:

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

Once OWCP or a similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

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

When other Government agencies are responsible for your care

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

When others are responsible for injuries

If another person or entity, through an act or omission, causes you to suffer an injury or illness, and if we pay benefits for that injury or illness, you must agree to the following:

- All recoveries you obtain (whether by lawsuit, settlement, or otherwise), no matter how described or designated, must be used to reimburse us in full for benefits we paid. Our share of any recovery extends only to the amount of benefits we have paid or will pay to you or, if applicable, to your heirs, administrators, successors, or assignees.
- We will not reduce our share of any recovery unless we agree in writing to a reduction, (1) because you do not receive the full amount of damages that you claimed or (2) because you had to pay attorneys' fees. This is our right of recovery.
- If you do not seek damages for your illness or injury, you must permit us to initiate recovery on your behalf (including the right to bring suit in your name). This is called subrogation.
- If we pursue a recovery of the benefits we have paid, you must cooperate in doing what is reasonably necessary to assist us. You must not take any action that may prejudice our rights to recover.

You must tell us promptly if you have a claim against another party for a condition that we have paid or may pay benefits for, and you must tell us about any recoveries you obtain, whether in or out of court. We may seek a lien on the proceeds of your claim in order to reimburse ourselves to the full amount of benefits we have paid or will pay.

We may request that you assign to us (1) your right to bring an action or (2) your right to the proceeds of a claim for your illness or injury. We may delay processing of your claims until you provide the assignment.

***Note*:** We will pay the costs of any covered services you receive that are in excess of any recoveries made.

The following are examples of circumstances in which we may subrogate or assert a right of recovery:

- When you or your dependent are injured on premises owned by a third party; or
- When you or your dependent are injured and benefits are available to you or your dependent, under any law or under any type of insurance, including, but not limited to:
  - Personal injury protection benefits
  - Uninsured and underinsured motorist coverage (does not include no-fault automobile insurance)
  - Workers' compensation benefits
  - Medical reimbursement coverage

Contact us if you need more information about subrogation.

Section 10. Definitions of terms we use in this brochure

Accidental injury

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

Admission

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

Assignment

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

Calendar year

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

Carrier

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

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See page 15.

Copayment

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

Cosmetic surgery

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

Covered services

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

Custodial care

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

1. Personal care including help in walking, getting in and out of bed, bathing, eating (by spoon, tube, or gastrostomy), exercising, or dressing;
2. Homemaking, such as preparing meals or special diets;
3. Moving the patient;
4. Acting as companion or sitter;
5. Supervising medication that can usually be self-administered; or
6. Treatment or services that any person can perform with minimal instruction, such as recording pulse, temperature, and respiration; or administration and monitoring of feeding systems.

The Carrier, its medical staff, and/or an independent medical review determines which services are custodial care.

Deductible

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

Durable medical equipment

Equipment and supplies that:

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

Experimental or investigational services

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

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

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

   Reliable evidence shall mean only:

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

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

For more detailed information, contact your Local Plan at the customer service telephone number located on the back of your Service Benefit Plan ID card.

Group health coverage

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

Intensive outpatient care

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

Lifetime maximum

The maximum amount the Plan will pay on your behalf for covered services you receive while you are enrolled in your option. Benefit amounts accrued are accumulated in a permanent record regardless of the number of enrollment changes. Please see page 76.

Local Plan

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

Medical necessity

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

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

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

Mental conditions/ substance abuse

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

Partial hospitalization

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

Plan allowance

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

- **PPO providers** – Our allowance (which we may refer to as the "PPA" for "Preferred Provider Allowance") is the negotiated amount that most Preferred providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with each local Blue Cross and Blue Shield Plan, and retail and internet pharmacies that contract with AdvancePCS) have agreed to accept as payment in full, when we pay primary benefits (see page 7 for exceptions).

  Our PPO allowance includes any known discounts that can be accurately calculated at the time your claim is processed. For PPO facilities, we sometimes refer to our allowance as the "Preferred rate." The Preferred rate may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf. (See page 87 for special information about limits on the amounts Preferred dentists can charge you under Standard Option.)

- **Participating providers** – Our allowance (which we may refer to as the "PAR" for "Participating Provider Allowance") is the negotiated amount that these providers (hospitals and other facilities, physicians, and other covered health care professionals that contract with some local Blue Cross and Blue Shield Plans) have agreed to accept as payment in full, when we pay primary benefits (see page 7 for exceptions). For facilities, we sometimes refer to our allowance as the "Member rate." The member rate includes any known discounts that can be accurately calculated at the time your claim is processed, and may be subject to a periodic adjustment after your claim is processed that may decrease or increase the amount of our payment that is due to the facility. However, your cost sharing (if any) does not change. If our payment amount is decreased, we credit the amount of the decrease to the reserves of this Plan. If our payment amount is increased, we pay that cost on your behalf.

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

  - For inpatient services by hospitals and other facilities that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is the average semiprivate room rate charged for inpatient care by similar institutions in the same area, as determined by your Local Plan;

  - For outpatient services by hospitals and other facilities that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is the billed amount (minus any amounts for non-covered services);

  - For physicians and other covered health care professionals that do not contract with your local Blue Cross and Blue Shield Plan, our allowance is equal to the greater of 1) the Medicare participating fee schedule amount for the service or supply in the geographic area in which it was performed or obtained (or 60% of the billed charge if there is no equivalent Medicare fee schedule amount) or 2) 80% of the 2002 Usual, Customary, and Reasonable (UCR) amount for the service or supply in the geographic area in which it was performed or obtained. Local Plans determine the UCR amount in different ways. Contact your Local Plan if you need more information. We may refer to our allowance for Non-participating providers as the "NPA" (for "Non-participating Provider Allowance");

  - For prescription drugs furnished by retail and internet pharmacies that do not contract with AdvancePCS, our allowance is the average wholesale price ("AWP") of a drug on the date it is dispensed, as set forth in the most current version of First DataBank's National Drug Data File;

  - For services you receive outside of the United States and Puerto Rico from providers that do not contract with us or with World Access, Inc., our allowance is an Overseas Fee Schedule that is based on amounts comparable to what Participating providers in the Washington, DC, area have agreed to accept.

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

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

Precertification

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

Preferred provider organization (PPO) arrangement

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

Prior approval

Written assurance that benefits will be provided by:

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

For more information, see the benefit descriptions in Section 5 and *How to get approval for…other services* on pages 13 and 14. See Section 5(e) for special authorization requirements for mental health and substance abuse benefits.

Routine services

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

Sound natural tooth

A tooth that is whole or properly restored (restoration with amalgams only); is without impairment, periodontal or other conditions; and is not in need of the treatment provided for any reason other than an accidental injury. For purposes of this Plan, a tooth previously restored with a crown, inlay, onlay, or porcelain restoration, or treated by endodontics, is not considered a sound natural tooth.

Us/We/Our

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

You/Your

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

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you join at any other time during the year, your employing office will tell you the effective date of coverage.

Your medical and claims records are confidential

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

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

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

When you retire

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

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

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

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

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

Enrolling in TCC. 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. It explains what you have to do to enroll.

- **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

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group 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.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB website, (www.opm.gov/insure/health) and refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and have information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long term care needs. Unfortunately, they are *WRONG*!
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. *LTC insurance can supplement care provided by family members, reducing the burden you place on them.*

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. *Many people now consider long term care insurance to be vital to their financial and retirement planning.*

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed $50,000. Home care for only three 8-hour shifts a week can exceed $20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. ***Long term care insurance can protect your savings.***

But won't my FEHB plan, Medicare, or Medicaid cover my long term care?

- Not FEHB. Look at the "*Not covered*" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older, or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. ***Long term care insurance can provide choices of care and preserve your independence.***

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- OPM's toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on OPM's website at www.opm.gov/insure/ltc.

Department of Defense/FEHB Demonstration Project

What is it?

The Department of Defense/FEHB Demonstration Project allows some active and retired uniformed service members and their dependents to enroll in the FEHB Program. The demonstration will last for three years and began with the 1999 Open Season for the year 2000. The 2001 Open Season enrollments will be effective January 1, 2002. DoD and OPM have set up some special procedures to implement the Demonstration Project, noted below. Otherwise, the provisions described in this brochure apply.

Who is eligible

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

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.
- If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHB Demonstration Project.

The demonstration areas

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

When you can join

You may enroll under the DoD/FEHB Demonstration Project during the 2001 Open Season, November 12, 2001 through December 10, 2001. Your coverage will begin January 1, 2002. DoD has set up an Information Processing Center (IPC) in Iowa to provide you with information about how to enroll. IPC staff will verify your eligibility and provide you with FEHB Program information, plan brochures, enrollment instructions, and forms. The toll-free phone number for the IPC is 1-877/DOD-FEHB (1-877/363-3342).

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during Open Season. Your coverage will begin January 1, 2002. If you become eligible for the DoD/FEHB Demonstration Project outside of Open Season, contact the IPC to find out how to enroll and when your coverage will begin.

DoD has a website devoted to the Demonstration Project. You can view information such as their Marketing/Beneficiary Education Plan, Frequently Asked Questions, demonstration area locations, and zip code lists at www.tricare.osd.mil/fehbp. You can also view information about the demonstration project, including "The 2002 Guide to Federal Employees Health Benefits Plans Participating in the DoD/FEHB Demonstration Project," on the OPM website at www.opm.gov.

Temporary Continuation of Coverage (TCC) eligibility

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

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

Other features

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

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear. This Index is not an official statement of benefits.

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Standard Option – 2002

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

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	PPO: 10%* of our allowance; $15 per office visit Non-PPO: 25%* of our allowance	23-24
Services provided by a hospital: • Inpatient	PPO: $100 per admission Non-PPO: $300 per admission	55-58
• Outpatient	PPO: 10%* of our allowance (no deductible for surgery) Non-PPO: 25%* of our allowance (no deductible for surgery)	59-61
Emergency benefits: • Accidental injury	PPO: Nothing for outpatient hospital and physician services within 72 hours; regular benefits thereafter Non-PPO: Any difference between our payment and the billed amount within 72 hours; regular benefits thereafter	65-67
• Medical emergency	Regular benefits	68
Mental health and substance abuse treatment	In-Network (PPO): Regular cost sharing, such as $15 office visit copay; $100 per inpatient admission Out-of-Network (Non-PPO): Benefits are limited	70-76
Prescription drugs	Retail Pharmacy Program: • PPO: 25% of our allowance; up to a 90-day supply • Non-PPO: 45% of our allowance (AWP); up to a 90-day supply Mail Service Prescription Drug Program: • $10 generic/$35 brand-name per prescription; up to a 90-day supply	77-84
Dental care	Scheduled allowances for diagnostic and preventive services, fillings, and extractions; regular benefits for dental services required due to accidental injury and covered oral and maxillofacial surgery	47, 86-90
Special features: Flexible benefits option; 24-hour nurse line; services for deaf and hearing impaired; travel benefit/services overseas; and health support programs		85
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $4,000 (PPO) or $6,000 (PPO/Non-PPO) per contract per year; some costs do not count toward this protection	18-19

Summary of benefits for the Blue Cross and Blue Shield Service Benefit Plan Basic Option – 2002

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Basic Option does not provide benefits when you use Non-preferred providers. For a list of the exceptions to this requirement, see page 11. There is no deductible for Basic Option.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	PPO: $20 per office visit for primary care physicians and other health care professionals; $30 per office visit for specialists Non-PPO: You pay all charges	23-24
Services provided by a hospital: • Inpatient	PPO: $100 per day up to $500 per admission Non-PPO: You pay all charges	55-58
• Outpatient	PPO: $30 per day per facility Non-PPO: You pay all charges	59-61
Emergency benefits: • Accidental injury	PPO: $50 copayment for emergency room care; $30 copayment for urgent care Non-PPO: $50 copayment for emergency room care	65-67
• Medical emergency	Same as for accidental injury	68
Mental health and substance abuse treatment	In-Network (PPO): Regular cost sharing, such as $20 office visit copayment (prior approval required); $100 per day up to $500 per inpatient admission Out-of-Network (Non-PPO): You pay all charges	70-76
Prescription drugs	Retail Pharmacy Program: • PPO: $10 generic/$25 formulary brand-name per prescription/50% coinsurance ($35 minimum) for non-formulary brand-name drugs. 34-day maximum supply on initial prescription; up to 90 days for refills with 3 copayments • Non-PPO: You pay all charges	77-84
Dental care	PPO: $20 copayment per evaluation (exam, cleaning, and x-rays); most services limited to 2 per year; sealants for children up to age 16; $20 copayment for dental services required due to accidental injury; regular benefits for covered oral and maxillofacial surgery Non-PPO: You pay all charges	47, 86-87, 91
Special features: Flexible benefits option; 24-hour nurse line; services for deaf and hearing impaired; travel benefit/services overseas; and health support programs		85
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $5,000 (PPO) per contract per year; some costs do not count toward this protection	18-19

2002 Rate Information for
Blue Cross and Blue Shield Service Benefit Plan

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

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

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Standard Option Self Only	104	$97.86	$41.12	$212.03	$89.09	$115.52	$23.46
Standard Option Self and Family	105	$223.41	$94.83	$484.06	$205.46	$263.75	$54.49
Basic Option Self Only	111	$94.85	$31.61	$205.50	$68.50	$112.23	$14.23
Basic Option Self and Family	112	$223.41	$75.74	$484.06	$164.10	$263.75	$35.40