Association Benefit Plan 2002

A PLAN FOR THE FUTURE

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

For changes in benefits see page 5.

Sponsored and administered by: The Association

Who may enroll in this Plan: Members of the Association

Annuitants (retirees) who are members of the Association may enroll in this Plan

Mutual of Omaha Insurance Company, the underwriter for Association Benefit Plan, has received accreditation from URAC (also known as the American Accreditation Healthcare Commission) for Health Utilization Management Standards. See the 2002 Guide for more information on accreditation.

Enrollment codes for this Plan:

421 - Self Only
422 - 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

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Introduction

Association Benefit Plan
PO Box 668587
Charlotte, NC 28266-8587

This brochure describes the benefits of the Association Benefit Plan under the Government Employees Health Association's contract (CS 1065) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. The Plan is underwritten by Mutual of Omaha Insurance Company. 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 are summarized on page 74. 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 Association 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 any 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 OPM at the Office of Personnel Management, Office of 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 1-800-634-0069 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 physicians, hospitals, and other 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 also have Preferred Provider Organizations (PPO):

Our fee-for-service plan offers services through a PPO. When you reside in the PPO network area and use our PPO providers, you will receive covered services at reduced cost. If you reside in Washington, DC, or in one of the states listed below, contact us at 1-800-634-0069 for information concerning your PPO. You can also go to the Mutual of Omaha website, www.mutualofomaha.com, for PPO information. Do not call OPM for our provider directory. Also, when you phone for an appointment, please verify that your physician is still a PPO provider.

The Out-of-network benefits are the standard benefits of this plan. PPO benefits apply only when you reside in the PPO network area and use a PPO provider**. You must present your PPO identification (ID) card confirming your PPO participation to be eligible for PPO benefits.** Provider networks may be more extensive in some areas than others. We cannot guarantee the availability of every specialty in all areas. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply. When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, emergency room physicians, anesthesiologists, and pathologists, may not all be preferred providers. If they are not, they will be paid as non-PPO providers.

The PPO Network Area consists of Washington, D.C. and selected counties and cities in the following states:

Alabama	Alaska	Arizona	Arkansas	California	Colorado
Connecticut	Delaware	Florida	Georgia	Idaho	Illinois
Indiana	Iowa	Maryland	Massachusetts	Michigan	Missouri
Nevada	New Jersey	New Mexico	New York	North Carolina	Ohio
Oregon	Pennsylvania	South Carolina	Tennessee	Texas	Utah
Virginia	Washington	West Virginia			

If you reside in the PPO network area and no PPO provider is available, or if you do not use a PPO provider, non-PPO benefits apply.

How we pay providers

Our participating providers are generally reimbursed according to an agreed-upon fee schedule and are not offered additional financial incentives based on care provided or not provided to you. Our standard provider agreements do not contain any contractual provisions that include incentives to restrict a providers ability to communicate with and advise patients of any appropriate treatment options. In addition, the Plan has no compensation, ownership, or other influential interests that are likely to affect provider advice or treatment decisions.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. If you want more information about us, call 1-800-634-0069, or write to Association Benefit Plan, PO Box 668587, Charlotte, NC 28266-8587.

Section 2. How we change for 2002

Do not rely 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 changed the address for sending disputed claims to OPM. (Section 8).
- The following four states have been added to the list of medically underserved in 2002: Georgia, Montana, North Dakota, and Texas. Louisana has been removed from the list of medically underserved states in 2002. See page 7.

Changes to this Plan

- We now cover intestinal transplants. (Section 5(b)).
- We changed speech therapy benefits by removing the requirement that services must be required to restore functional speech. (Section 5(a)).
- We clarified the brochure to better explain that the Out-of-network benefits are the standard benefits of this Plan, that PPO benefits apply only when you reside in the PPO network area and use a PPO provider, and that when no PPO provider is available, non-PPO benefits apply.
- We expanded our optional hospital and physician Preferred Provider Organization (PPO) network area to include selected counties and cities in the following states: Alabama, Arizona, Arkansas, Colorado, Connecticut, Florida (North), Georgia, Illinois, Indiana, Iowa, Massachusetts, Michigan, Missouri, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, South Carolina, Tennessee, Texas, Utah, Virginia (Roanoke) and West Virginia. (Section 4).
- If you reside in the PPO network area and use PPO providers, annual routine preventative care services provided outside the physician's office will be paid at 100% of the Plan allowance, not subject to the deductible. (Section 5(a)).
- A routine mammogram is now available annually for women 35 years and older. (Section 5(a)).
- If you have an accidental injury, we will pay 100% of the Plan allowance, not subject to the deductible, of the first $500 of your outpatient expenses. Your subsequent outpatient care will be paid under the appropriate benefit and at your applicable copayment/coinsurance amount. (Section 5(d)).
- If you have an accidental dental injury while enrolled in the Plan, we will pay 80% of the Plan allowance, not subject to the deductible, until the treatment is completed as long as you remain enrolled in the Plan. (Section 5(h)).
- Smoking cessation benefits will be limited to $100 per 12 months and will be paid at your applicable copayment/coinsurance amount, subject to the calendar year deductible. (Section 5(a)).
- Physical, speech, and occupational therapy visits will be limited to total combined 90 visits. We removed speech therapy limitations. (Section 5(a)).
- Your calendar year deductible will increase to $300 per person or $600 per family. (Section 4)
- Your inpatient hospital copayment will increase to $100 for PPO; and $200 for Non-PPO and Out-of-network facilities. (Section 5(c)).
- Your out-of-pocket maximum for PPO and Out-of-network providers will increase to $2,500 and to $3,500 for Non-PPO providers. (Section 4).
- Your share of the premiums will increase by 15.4% for Self Only or 13.2% for Self and Family.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card and a Prescription Drug Card when you enroll. You should carry both cards with you at all times. You must show your ID card whenever you receive services from a medical or dental provider, or your Prescription Drug Card to fill a prescription at a participating Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, or your health benefits enrollment confirmation (for annuitants).

If you do not receive your cards within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-634-0069.

Where you get covered care

You can get care from any "covered provider" or "covered facility." How much we pay – and you pay – depends on the type of covered provider or facility you use. If you reside in the PPO network area and use our preferred providers, you will pay less.

- **Covered providers**

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

— **Physician**: Doctors of medicine or psychiatry (M.D.), osteopathy (D.O.), dental surgery (D.D.S.), medical dentistry (D.M.D.), podiatric medicine (D.P.M.), and optometry (O.D.) when acting within the scope of their licenses or certification.

— **Qualified Clinical Psychologist**: An individual who has earned either a Doctoral or Masters Clinical Degree in psychology or an allied discipline and who is licensed or certified in the state where services are performed. This presumes a licensed individual has demonstrated to the satisfaction of state licensing officials that he/she, by virtue of academic and clinical experience, is qualified to provide psychological services in that state.

— **Nurse Midwife**: A person who is certified by the American College of Nurse Midwives or is licensed or certified as a nurse midwife in states requiring licensure or certification.

— **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) is licensed or certified as a nurse practitioner or clinical nurse specialist in states requiring licensure or certification.

— **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) in states requiring licensure, certification or registration, is licensed, certified, or registered as a social worker where the services are rendered.

— **Physician Assistant**: A person who is licensed, registered, or certified in the state where services are performed.

— **Licensed Professional Counselor or Master's Level Counselor**: A person who is licensed, registered, or certified in the state where services are performed

— **Nursing School Administered Clinic**: A clinic that is

1) licensed or certified in the state where the 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

— **Christian Science Practitioner**: If you choose to visit a Christian Science practitioner instead of a physician, the charges are still considered allowable expenses. To qualify for benefits, you must make this choice annually. The benefits will then apply to all subsequent expenses incurred during the year. You can change your mind only at the time of your first claim each year. The practitioner you choose must be listed as such in the *Christian Science Journal* that is current at the time the service is provided. Your choice will not apply to, or prevent payment of, a physician's maternity charges.

Medically underserved areas. We cover any licensed medical practitioner for any covered service performed within the scope of that license in states OPM determines are "medically underserved." For 2002, the states are: Alabama, Georgia, Idaho, Kentucky, Mississippi, Missouri, Montana, New Mexico, North Dakota, South Carolina, South Dakota, Texas, Utah, and Wyoming.

- **Covered facilities**

Covered facilities include:

- **Hospital**

1) An institution that is accredited as a hospital under the hospital accreditation program of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); or

2) Any other institution that is operated pursuant to law, under the supervision of a staff of doctors and with 24-hours-a-day nursing service, and that is primarily engaged in providing:

a) General patient care and treatment of sick and injured persons through medical, diagnostic and major surgical facilities, all of which facilities must be provided on its premises or under its control; or

b) specialized inpatient medical care and treatment of sick or injured persons through medical and diagnostic facilities (including X-ray and laboratory) on its premises, under its control, or through a written agreement with a hospital (as defined above) or with a specialized provider of those facilities.

In no event shall the term hospital include a convalescent nursing home or institution or part thereof that:

1) is used principally as a convalescent facility, rest facility, nursing facility or facility for the aged;

2) furnishes primarily domiciliary or custodial care including training in the routines of daily living; or

3) is operated as a school.

For inpatient and outpatient treatment of alcohol and drug abuse, the term hospital also includes a free-standing alcohol and drug abuse treatment facility approved by the JCAHO.

- **Skilled nursing facility**: An institution, or that part of an institution that provides convalescent skilled nursing care 24 hours a day and is classified as a skilled nursing facility under Medicare.

- **Birthing Center**: A licensed facility that is equipped and operated solely to provide prenatal care, to perform uncomplicated spontaneous deliveries and to provide immediate post-partum care.

- **Hospice**: A facility that meets all of the following:

  1) primarily provides inpatient hospice care to terminally ill persons;

  2) is certified by Medicare as such, or is licensed or accredited as such by the jurisdiction it is in;

  3) is supervised by a staff of M.D.s or D.O.s, at least one of whom must be on call at all times; and

  4) provides 24-hour-a-day nursing services under the direction of an R.N. and has a full-time administrator; and

  5) provides an ongoing quality assurance program.

What you must do to get covered care

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

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 PPO 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 PPO 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 until the end of your postpartum care, even if it is beyond the 90 days.

Hospital care:

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our customer service department immediately at 1-800-634-0069.

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 won't 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 may not pay any benefits.

How to precertify an admission:

- You, your representative, your physician, or your hospital must call us at 1-800-634-0069 before 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, the physician, or the 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 physician;

— Name of hospital or facility; and

— Number of planned days of confinement.

- We will then tell the physician and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your physician, 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 physician or the hospital must ask us to approve the additional days.

What happens when you do not follow the precertification rules

- When we precertified the admission but you remained in the hospital beyond the number of days we approved and did not get the additional days precertified, then:

  — for the part of the admission that was medically necessary, we will pay inpatient benefits, but

  — for the part of the admission that was not medically necessary, we will pay only medical services and supplies otherwise payable on an outpatient basis and will not pay inpatient benefits.

- If no one contacted us, we will decide whether the hospital stay was medically necessary.

  — If we determine that the stay was medically necessary, we will pay the inpatient charges, less the $500 penalty.

  — If we determine that it was not medically necessary for you to be an inpatient, we will not pay inpatient hospital benefits. We will only pay for any covered medical supplies and services that are otherwise payable on an outpatient basis.

- If no one contacted us for specified services such as Hospice Care, Skilled Nursing Facility Care, Home Health Care, we will disqualify higher paid benefits.

- If we denied the precertification request, 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.

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**

Some other services require precertification, or prior authorization, such as:

- Home health care
- Hospice care
- Organ/tissue transplants
- Skilled nursing facilities
- Psychiatric and substance abuse treatment
- Surgery for morbid obesity

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 services. You will only be responsible for one copayment per day to a provider or facility.

  Example: When you see your PPO physician you pay a copayment of $10 per visit, and when you go in a PPO hospital, you pay a copayment of $100 per admission.

- **Deductible**

  A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible.

  - The calendar year deductible is $300 per person. Under a family enrollment, the deductible is satisfied for all family members when the combined covered expenses applied to the calendar year deductible for family members reach $600.

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

- **Coinsurance**

  Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your deductible.

  Example: You pay 10% of our allowance for an X-ray.

  Note: If your provider routinely waives (does not require you to pay) your copayments, deductibles, or coinsurance, 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.

  For example, if your physician ordinarily charges $100 for a service but routinely waives your 10% coinsurance, the actual charge is $90. We will pay $81 (90% of the actual charge of $90).

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

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

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

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

- **Non-PPO providers**, on the other hand, have no agreement to limit what they will bill you. For instance,

  — **When reside in the PPO network area and use a non-PPO provider**, you will pay your deductible and coinsurance—**plus** any difference between our allowance and charges on the bill. Here is an example: You see a non-PPO physician who charges $150 and our allowance is again $100. Because you've met your deductible, you are responsible for your coinsurance, so you pay **25%** of our $100 allowance ($25). Plus, because there is no agreement between the non-PPO physician and us, he can bill you for the $50 difference between our allowance and his bill.

  — **When you reside outside the PPO network area**, you will pay your deductible and coinsurance – **plus** any difference between our allowance and charges on the bill. As in the example above, once you have met your deductible, you are responsible for your coinsurance. You will pay **15%** of our allowance ($15) and the physician can bill you for the $50 difference between our allowance and his bill.

The following table illustrates the examples of how much you have to pay out-of-pocket for services from a PPO physician vs. a non-PPO physician when you reside in the PPO network area. The table uses our example of a service for which the physician charges $150 and our allowance is $100. The table shows the amount you pay if you have met your calendar year deductible.

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

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

If your out-of-pocket coinsurance expenses exceed your catastrophic limit in a calendar year, we will pay 100% of the Plan allowance for the remainder of the year. The calendar year limits are:

- PPO providers: $2,500
- Non-PPO providers: $3,500
- Out-of-network providers: $2,500

Out-of-pocket expenses are:

- Your $300/$600 calendar year deductible;

- The percentage you pay for covered services after you have met your deductible;
- The percentage you pay for surgery, anesthesia and extended medical care after an accidental injury; and
- Your copayment for hospital admissions.

The following cannot be included in your out-of-pocket expenses:

- Expenses in excess of the Plan allowance or maximum benefit limitations;
- Non-covered services and supplies;
- Prescription drug copayments;
- PPO copayments;
- Expenses for dental care including the 20% you pay for dental care after an accidental injury; or
- Any amounts you pay if benefits have been reduced because of noncompliance with our cost containment requirements.

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. If your claim has been paid in error for any reason, we shall make a diligent effort to recover an overpayment to you from you or, if to the provider, from the provider. We may reduce subsequent benefit payments to the member or to a provider on behalf of the member to offset overpayments.

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 or 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, not on the actual charge;
- you are responsible for your applicable deductibles, 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; and
- the law prohibits a hospital from collecting more than the Medicare equivalent amount.

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

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

If your physician…	Then you are responsible for…
Participates with Medicare or accepts Medicare assignment for the claim and is a member of our PPO network,	your deductibles, coinsurance, copayments; and any balance up to the Medicare approved amount;
Participates with Medicare and is **not** in our PPO network,	your deductibles, coinsurance, copayments, and any balance up to the Medicare approved amount;
Does not participate with Medicare,	your deductibles, coinsurance, copayments, and any balance up to 115% of the Medicare approved amount

It is generally to your financial advantage to use a physician who participates with Medicare. Such physicians are 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 the 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 A (Hospital insurance) and Medicare B (Medical insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to an institutional 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 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: 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 Medicare will send you 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 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. We will still limit our payment to the amount we would have paid after Medicare's payment.

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 5 for how our benefits changed this year and page 74 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800-634-0069.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: $300 per person ($600 per family). The calendar year deductible applies to almost all benefits in this Section. We added - * - to show when the calendar year deductible **does not** apply.
- The Out-of-network benefits are the standard benefits of this Plan. PPO benefits apply only when you reside in the PPO network area and use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We added asterisks - * - to show when the calendar year deductible does not apply.	
Diagnostic and treatment services	
Professional services of physicians • In physician's office	PPO: $10 copayment* Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount.
Professional services of physicians • In a hospital or urgent care center • In a skilled nursing facility • Second surgical opinion • At home	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount.
Note: For physical therapy treatment, see *Physical, occupational and speech therapies*.	

Lab, X-ray and other diagnostic tests	You pay
Tests, such as: • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG • Sonograms	PPO: Services **in physician's office—**$10 copayment* PPO: Services **outside physician's office**—10% of the Plan allowance Note: If your PPO provider uses a non-PPO lab or radiologist, we will pay non-PPO benefits for any lab and X-ray charges. Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount.
Not covered: *Preventative medical care and services (including periodic checkups and immunizations such as polio, flu, mumps, and smallpox shots), except as provided under Preventative care, adult and children, page 20* *Telephone consultations*	*All charges*
Preventive care, adult	
One annual routine physical examination per person to include a history and physical, chest X-ray, urinalysis, blood tests, and EKG (electrocardiogram). One annual cervical cancer screening (pap smear) for women age 18 and older. Note: if you see another physician for your pap smear, the office visit will be covered. One annual Prostate Specific Antigen test (PSA—prostate cancer screening) for men age 40 and older. One annual fecal occult blood test (colorectal cancer screening) for members age 40 and older. A sigmoidoscopy once every five years starting at age 50. One annual routine mammogram (breast cancer screening) for women age 35 and older: **NOTE**: Your physician's bill **must** clearly state "Routine Physical Exam". If a medical diagnosis is provided on the bill, those services will be paid under the medical benefit.	PPO: **Services in physician's office**—$10 copayment* PPO: **Services outside physician's office—** Nothing* Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Out-of-Network: 15% of the Plan allowance and any difference between our allowance and the billed amount.*

Preventative care, adult - *Continued*	**You Pay**
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Pneumococcal vaccine, annually, age 65 and over • Influenza vaccine, annually, regardless of age	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount
Preventive care, children	
• Childhood immunizations recommended by the American Academy of Pediatrics (to age 22)	PPO: Nothing* Non-PPO: Only the difference between the Plan allowance and the billed amount* Out-of-network: Only the difference between the Plan allowance and the billed amount*
• For well-child care charges for routine examinations and care (to age 2)	PPO: 10% of the Plan allowance. Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount. Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount
Maternity care	
Complete maternity (obstetrical) care such as: • Prenatal care • Amniocentesis • Inpatient delivery • Initial, routine examination of your newborn infant covered under your family enrollment • Circumcision of your newborn infant • Postnatal care	PPO: 10% of the Plan allowance* Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount* Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount*
Note: Here are some things to keep in mind • You do not have to precertify your normal delivery; see page 9 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 physician or your hospital must precertify.	

Maternity care- *Continued*	**You Pay**
• We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See *Hospital benefits* (Section 5(c)) and *Surgery benefits* (Section 5(b)). • If your baby stays in the hospital after your discharge and is covered under yourself and Family enrollment, you must pay a separate hospital admission. See Section 5(c), *Hospital benefits*. • Bassinet or nursery charges on which you and your baby are confined are considered your maternity expenses, not your baby's. • Sonograms and other related tests that are not included in your routine prenatal or postnatal care are covered in Lab, X-ray, and other diagnostic tests, page 19.	
Outpatient maternity (obstetrical care) for covered hospital and physician services at the time of delivery, including the initial, routine examination of your newborn infant covered under your family enrollment, when: • Delivery is on an outpatient basis; • Delivery is at a licensed birthing center; or • Inpatient delivery results in a hospital confinement of one day (overnight) or less and no more than one day's room and board charge applies	PPO: Nothing* Non-PPO: Only the difference between the Plan allowance and the billed amount* Out-of-network: Only the difference between the Plan allowance and the billed amount*
Note: If you or your newborn child is transferred from a birthing center to a hospital due to medical complications, the birth center expenses will be paid as inpatient care. If you and your child leave the hospital against medical advice, this outpatient benefit is not payable.	
Not covered: *Routine sonograms to determine fetal age, size or sex; or 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 or rape or incest*	*All charges*

Family planning	You Pay
A broad range of voluntary family planning services, limited to: • Voluntary sterilization (such as Norplant) • Surgically implanted contraceptives • Intrauterine devices (IUDs)	PPO: 10% of the Plan allowance* Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount* Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount*
• Injection of contraceptive drugs (such as Depo-Provera) Note: We cover oral contraceptive drugs in Section 5(f), *Prescription drug benefits*. Note: We cover contraceptive drugs in Section 5(f).	PPO: $10 copay* Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: reversal of voluntary surgical sterilization, genetic counseling,	*All charges.*
Infertility services	
Diagnosis and treatment of infertility including prescription drugs, up to $5,000 per person per lifetime, except as shown in *Not covered*.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount

Infertility services- *Continued*	**You Pay**
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* — artificial insemination — in vitro fertilization — embryo transfer and GIFT — intravaginal insemination (IVI) — intracervical insemination (ICI) — intrauterine insemination (IUI) • *Services and supplies related to ART procedures.* • *Cost of donor sperm* • *Cost of donor egg*	*All charges*
Allergy care	
Allergy testing, injections and treatment Note: We cover allergy serum in Section 5(f), *Prescription drug benefits*	PPO services **in physician's office**: $10 copayment* PPO services **outside physician's office**: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: Provocative food testing, end point titration techniques, hair analysis, and sublingual allergy desensitization	*All charges*

Treatment therapies	You Pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed in Section 5(b), Organ/tissue transplants. Note: We cover chemotherapy drugs in Section 5(f). • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Respiratory and inhalation therapies • Growth hormone therapy (GHT) Note: – We only cover GHT when you obtain prior approval. Call 1-800-634-0069 for preauthorization. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See services requiring our prior approval in Section 3. Note: Growth hormone is covered under the prescription drug benefit.	PPO services **in physician's office**: $10 copayment* PPO services **outside physician's office**: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount
Physical, occupational, and speech therapies	
90 total combined visits per calendar year for the following: • Visits for the services of each of the following: — physicians; — qualified physical therapists; — speech therapists; and — occupational therapists	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount
Note: We only cover therapy when a physician: 1) orders the care; 2) identifies the specific professional skills you require and the medical necessity for skilled services; and 3) indicates the length of time you need the services.	

Physical, occupational, and speech therapies (continued)	You Pay
Not covered: • *Exercise programs*	*All charges*
Hearing services (testing, treatment, and supplies)	
First hearing aid and testing only when necessitated by accidental injury or intra-aural surgery. Note: Expenses must be incurred within one year of the date of the accident or surgery.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Hearing aids, testing and examinations for them, except for accidental injury or intra-aural surgery.*	*All charges*.
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses per lifetime to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) Note: Services must be received within one year of the date of accident or surgery.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Eyeglasses or contact lenses and examinations for them, except for accidental injury and intraocular surgery* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery* • *Eye refractions*	*All charges.*

Foot care	You pay
No routine benefits	All charges
Orthopedic and prosthetic devices	
• Orthopedic braces, canes, casts, cervical collars, cervical traction kits, crutches splints and trusses • Artificial limbs and eyes to replace natural limbs and eyes; stump hose • Two externally worn breast prostheses and two surgical bras per calendar year, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See Section 5(b), *Surgery procedures*, for coverage of the surgery to insert the device.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount
• Two wigs per lifetime, up to a maximum of $150 each, when required due to hair loss in connection with chemotherapy or radiation treatment	PPO: 10% of the Plan allowance* Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount* Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount*
Not covered: • *Orthopedic and corrective shoes and other supportive devices for the feet* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices*	*All charges*

Durable medical equipment (DME)	You Pay
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 purchase or rental up to the purchase price, at our option, including repair and adjustment, of durable medical equipment, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds; • Respirators; • Wheelchairs; • Crutches; and • Walkers.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: Sun or heat lamps, whirlpool baths, heating pads, air purifiers, humidifiers, air conditioners, and exercise devices	*All charges*

Home health services	You pay
For services provided on a **part-time basis** (less than an 8-hour shift): **If precertified**, 90 visits per calendar year up to a maximum Plan payment of $80 per visit when: • A registered nurse (R.N.) or licensed practical nurse (L.P.N.) provides the services; • A licensed therapist provides physical, occupational or speech therapy; • The attending physician orders the care; • The physician identifies the specific professional skills required by the patient and the medical necessity for skilled services; and • The physician indicates the length of time the services are needed.	PPO: Charges in excess of $80 per visit* (90 visit maximum) Non-PPO: Charges in excess of $80 per visit and any difference between the Plan allowance and the billed amount* (90 visit maximum) Out-of-network: Charges in excess of $80 per visit and any difference between the Plan allowance and the billed amount* (90 visit maximum)

Home health services (continued)	You pay
If not precertified, 40 visits per calendar year up to a maximum plan payment of $40, subject to the above provisions.	PPO: Charges in excess of $40 per visit.* (40 visit maximum) Non-PPO: Charges in excess of $40 per visit and any difference between the Plan allowance and the billed amount* (40 visit maximum) Out-of-network: Charges in excess of $40 per visit and any difference between the Plan allowance and the billed amount* (40 visit maximum)
For private duty nursing provided on a ***full-time basis*** (more than an 8-hour shift) by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) when: • the care is ordered by the attending physician, and • your physician identifies the specific professional nursing skills that you require, as well as the length of time needed.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative;* • *Custodial care as defined in Section 10, Definitions.*	*All charges.*
Chiropractic	
No benefits.	All charges
Alternative treatments	**You Pay**
Acupuncture when used as an anesthetic agent for covered surgery	PPO: 10% of the Plan allowance* Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount* Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount*

Alternative treatments (continued)	You Pay
Not covered: • *Chiropractic services* • *Chelation therapy except for acute arsenic, gold, mercury, or lead poisoning* • *Naturopathic services* *(Note: Benefits of certain alternative treatment providers may be covered in medically underserved areas; see pages 8)*	*All charges*
Educational classes and programs	
Coverage is limited to: • Smoking Cessation – Up to $100 maximum for one program per 12 months to include 1. Individual/Group counseling and over-the-counter (OTC) drugs and	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount
2. Office visits for Smoking Cessation	PPO: $10 copayment* Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount
Note: Prescription drugs are covered under Section 5(f), Prescription drug benefits.	
• Healthy*directions*[sm] a disease management program for members and covered dependents with asthma, diabetes, or congestive heart failure (CHF). Your health is important to us! If you or your covered dependent have asthma, diabetes or congestive heart failure (CHF), you will be contacted to voluntarily participate. If you would like to contact us for more information about this program, please call 1-800-228-0286.	Nothing

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible does not apply for these benefits; however, we added asterisks -*- to show that the calendar year deductible does not apply.
- The Out-of-network benefits are the standard benefits of this Plan. PPO benefits apply only when you reside in the PPO network area and use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e., hospital, surgical center, etc.).
- **YOU MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES. Please refer to the precertification information shown in Section 3 to be sure which services require precertification.**

IMPORTANT

Benefit Description	You pay
NOTE: We added asterisks - * - to show when the calendar year deductible **does not** apply	
Surgical procedures	
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity—a condition in which an individual (1) is the greater of 100 pounds or 100% over his or her normal weight (in accordance with the Plan's underwriting standards) with complicating conditions; and (2) has been so for at least five years with documented unsuccessful attempts to reduce under a doctor-monitored diet and exercise program • Insertion of internal prosthetic devices. See Section 5(a), *Orthopedic and prosthetic devices*, for device coverage information.	PPO: 10% of the Plan allowance* Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount* Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount*

Surgical procedures—*Continued*	**You Pay**
• Voluntary sterilization, Norplant (a surgically implanted contraceptive), and intrauterine devices (IUDs) • Treatment of burns • Surgical treatment of bunions or spurs • Assistant surgeons - we cover up to 20% of our allowance for the surgeon's charge Note: For related services, see applicable benefits section (i.e., for inpatient hospital benefits, see Section 5(c).	PPO: 10% of the Plan allowance* Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount* Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount (No deductible)*
When multiple or bilateral surgical procedures performed during the same operative session add time or complexity to patient care, our benefits are: • For the primary procedure: — PPO: 90% of the Plan allowance or* — Non-PPO: 75% of the Plan allowance or* — Out-of-network: 85% of the Plan allowance* • For the secondary procedure(s): — PPO: 90% of one-half of the Plan allowance or* — Non-PPO: 75% of one-half of the Plan allowance* — Out-of-network: 85% of one-half of the Plan allowance* Note: Multiple or bilateral surgical procedures performed through the same incision are "incidental" to the primary surgery. That is, the procedure would not add time or complexity to patient care. We do not pay extra for incidental procedures.	PPO: 10% of the Plan allowance for the primary procedure and 10% of one-half of the Plan allowance for the secondary procedure(s)* Non-PPO: 25% of the Plan allowance for the primary procedure and 25% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount* Out-of-network: 15% of the Plan allowance for the primary procedure and 15% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount*
Not covered: • *Reversal of voluntary sterilization* • *Services of a standby surgeon, except during angioplasty or other high risk procedures when we determine standbys are medically necessary* • *Routine treatment of conditions of the foot* • *Radial keratotomy, or other refractive surgery* • *Removal of corns or calluses, or the trimming of toenails* • *Telephone consultations*	*All charges.*

Reconstructive surgery	You Pay
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: — the condition produced a major effect on the member's appearance and — the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; and webbed fingers and toes. • All stages of breast reconstruction surgery following a mastectomy, such as: — surgery to produce a symmetrical appearance on the other breast; — treatment of any physical complications, such as lymphedemas; — breast prostheses; and surgical bras and replacements (see Prosthetic devices for coverage)	PPO: 10% of the Plan allowance* Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount* Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount*
Note: Internal breast prostheses are covered under 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.	
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation or sexual dysfunction*	*All charges*

Oral and maxillofacial surgery	You Pay
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Surgical correction of temporomandibular joint (TMJ) dysfunction • Surgical removal of impacted teeth, including anesthesia charges • Other surgical procedures that do not involve the teeth or their supporting structures	20% of the Plan allowance and any difference between the Plan allowance and the billed amount*
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)* • *Pre- and post-operative examinations in preparation for surgical removal of impacted teeth*	*All charges*
Organ/tissue transplants	
Limited to: • Cornea • Heart • Lung • Kidney • Kidney/Pancreas • Liver • Pancreas • Intestinal transplant • Allogeneic bone marrow transplants • Autologous bone marrow transplants – only for patients with acute lymphocytic or nonlymphocytic leukemia, advanced Hodgkin's lymphoma, advanced nonHodgkin's lymphoma, advanced neuroblastoma, breast cancer, multiple myeloma, epithelial ovarian cancer, and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	PPO: 10% of the Plan allowance* Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount* Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount*

Organ/tissue transplants—*Continued*	**You Pay**
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Transplants not listed as covered* • *Implants of artificial organs*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient) • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	PPO: 10% of the Plan allowance* Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount* Out-of-network: 15% of the Plan allowance and 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.
- The calendar year deductible applies to only a few benefits. We added asterisks -*- to show when the calendar year **does not** apply.
- The Out-of-network benefits are the standard benefits of this Plan. PPO benefits apply only when you reside in the PPO network area and use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e. hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e. physicians, etc.) are in Section 5(a) or (b).
- **YOU MUST GET PRECERTIFICATION OF HOSPITAL STAYS; FAILURE TO DO SO WILL RESULT IN A MINIMUM $500 PENALTY.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification.

IMPORTANT

Benefit Description	You pay
NOTE: We added asterisks - * - to show when the calendar year deductible **does not** apply	
Inpatient hospital	
Room and board, such as • semiprivate or intensive care accommodations; • general nursing care; and • meals and special diets. NOTE: We only cover a private room when you must be isolated to prevent contagion. Otherwise, we will pay the hospital's average charge for semiprivate accommodations. If the hospital only has private rooms, we base our payment on the average semiprivate rate of the most comparable hospital in the area. Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics • Internal breast prostheses not related to cosmetic surgery	PPO: $100 per admission* Non-PPO: $200 per admission and 25% of the covered charges* Out-of-network: $200 per admission*

Inpatient hospital-Continued	You Pay
• Take-home drugs are covered under Section 5(f), *Prescription drug benefits* • Take-home medical supplies, appliances, medical equipment, and any covered items billed by a hospital are covered under Section 5(a), *Durable Medical Equipment.*	
Pre-admission testing when testing is: • performed within 7 days before your scheduled hospital admission; • related to your covered hospital confinement; • accepted by the hospital instead of tests performed during your confinement; and • repeated only if your medical record shows the pre-admission test results and the need for repeated tests when you are admitted. NOTE: Charges for professional services of a physician when billed by the hospital are paid separately. For example, when the hospital bills for your surgeon's charges, we pay under *Surgical services*, Section 5(b); and for your physical therapist's charges, we pay under *Physical, occupational, and speech therapies,* Section 5(a).	PPO: Nothing* Non-PPO: Nothing* Out-of-network: Nothing*
Hospitalization for dental procedures • We cover hospital services related to dental procedures (even though the dental procedure itself may not be covered) only when a nondental physical impairment exists that makes hospitalization necessary to safeguard your health.	PPO: Nothing* Non-PPO: Nothing* Out-of-network: Nothing*
Not co*vered:* • *A hospital admission that is not medically necessary, i.e., the medical services did not require the acute hospital inpatient (overnight) setting but could have been provided in a doctor's office, the outpatient department of a hospital, or some other setting without adversely affecting your condition or quality of medical care rendered.* • *Inpatient hospital services and supplies for surgery that we do not cover* • *Custodial care (see definition) even when provided by a hospital.* • *Non-covered facilities, such as nursing homes, rest homes, places for the aged, convalescent homes or any place that is not a hospital, skilled nursing facility, or hospice* • *Personal comfort items, such as radio, television, telephone, beauty and barber services* • *Private nursing care*	*All charges.*

Outpatient hospital or ambulatory surgical center	You Pay
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service • Internal breast prostheses not related to cosmetic surgery Note: We cover directly related services and supplies rendered at the time of the surgery at 100% of the Plan allowance. We cover hospital services related to dental procedures (even though the dental procedure itself may not be covered) only when a nondental physical impairment exists that makes hospitalization necessary to safeguard your health.	PPO: 10% of the Plan allowance Non-PPO: 25% of the Plan allowance and any difference between our allowance and the billed amount Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount
Skilled nursing care facility benefits	
If precertified, we cover semiprivate room, board, services and supplies in a Skilled Nursing Facility (SNF) for up to 60 days when: 1) confinement is medically necessary and 2) when the confinement is under the supervision of a physician	PPO: Charges in excess of 60-day maximum* Non-PPO: Charges in excess of 60-day maximum and the difference between the Plan allowance and the billed amount* Out-of-network: Charges in excess of 60-day maximum and the difference between the Plan allowance and the billed amount*
If not precertified, we cover semiprivate room, board, services and supplies for up to 30 days subject to the above conditions Note: SNF benefits will be restored for each new period of confinement. There is a new period of confinement when at least 60 days have elapsed since you were last confined in an SNF.	PPO: 20% and charges in excess of the 30-day maximum* Non-PPO: 20% of the Plan allowance and any difference between our allowance and the billed amount for 30 days, then all additional charges* Out-of-network: 20% of the Plan allowance and any difference between our allowance and the billed amount for 30 days, then all additional charges*
Not covered: Custodial care	*All charges.*

Hospice care	You Pay
Hospice is a coordinated inpatient and outpatient program of maintenance and supportive care for the terminally ill provided by a medically supervised team under the direction of a Plan-approved independent hospice administration. **If precertified**, we pay $7500 for inpatient or outpatient hospice care	PPO: Charges in excess of $7500 maximum* Non-PPO: Charges in excess of $7500 maximum and the difference between the Plan allowance and the billed amount* Out-of-network: Charges in excess of $7500 maximum and the difference between the Plan allowance and the billed amount*
If not precertified, we pay $4500 for inpatient or outpatient hospice care Note: One hospice program is covered per lifetime. This benefit does not apply to services covered under any other provisions of the Plan.	PPO: Charges in excess of $4500 maximum* Non-PPO: Charges in excess of $4500 maximum and the difference between the Plan allowance and the billed amount* Out-of-network: Charges in excess of $4500 maximum and the difference between the Plan allowance and the billed amount*
Ambulance	
We pay the first $50 for: • Local professional ambulance service when medically appropriate • Transportation by professional ambulance, railroad or commercial airline on a regularly scheduled flight to the nearest hospital equipped to furnish special and unique treatment	PPO: 10% of Plan allowance after $50 benefit Non-PPO: 25% of Plan allowance and any difference between our allowance and the billed amount after $50 benefit Out-of-network: 15% of Plan allowance and any difference between our allowance and the billed amount after $50 benefit

Section 5 (d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- The calendar year deductible is: $300 per person ($600 per family). The calendar year deductible applies to almost all benefits in this Section. We added asterisks -*- to show when the calendar year deductible **does not apply**.
- The Out-of-network benefits are the standard benefits of this Plan. PPO benefits apply only when you reside in the PPO network area and use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is an accidental injury?

An accidental injury is a bodily injury that requires immediate medical attention and is sustained solely through violent, external, and accidental means, such as broken bones, animal bites, insect bites and stings, and poisonings. Accidental dental injury is under Section 5(h), *Dental benefits.*

Benefit Description	You pay After the calendar year deductible
NOTE: We added asterisks - * - to show when the calendar year deductible **does not** apply	
Accidental injury	
We pay the first $500 for your accidental injury outpatient care for: • Outpatient facility charges • Physician services and supplies • Related x-ray, laboratory expenses, or durable medical equipment Note: Charges in excess of the $500 benefit will be paid under the applicable benefit (i.e., follow-up physician visits, see Section 5(a))..	PPO: Nothing up to the $500 maximum benefit* Non-PPO: Only the difference between our allowance and the billed amount up to the $500 maximum benefit* Out-of-network: Only the difference between our allowance and the billed amount up to the $500 maximum benefit*

Medical emergency	
Outpatient medical or surgical services and supplies	PPO: 10% of Plan allowance Non-PPO: 25% of Plan allowance and any difference between our allowance and the billed amount Out-of-network: 15% of the Plan allowance and any difference between our allowance and the billed amount.
Ambulance	
We pay $50 for: • Local professional ambulance service when medically appropriate • Transportation by professional ambulance, railroad or commercial airline on a regularly scheduled flight to the nearest hospital equipped to furnish special and unique treatment	PPO: 10% of Plan allowance after the $50 benefit Non-PPO: 25% of Plan allowance and any difference between our allowance and the billed amount after the $50 benefit Out-of-network: 15% of Plan allowance and any difference between our allowance and the billed amount after the $50 benefit

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

IMPORTANT

If you reside in the PPO Network Area, you may choose to get PPO or Non-PPO care. If you reside outside the network area, you will receive out-of-network care. PPO members who choose PPO care must get our approval for services and follow a treatment plan we approve. Cost-sharing and limitations for PPO or out-of-network mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions

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

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- The calendar year deductible is $300 per person ($600 per family) and applies to almost all benefits in this Section. We added asterisks -*- to show when the calendar year deductible **does not apply.**
- The Out-of-network benefits are the standard benefits of this Plan. PPO benefits apply only when you reside in the PPO network area and use a PPO provider. When no PPO provider is available, non-PPO benefits apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **PPO MEMBERS WHO CHOOSE PPO CARE MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits descriptions below.
- PPO mental health and substance abuse benefits are listed below, then Non-PPO and Out-of-network benefits begin on page 44.

IMPORTANT

Benefit Description	You Pay After the calendar year deductible
NOTE: The calendar year deductible applies to almost all benefits in this Section. We added asterisks - * - to show when the calendar year deductible **does not** apply	
PPO Network benefits	
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: PPO benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.

PPO Network benefits-Continued	You Pay
• Professional services provided by a physician	PPO: 10% of the Plan allowance*
• Other professional services (i.e., psychologists, clinical social workers, licensed counselors), inpatient professional services, and outpatient hospital services • Services in approved alternative care settings, such as partial hospitalization or facility-based intensive outpatient treatment • Diagnostic tests • Psychological testing	PPO: 10% of the Plan allowance
• Medication management	PPO: $10 copayment*
• Inpatient hospital charges	PPO: $100 per admission*
Not covered: • *Services we have not approved.* • *All charges for chemical aversion therapy, conditioned reflex treatments, narcotherapy or any similar aversion treatments and all related charges (including room and board)* • *Any provider not specifically listed as covered* • *Counseling or therapy for marital, educational or behavioral problems, or related to mental retardation or learning disabilities* • *Community-based programs such as self-help groups or 12 step program* • *Treatments for learning disabilities and mental retardation* • *Services by pastoral, marital, or drug/alcohol counselors* • *Biofeedback, conjoint therapy, hypnotherapy, interpretation/preparation of reports* • *Telephone consultations*	*All charges*
Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.	

Preauthorization and Precertification

To be eligible to receive these enhanced mental health and substance abuse benefits you must obtain a treatment plan and follow all of our network authorization processes. These include:

- Outpatient mental health and substance abuse benefits will be reduced by 50% if services are not preauthorized within two business days of the initial visit.
- Preauthorization and concurrent review are required for all levels of care whether in-or out-of-network.
- The medical necessity of your inpatient services must be precertified for you to receive full Plan benefits. Otherwise, the benefits payable will be reduced by $500. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged.

You, your representative, your physician, or your hospital must call Mutual of Omaha's Care Review Unit prior to admission. The toll-free number is 1-800-634-0069.

You must provide the following information: enrollee's name and Plan identification number; patient's name, birth date and phone number; reason for hospitalization, proposed treatment; name of hospital or facility; name and number of admitting physician; and number of planned days of confinement.

Non-PPO and Out-of-network benefits	You Pay
Mental Health • Professional services by physicians, psychologists, clinical social workers or licensed counselors, and inpatient professional services	**Non-PPO**: 50% of the Plan allowance and any difference between our allowance and the billed amount (**$50 visit maximum**) **Out-of-network:** 15% of the Plan allowance and the difference between our allowance and the billed amount
• Psychological testing • Medical management	**Non-PPO**: 25% of the Plan allowance and the difference between our allowance and the billed amount **Out-of-network**: 15% of the Plan allowance and the difference between our Plan and the billed amount
• Outpatient hospital charges	**Non-PPO**: 50% of the Plan allowance and the difference between our allowance and the billed amount **Out-of-network**: 15% of the Plan allowance and the difference between our Plan and the billed amount
• Inpatient hospital charges	**Non-PPO**: $200 per admission and 25% of the covered charges* **Out-of-network**: $200 per admission*
• Services in approved alternative care settings, such as partial hospitalization or facility-based intensive outpatient treatment	**Non-PPO**: All charges **Out-of-network**: 15% of the Plan allowance and any difference between our allowance and the billed amount
Substance Abuse • Inpatient care includes room and board and ancillary charges for confinements in a treatment facility for rehabilitative treatment of alcoholism or substance abuse	**Non-PPO**: $200 per admission and 25% of the covered charges **up to $10,500 per 28-day program*** **Out-of-network**: $200 per admission*
• Outpatient benefits (including aftercare)	**Non-PPO:** 25% of the Plan allowance and the difference between our allowance and the billed amount **up to the maximum $4,000 benefit** **Out-of-network:** 15% of the Plan allowance and the difference between our allowance and the billed amount
• Services in approved alternative care settings, such as partial hospitalization or facility-based intensive outpatient treatment	**Non-PPO**: All charges **Out-of-network**: 15% of the Plan allowance and any difference between our allowance and the billed amount

Non-PPO and Out-of-network benefits-Continued	You Pay
Not covered: • *Services we have not approved.* • *All charges for chemical aversion therapy, conditioned reflex treatments, narcotherapy or any similar aversion treatments and all related charges (including room and board)* • *Any provider not specifically listed as covered* • *Counseling or therapy for marital, educational or behavioral problems, or related to mental retardation or learning disabilities* • *Community-based programs such as self-help groups or 12 step program* • *Treatments for learning disabilities and mental retardation* • *Services by pastoral (except in medically underserved areas), marital, or drug/alcohol counselors* • *Biofeedback, conjoint therapy, hypnotherapy, interpretation/preparation of reports* • *Telephone consultations*	*All charges.*

Lifetime maximum	Non-PPO inpatient or outpatient care for the treatment of alcoholism and drug abuse is limited to three treatment programs per lifetime. Withdrawal from a treatment program prior to completion constitutes use of one program.
Preauthorization and Precertification	Preauthorization of treatment programs is not required.The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive these benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See Section 3 for details. Precertification is not required for overseas care.

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

- Section 3, *How you get care*, for information about catastrophic protection for these benefits
- Section 7, *Filing a claim for covered services*, for information about submitting non-PPO and Out-of-network claims

Section 5 (f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described below.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Certain drugs require prior authorization or may be subject to quantity limits. If your prescription is for a drug requiring prior authorization, additional information from your physician will be needed before the medication is dispensed. Your physician may call 1-800-634-0069 to begin the review process.
- The calendar year deductible does not apply to almost all benefits in this Section. We added asterisks - * - to show when the calendar year deductible **does not** apply.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works, with special sections for members who are age 65 or over. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

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

- **Who can write your prescription.** A licensed physician or dentist must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a network pharmacy or by mail. To locate a network pharmacy in your area, call 1-800-752-0598 or you may also visit Mutual of Omaha's website at www.mutualofomaha.com. We will send you information on the mail order drug program. To use the program: 1) complete the initial mail order form; 2) enclose your prescription and copayment; 3) mail your order to Express Scripts, Inc., PO Box 27226, Albuquerque, NM 87125-9908; 4) allow two to three weeks for delivery. You will receive forms for refills and future prescription orders each time you receive drugs or supplies under this program. If you have questions about the mail order program, call 1-800-417-8173.
- **We use a formulary.** A formulary is a list of selected FDA-approved commonly prescribed medications from which your physician or dentist may choose to prescribe. The formulary is designed to inform you and your physician about quality medications that, when prescribed in place of other nonformulary medications, can help contain the increasing cost of prescription drug coverage without sacrificing quality. To find out if your medication is on the formulary call Express Scripts, Inc., at 1-800-752-0598 or visit Mutual of Omaha's website at www.mutualofomaha.com. If you are prescribed a drug not on the formulary, you will pay a higher copayment. If due to medical reasons unique to you for which a nonformulary is mandatory, you may request an exception in writing through the Disputed Claims Process as described on page 57. If the exception is approved, you will pay the formularly copayment.
- **Why use generic drugs?** Generic drugs are lower-priced drugs that are the therapeutic equivalent to more expensive brand-name drugs. 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 sets quality standards for generic drugs to ensure that these drugs meet the same standards of quality and strength as brand-name drugs.
- **Some drugs require prior authorization**. Prior Authorization Requirements (PAR) are applied to encourage appropriate use of medications that are most likely to have certain risk factors. These requirements apply to drugs that may be used in amounts that exceed dosage or length of treatment recommendations or that may be more costly than medications that are proven to be clinically and therapeutically similar. If your prescription is identified as a drug requiring PAR, your physician should call Customer Service at 1-800-634-0069.
- **These are the dispensing limitations.** When you obtain prescription drugs from a pharmacy using your Prescription Drug Card, you may obtain up to a 30-day supply of covered drugs. If purchasing more than a 30-day supply on the same day, any expense exceeding that supply limit will not be covered through the pharmacy arrangement. You may purchase your covered prescription drugs and supplies by presenting your prescription drug card and your prescription to a participating provider. Prescription refills will be covered when no more than 50% of the 30-day supply remains based on your physician's prescription.

If your physician or dentist prescribes a medication that will be taken over an extended period of time, you should request two prescriptions—one for immediate use with a participating retail pharmacy and the other for up to a 90-day supply from the Mail Order Program. Express Scripts, Inc., will fill your prescription. All drugs and supplies covered by the Plan are available under this program except fertility drugs. If you have questions about a particular drug or a prescription, and to request your first order forms, call 1-800-417-8173. If a generic equivalent to the prescribed drug is available, Express Scripts will dispense the generic equivalent instead of the brand name unless you or your physician specifies that the brand name is required.

Benefit Description	You Pay
NOTE: The calendar year deductible applies to almost all benefits in this Section. We added asterisks - * - to show when the calendar year deductible **does not** apply	
Covered medications and supplies	
Each new enrollee will receive a prescription drug card (two cards if enrolled in a Family plan), a mail order form/patient profile and a pread-dressed reply envelope. If you need additional cards, call 1-800-634-0069. You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail: • Drugs, vitamins and minerals that by Federal law of the United States require a doctor's prescription for their purchase • Insulin • FDA-approved drugs and devices requiring a doctor's prescription for the purpose of birth control • Needles and syringes for the administration of covered medications • Diabetic, colostomy, and ostomy supplies Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. Your physician must specify "dispense as written" if a brand name drug is required. • When purchasing drugs at a pharmacy, you must use your Prescription Drug Card. Please call us to request additional prescription drug cards for family members. • We have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. To order a prescription drug brochure, call Customer Service at 1-800-752-0598.	• **Network Retail**: $10 generic* $20 formulary brand name* $30 nonformulary brand name* • **Network Retail Medicare**: $5 generic* $15 formulary brand name* $25 nonformulary brand name* • **Network Mail Order**: $15 generic* $30 formulary brand name* $45 nonformulary brand name* • **Network Mail Order Medicare**: $8 generic* $23 formulary brand name* $38 nonformulary brand name* Note: If there is no generic equivalent available, you will still have to pay the brand name copay.

Covered medications and supplies-*Continued*	**You Pay**
If you are **overseas** and do not order prescription drugs through the Mail Order Prescription Drug Program: If you are provided drugs directly by a physician or covered facility (not a pharmacy): If you do not use your prescription drug card to purchase needles and syringes for the administration of covered medications or diabetic, colostomy or ostomy supplies:	20%
Not covered: • *Drugs and supplies for cosmetic purposes* • *Nutritional supplements and vitamins (including prenatal) that do not require a prescription* • *Medication that does not require a prescription under Federal law even if your physician prescribes it or a prescription is required under your State law* • *Medical supplies such as dressings and antiseptics* • *Medication for which there is a non-prescription equivalent available* • *Prescriptions received from non-participating pharmacies unless overseas or through a covered physician or facility. Call 1-800-752-0598 to locate a participating pharmacy.* • *Drug copayments* • *Fertility drugs are covered only under "Infertility services"*	*All Charges*

Section 5 (g). Special features

Special features	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. • Alternative benefits are subject to our ongoing review. • By approving an alternative benefit, we cannot guarantee you will get 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	For any of your health concerns, 24 hours a day, 7 days a week, you may call the Optum NurseLine at toll free 1-877-861-3861 and talk with a registered nurse who will discuss treatment options and answer your health questions. A PIN number is needed to access the nurse line. If you needed assistance, please call 1-800-634-0069.
High risk pregnancies	You have access to Mutual of Omaha's Health Maternity Program, which provides educational material and support to pregnant women. Contact Customer Service at 1-800-634-0069 for more information.
Centers of excellence	Mutual of Omaha has special arrangements with facilities to provide services for tissue and organ transplants—its Medical Specialty Network. The network was designed to give you an opportunity to access providers that demonstrate high quality medical care for transplant patients. For additional information regarding our transplant network, please call 1-800-228-0286.
Services overseas	Our overseas customers receive the same out-of-network benefits and prompt customer service as their stateside counterparts. There is no additional claims processing time for foreign claims.

Section 5 (h). Dental benefits

IMPORTANT

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

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

IMPORTANT

Accidental injury benefit	You Pay
We cover outpatient restorative services necessary to promptly repair (but not replace) sound natural teeth until treatment is completed. The need for these services must result from an accidental injury from an external force such as a blow or fall that requires immediate attention (not from biting or chewing). You must be enrolled in the Plan at the time of injury and must remain in the Plan until treatment is completed.	20% of the Plan allowance and any difference between our allowance and the billed amount*

Dental benefits

Service	We pay (scheduled allowance)	You pay
Routine oral examinations including X-rays, cleaning, diagnosis, and preparation of a treatment plan	$39 twice per year	All charges in excess of the scheduled amounts listed to the left*
Dental fillings:		
• One surface	$12	
• Two surfaces	$19	
• Three or more surfaces	$24	

Not covered:

- *Charges for tooth extractions, dental implants, preparation for orthodontic treatment or dentures, or other dental work or surgery that involves any tooth structure, alveolar process, abscess, periodontal disease or disease of the gingival tissue*
- *Dental appliances, study models, splints, and other devices or dental services associated with the treatment of temporomandibular joint (TMJ) dysfunction*
- *Crowns and root canals*
- *Other dental services not listed as covered*

Note: Surgical removal of impacted teeth is covered in Section 5(b), *Surgical and Anesthesia Services*.

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 disputed claim about them**. Fees you pay for these services do not count toward FEHB deductibles or out-of-pocket maximums.

Supplemental Dental

Consumer Dental Care offers a reduced fee dental program to individuals located in Maryland and Washington, DC, through Consumer Dental Corp.; and to individuals located in Virginia through Consumer Dental Care of Virginia, Inc.

Through the Consumer Dental Care *Select* you can enjoy reduced savings on all areas of dentistry to include:

- **Diagnostic/Preventative, Restorative**
- **Crowns and Bridges**
- **Periodontics**
- **Orthodontics**
- **Dentures**
- **Endodontics**
- **Oral Surgery**

Additional features include:

No deductibles

No pre-existing conditions (except orthodontics in progress)

No claim forms

No maximum level of benefits

Retired persons are eligible

Over 1,500 Participating General Dentists and Specialists

Extremely attractive rates!

Vision Care

Outlook Vision Services offers you and your dependents the opportunity to purchase eye wear at special discount prices. Enrollment in Outlook Vision Services provides the following benefits:

- **Substantial savings** on eye wear purchases with over **8,000 optical providers** located nationwide (not available in CA).
- Discounts on eye exams at select locations where approved (not available in CA or WA)
- Optical providers consist of but are not limited to: Sears, J.C. Penney Optical, Vision Works, D.O.C. Optics, Shopko Optical, LensCrafters, Pearle, and many others
- **Save up to 50%** of retail prices on eye wear: lenses, frames, contact lenses, prescription and nonprescription sunglasses and accessories.
- **Save up to 50%** off on contact lenses when ordering though **Outlook's** unique mail order contact lens replacement program.
- **Unlimited** selection on eye wear with no limit on quantities
- **NO** waiting periods, **NO** pre-existing conditions, **NO** paperwork
- Benefits cover the entire household at extremely attractive rates!

HearPO

HearPO is a nationwide network of credentialed audiology professionals who provide quality hearing care services and hearing instruments throughout the United States.

- HearPO provides substantial savings off the manufacturer's suggested retail price of all HearPO brand hearing devices, including the latest programmable and digital technology.

- HearPO provides discounts on repairs and hearing aid batteries.
- There is a 60-day trial period with a money back guarantee.
- HearPO professionals conduct comprehensive follow-up services at no charge for one year.

You can reach HearPO on 1-888-HEARING (432-7464) or on the Internet at www.hearpo.com. **You must identify yourself as a member of Diversified Federal Groups, the name on your prescription drug card**. Or you may call 1-703-613-7215 or 1-800-769-6953.

Glucose Monitors

Plan members diagnosed with diabetes may receive a free glucose monitor from Roche Diagnostics who provides the Accu-Check Advantage monitor; or from Bayer Diagnostics who provides the Elite, Elite XL, and Dex monitors.

The monitor is a small device that diabetics used to check and monitor their blood sugar. Monitoring and controlling blood sugars is essential for managing diabetes and preventing unnecessary complications. To obtain a glucose monitor, call one of the manufacturers listed below:

Roche Diagnostic	**Bayer Diagnostic**
Accu-Check Advantage monitor	*Elite, Elite XL, or Dex monitors*
1-800-207-2312	*1-877-229-3777*

You must identify yourself as a Mutual of Omaha Member. If you have difficulty obtaining a free glucose monitor, please call the Plan at 1-800-634-0069.

Lifestyle Prescription Medications

Many lifestyle prescription drugs are available at a discounted rate through participating pharmacies and the Plan's mail order program. You are responsible for the entire cost of the drugs; however, they are available to you at Mutual of Omaha's preferred contracted rate. The following lifestyle prescription drugs are covered under this benefit:

Cosmetic: Renova, Vaniqua, Propecia

Infertility: A.P.L., Chorex-5, Chorex-10, Chronon 10, Clomid, Clomiphene, Crinone gel, Fertinex, Follistem, Gonal-F, Gonic, HCG, Humegon, Pergonal, Pregnyl, Profasi, Repronex, Serophone

Obesity: Adipost, Didrex, Ionamin, Merida, Phendimetrazine, Phentermine, Sanorex, Tenuate, Xenical

Sexual Dysfunction: Caverject, Edex, Muse, Viagra

This list is subject to change and may be subject to medical necessity review if they are covered under another benefit provision (i.e., Infertility). If you have a question on drug coverage, call 1-800-634-0069.

American WholeHealth Networks

American WholeHealth is a national leader in offering discounted alternative medicine services.

Over 24,000 credentialed practitioners in **chiropractic care**, **massage therapy, acupuncture, nutritional counseling,** and **relaxing techniques**

Alternative health information offering the most diverse and complete set of solutions for those seeking alternative medicine services

Discounts on vitamins and supplements on-line or by catalog

Long Term Care

When you or a family member require help with normal daily activities due to aging or a disabling accident or illness, you may need long term care assistance. Long term care situations can quickly deplete a family's lifetime of savings. Long Term Care guards against this circumstance. Long Term Care insurance underwritten by Mutual of Omaha Insurance Company is available to you, your spouse, parents and parents-in-law under the age of 80.

For additional information or enrollment in any of these programs, please call 1-800-769-6953.

NON-FEHB Benefits are not part of the FEHB contract

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

The exclusions in this section apply to all benefits. **Although we may list a specific service as a benefit, we will not cover it unless 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;
- 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;
- Expenses furnished without charge while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions or (2) during combat;
- Services furnished by immediate relatives or household members. Immediate relatives include spouse, parent, child, brother or sister by blood, marriage, or adoption;
- Services furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered;
- Any portion of a provider's fee or charge that has been waived (if a fee is routinely waived, the Plan will calculate the actual fee by reducing the fee by the amount waived); or
- Charges you or the Plan has no legal obligation to pay, such as excess charges for an annuitant 65 or older who are not covered by Medicare Part A and/or Part B, physician charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge), or State premium taxes however applied;

Procedures, services, drugs and supplies not specifically listed as covered. Listed below are examples of some of the Plan's exclusions:

- Acupuncture, except when used as an anesthetic agent for covered services;
- Chiropractic services;
- Custodial care, even when provided by a hospital;
- Eyeglasses and contact lenses (except as covered in Section 5(a));
- Radial keratotomy and other refractive surgeries;
- Hearing aids, testing and examinations for them, except for accidental injury or intra-aural surgery;
- Services, drugs, or supplies related to weight control or any treatment of obesity except surgery for morbid obesity as described in Section 5(b);
- Cosmetic surgery except repair of accidental injury;
- Counseling or therapy for marital, educational or behavioral problems;
- Treatment for learning disabilities and mental retardation**;**
- Telephone Consultations;
- Routine treatment for conditions of the foot; or
- Educational training.

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 1-800-634-0069.

In most cases, providers and facilities file claims for you. Your physician must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call us at 1-800-634-0069.

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. Itemized bills and receipts should be sent to Association Benefit Plan, PO Box 668587, Charlotte, NC 28266-8587.

- Name of patient and relationship to enrollee;
- Plan identification number of the 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.

You should use the Plan's standard claim form to file dental claims. Attach the dentist's itemized bill. The bill must include the name of the patient, dates of service, itemized charges and the dentist's tax ID number.

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

In addition:

- You must send a copy of the explanation of benefits (EOB) 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 and must include nursing notes.
- Claims for rental or purchase of durable medical equipment; private duty nursing; and physical, occupational, and speech therapy may require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.

Records

Keep a separate record of the medical expenses of each covered family member as deductibles and maximum allowances apply separately to each person. Save copies of all medical bills, including those you accumulate to satisfy a deductible. In most instances they will serve as evidence of your claim. We will not provide duplicate or year-end statements.

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim within two years of the date you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity and provided the claim was submitted as soon as reasonably possible. 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, you must send a completed claim form and the itemized bills.

- Overseas (foreign) claims for prescription drugs and supplies that are not ordered through the Mail Order Prescription Drug Program must include receipts that include the prescription number, name of drug or supply, prescribing physician's name, date, and charge.
- Claims for overseas (foreign) services should include an English translation.
- Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred.

When we need more information

- Annually you may be asked to verify other health care coverage. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: (a) Write to us within 6 months from the date of our decision; and (b) Send your request to us at: Association Benefit Plan, PO Box 668587, Charlotte, NC 28266-8587*;* 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 arrange for the health care provider to give you the care); or (b) Write to you and, if applicable, maintain our denial—go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us—if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, 1900 E Street, NW, Washington, D.C. 20415-3620.

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 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 its disputed claim decision. This information will become part of the court record.

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

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

a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 1-800-634-0069 and we will expedite our review; or

b) We denied your initial request for care or preauthorization/prior approval, then:

— If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or

— You can call OPM's Health Benefits Contracts Division II at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you 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.

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

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

- **What is Medicare**

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. 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 and 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 Original Medicare, like 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.

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 Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 1-800-634-0069.
- **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:
- If you are enrolled in Medicare Part B, we will waive copayments and coinsurance for medical services and supplies provided by physicians and other health care professionals. We will also waive deductibles and coinsurance for extended dental treatment for accidental dental injuries.
- If you are enrolled in Medicare Part A, we will waive hospital copayments and coinsurance.

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

Primary Payer Chart		
A. When either you—or your covered spouse—are age 65 or over and …	**Then the primary payer is…**	
	Original Medicare	**This Plan**
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when…	✓	
a) The position is excluded from FEHB, or		
b) The position is not excluded from FEHB		✓
(Ask your employing office which of these applies to you.)		
1) 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),	✓	
2) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
3) 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		✓
c) Are a former spouse of an annuitant	✓	
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 another type of Medicare+Choice Plan—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. 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 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.

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

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

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

Section 10. Definitions of terms we use in this brochure

Admission

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

Assignment

Your authorization for the Plan to issue payment of benefits directly to the provider. We reserve the right to pay the member 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.

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 12.

Confinement

An admission (or series of admissions separated by less than 60 days) to a hospital as an inpatient for any one illness or injury. There is a new confinement when an admission is:

1) for a cause entirely unrelated to the cause for the previous admission;
2) for an enrolled employee who returns to work for at least one day before the next admission; or
3) for a dependent or annuitant when confinements are separated by at least 60 days.

Congenital anomalies

A condition existing at or from birth that is a significant deviation from the common form or anomaly norm. For purposes of this Plan, congenital includes protruding ear deformities, cleft lips, cleft palates, webbed fingers or toes, and other conditions that we may determine to be congenital anomalies. In no event will the term congenital anomaly include conditions relating to teeth or intra-oral structures supporting the teeth.

Copayment

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive covered services. See page 12.

Cosmetic surgery

Any operative procedure or any portion of a procedure performed primarily to improve physical appearance and/or treat a mental condition through a change in bodily form.

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 could be provided safely and reasonably by a person who is not medically skilled, or are designed mainly to help the patient with daily living activities. These activities include but are not limited to:

1) personal care such as help in: walking; getting in or out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;

2) homemaking, such as preparing meals or special diets;

3) moving the patient;

4) acting as a companion or sitter;

5) supervising medication that can usually be self administered; or

6) treatment services such as recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 12.

Effective date

The date the benefits described in this brochure are effective:

1) January 1 for continuing enrollments and for all annuitant enrollments;

2) the first day of the first full pay period of the new year for enrollees who change plans or options or elect FEHB coverage during Open Season for the first time; or

3) for new enrollees during the calendar year, but not during Open Season, the effective date of enrollment as determined by your employing office or retirement system.

Experimental or investigational services

A drug, device, or biological product is experimental or investigational if it cannot lawfully be marketed without approval of the U.S. Food and Drug Administration (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 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 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.

Group health coverage

Health care coverage that you are eligible for because of employment, membership in, or connection with, a particular organization or group that provides payment for hospital, medical or other health care service or supplies, or that pays a specific amount for each day or period hospitalization.

Home health care agency

A public agency or private organization under Medicare that is licensed as a home health care agency by the State and is certified as such.

Home health care plan

A plan of continued care and treatment when you are under the care of a physician, and when certified by the physician that, without the home health care, confinement in a hospital or skilled nursing facility would be required.

Hospice care program

A coordinated program of home and inpatient pain control and supportive care for the terminally-ill patient and the patient's family. Care is provided by a medically supervised team under the direction of an independent hospice administration that we approve.

Intensive outpatient Program (IOP)

IOPs offer time-limited services that are coordinated, structured, and intensively therapeutic. Such programs are designed to treat a variety of individuals with moderate to marked impairment in at least one area of daily life resulting from psychiatric or addictive disorders. At a minimum, IOPs offer three to four hours of active treatment per day at least two to three days per week.

Medical necessity

Services, drugs, supplies, or equipment provided by a hospital or covered provider of health care services that we determine:

1) are appropriate to diagnose or treat your condition, illness or injury;
2) are consistent with standards of good medical practice in the United States;
3) are not primarily for the personal comfort of the patient, the family, or the provider;
4) are not a part of or associated with the 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 a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not in itself make it medically necessary.

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 to be determined by the Plan; or disorders listed in the ICD requiring treatment for abuse of or dependence upon substances such as alcohol, narcotics, or hallucinogens.

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. We determine our allowance as follows:

Twice a year the Health Insurance Association of America (HIAA) compiles actual claims received in each Zip Code area throughout the United States. HIAA guides are applied at the 90^{th} percentile to surgery, physician services, therapy, X-ray and lab expenses.

PPO providers accept the plan allowance as payment in full.

For more information, see Section 4, Differences between our allowance and the bill.

Partial hospitalization

A time-limited, ambulatory, active treatment program that offers therapeutically intensive, coordinated, and structured clinical services with a stable therapeutic environment. At a minimum, 20 hours of scheduled programming extended over a minimum of five days per week will be provided by a partial hospitalization program that is either licensed or JCAHO accredited.

Routine physical examination

A complete evaluation, including a comprehensive history and physical examination, without symptoms or illness.

Sound natural tooth

A tooth that is whole or properly restored and is without impairment, periodontal, or other conditions and is not in need of the treatment provided for any other reason other than an accidental injury.

Us/We

Us and we refer to the Association Benefit Plan

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support. In order to determine qualification, a medical certificate must state your child is incapable of self support. The medical certificate must be submitted to your employing office at least 60 days prior to your child reaching age 22.

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

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

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

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined 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.

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 former 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, your employing or retirement office 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 web site (www.opm.gov/insure/health); 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 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 when you can't take care of yourself becuase of an extended illness or injury, or an age-related disease such as Altzheimer'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 insuance 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 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?

- Our toll-free teleservice center will begin in mid-2002. In the mean-time, You can learn more about the program on our web site at www.opm.gov/insure/ltc.

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

Summary of Benefits for the Association Benefit Plan - 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 not subject to the $300 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount.

Benefits	You Pay	Page
Medical services provided by physicians:	PPO: $10 copayment*	18
• Diagnostic and treatment services provided in the office	Non-PPO: 25% of our allowance Out-of-network: 15% of our allowance	
Services provided by a hospital:	PPO: $100 admission	35
• Inpatient	Non-PPO: $200 admission; 25% of charges* Out-of-network: $200 admission*	
• Outpatient	PPO: 10% of our allowance Non-PPO: 25% of our allowance Out-of-network: 15% of our allowance	37
Emergency benefits:		
• Accidental injury	Nothing for your outpatient care up to $500*	39
• Medical emergency	Regular benefits	40
Mental health and substance abuse treatment	PPO: Regular cost sharing Non-PPO: Benefits are limited Out-of-network: Regular cost sharing	41 44 44
Prescription drugs	Retail copay: $10 generic, $20 formulary, $30 brand name* Mail order: $15 generic, $30 formulary, $45 brand name* Medicare retail and mail order copays* Overseas retail: 20%	46
Dental care	Routine exams and fillings; fee schedule	50
Special features	Flexible benefits option 24-hour nurseline High risk pregnancies Center of excellence Services overseas	49 49 49 49 49

Protection against Catastrophic costs . . . . . (your out-of-pocket maximum)	PPO: Nothing after $2,500/Self Only or Family enrollment per year Non-PPO: Nothing after $3,500/Self Only or Family enrollment per year Out-of-network: Nothing after $2,500/ Self Only or Family enrollment per year Some costs do not count toward this protection	13

2002 Rate Information for Association Benefit Plan

FEHB benefits of this Plan are described in the Association Benefit Plan brochure

Type of Enrollment	Code	Premium		Premium	
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Self	**421**	**$97.86**	**$47.27**	**$212.03**	**$102.42**
Self and Family	**422**	**$223.41**	**$110.92**	**$484.06**	**$240.32**

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