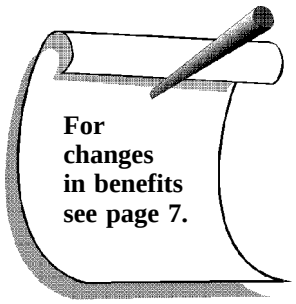
SSEHA Health Benefit Plan

http://www.CareFirst.com

2002

A fee-for-service plan



Sponsored and administered by:
U.S. Secret Service Employees Health Association

Who may enroll in this Plan: *Only employees and retirees of the U.S. Secret Service are eligible to be enrolled in this Plan.*

To become a member or associate member: *To be enrolled you must be, or must become, a member of the U. S. Secret Service Employees Health Association*

Membership dues: There is a one-time only fee of $5. New members will be billed dues when the Plan receives notice of enrollment.

Enrollment codes for this Plan:

Y71 - Self Only
Y72 - Self and Family

Authorized for distribution by the:

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

FEHB
Federal Employees
Health Benefits Program

RI 72-011

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Introduction

U.S. Secret Service Employees Health Association (SSEHA) Health Benefit Plan
950 H Street, NW
Washington, DC 20223.

This brochure describes the benefits of U.S. Secret Service Employees Health Association under our contract (CS 2276) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this plan you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and are summarized on page 63. Rates are shown at the end of this brochure.

Plain Language

Teams of Government 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 SSEHA
- 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 other, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm/insure or email OPM us 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 800-680-9695 and explain the situation.
- If we do not resolve the issue, call **THE HEALTH CARE FRAUD HOTLINE—202/418-3300** or write to: The United States Office of Personnel Management, Office of the Inspector General Fraud Hotline, 1900 E Street, NW, Room 6400, Washington, DC 20415.

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or are 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.

How we pay providers

Participating providers are paid up to CareFirst Plan Allowance. CareFirst makes all payments directly to the provider.

Non-participating providers are paid up to CareFirst Plan Allowance, all remaining balances are the responsibility of the member. The payment is made directly to the member.

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

- The CareFirst, Inc. Board of Directors has the ultimate authority and accountability for the quality of care and service provided by the Plan. The CareFirst, Inc. Board of Directors delegates the responsibility for broad oversight of the Quality Improvement (QI) Program to the Service and Quality Oversight Committee, a committee of the CareFirst, Inc., Board of Directors. The Service and Quality Oversight Committee meets quarterly to review and approve the QI Program Description, Annual Evaluation, and Annual QI Work Plan, and to review progress in meeting the QI Program Objectives. CareFirst BlueCross BlueShield does evaluate the clinician's compliance with clinical guidelines and protocols, patient centered outcomes, member health status and patient satisfaction.

- CareFirst BlueCross BlueShield has been in existence for the past 60 years. CareFirst BlueCross BlueShield became operational in 1934.

- CareFirst BlueCross BlueShield is a not-for-profit company.

If you want more information about us, call 800-424-7474 extension 6039 or 202-479-6039, or write to Member Services, 550 12th St., S.W., Washington, DC 20065. You may also visit our website at www.CareFirst.com.

- BlueCard Program. The independent Blue Cross and Blue Shield licensees throughout the country are working together in a new cooperative arrangement called the BlueCard Program. Under this program, if the Member receives services outside the CareFirst service area from a health care provider that participates with another Blue Cross and/or Blue Shield licensee ("Host Plan"), the Member is responsible only for the Coinsurance, Copayment, and/or Deductible. The calculation of the Member's liability for covered services for claims incurred will be processed through the BlueCard Program. The Member's Coinsurance, Copayment, and/or Deductible payments will be based on the lower of the provider's billed charges or the negotiated rate that CareFirst pays the Host Plan.

  The negotiated rate paid by CareFirst to the Host plan for health care services provided through the BlueCard Program will represent one of the following:

  – the actual price paid on the claim; or

  – an estimated price that reflects adjusted aggregate payments expected to result from settlements or other non-claims transactions with all of the host plan's health care providers OR one or more particular providers; or

  – a discount from billed charges representing the Host plan's expected average savings for all of its providers or for a specified group of providers.

Host Plans using either the estimated price or average savings factor may prospectively adjust the estimated or average price to correct for overestimated or underestimated past prices.

In addition, in a small number of states, statutes require Blue Cross and/or Blue Shield Plans to use a basis for calculating the Member's liability for covered services that does not reflect the entire savings realized or expected to be realized on a particular claim. Therefore, when this payment method results in a conflict of statutes or regulations between two states, CareFirst is obligated to comply with the statutes of the jurisdiction in which this Agreement was issued.

Contract Solely Between the Group and the Plan.

The Group, on behalf of itself and its Members, hereby expressly acknowledges its understanding that this Contract constitutes a contract solely between the Group and the Plan; that the Plan is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association") permitting the Plan to use the Blue Cross and Blue Shield Service Marks in the District of Columbia and portions of Maryland and Virginia; and that the Plan is not contracting as the agent of the Association. The Group, on behalf of itself and its Members, further acknowledges and agrees that it has not entered into this Contract based upon representations by any person other than the Plan; and no person, entity, or organization other than the Plan shall be held accountable or liable to the Group for any of the Plan's obligations to the Group created under this Contract. This paragraph shall not create any additional obligations whatsoever on the part of the Plan other than those obligations created under other provisions of this Contract.

CareFirst has JCAHO accreditation from the Joint Commission on Accreditation of Hospitals Organization.

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)
- Four states are added to the list of medically underserved areas: Georgia, Montana, North Dakota, and Texas. Louisiana is no longer medically underserved. (Section 3)

Changes to this Plan

- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a)
- We now cover certain 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)
- Your share of the non-Postal premium will increase by 11.3% for Self Only and 11.3% for Self and Family.
- We clarified the brochure to better explain that the non-PPO benefits are the standard benefits of this Plan, that PPO benefits apply only when you use a PPO provider, and that when no PPO provider is available, non-PPO benefits apply.
- We clarified the Preventive care, adult benefits by removing the entry for blood lead level testing for adults because it is a test more typically done for children. (Section 5(a)
- Prescription drug copays will increase to $10 for generic drugs and $20 for brand name drugs. (Section 5 (f)

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-424-7474 extension 6039 or 202-479-6039.

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 use our participating 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:

- a licensed doctor of medicine (M.D) or a licensed doctor of osteopathy (D.O.)
- a licensed or certified chiropractor, nurse anesthetist, dentist, podiatrist, occupational therapist and speech therapist practicing within the scope of their license or certification; and
- other covered providers who may render services without the supervision of a M.D. but for whom the Carrier provides benefits include a qualified clinical psychologist, clinical social worker, optometrist, nurse midwife and nurse practitioner/clinical specialist. For purposes of this FEHB brochure, the term "doctor" includes all of these providers when the services are performed within the scope of their license or certification.

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

• Covered facilities

Covered facilities include: Ambulatory surgical facilities – A facility Accredited by Joint Commission on Accreditation of Health Care Organizations or approved by the Carrier, designed for the treatment of minor, elective surgical procedures on an ambulatory basis.

- Extended care facility – A facility approved by the Carrier or eligible for payment under Medicare, possessing an organized medical staff providing continuous non-custodial inpatient care for convalescent patients not requiring acute hospital care yet not at a stable stage of illness.
- Hospice – A facility that provides short periods of stay for a terminally ill person in a home-like setting for either direct care or respite. This facility may be either free standing or affiliated with hospital. It must operate as an integral part of the hospice care program.

- Hospital – A facility conforming to the standards of and accredited by the Joint Commission on Accreditation of Health Care Organizations providing inpatient diagnosis and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of licensed doctors of medicine (M.D.) or licensed doctors of osteopathy (D.O.). The hospital must provide continuous 24-hour-a-day professional registered nursing (R.N.) services and may not be an extended care facility (other than an approved ECF); a nursing home; a place of rest; an institution for exceptional children, the aged, drug addicts, or alcoholics; or custodial or domiciliary institution having the primary purpose of furnishing food, shelter, training, or non-medical personal services. This definition includes college infirmaries and Veterans administration hospitals.

- Non-participating hospital – a hospital not having, at the time services are rendered, a participating agreement with the Blue Cross Plan in the area where services are rendered. College infirmaries and Veterans Administration hospitals are considered non-participating hospitals. The Carrier may, at its discretion, recognize any institution located outside of the 50 states and District of Columbia as a non-participating hospital.

- Participating hospital – A participating hospital having, at the time services are rendered, a participating agreement with the Blue Cross Plan in the area where services are rendered, and thereby agreeing to complete and file claims for covered hospital billed services on behalf of covered patients, to admit covered patients without requiring admission deposits, and to accept benefit payments directly from the Blue Cross Plan with which the hospital participates.

- Cancer research facility – A facility that is:

  1) A National Cooperative Cancer Study Group Institution that is funded by the National Cancer Institute (NCI), and has been approved by a cooperative Group as a bone marrow transplant center;

  2) A NCI-designated Cancer Center; or

  3) An Institution that has an NCI-funded, peer-review grant to study allogenic bone marrow transplants of autologous bone marrow transplants (autologous stem cell support) and atologous peripheral stem cell support.

- Renal dialysis center – A freestanding facility approved by the Carrier and designed specifically for the treatment of chronic renal disease.

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 specialist because we terminate our contract with specialist for other than cause,

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

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist and any benefits continue 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 800-424-7474 extension 6039 or 202-479-6039.

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. In addition, if the stay is not medically necessary, we will not pay any benefits.

How to precertify an admission:

- You, your representative, your doctor, or your hospital must call us at 800-553-8700 or 202-479-6718 at least two days 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 doctor, 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 doctor;
  - Name of hospital or facility; and
  - Number of planned days of confinement.
- We will then tell the doctor and/or hospital the number of approved inpatient days and we will send written confirmation of our decision to you, your doctor, and the hospital.

Maternity care

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

If your hospital stay needs to be extended:

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

What happens when you do not follow the precertification rules

- When we precertified the admission but you remained in the hospital beyond the number of days we approved and 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 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 services require precertification.

- All inpatient medical services.
- All inpatient mental health and substance abuse services.

Section 4. Your costs for covered services

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

- **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. Copayments do not count toward any deductible.

- The calendar year deductible is $200 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 $400 under High Option

- There is a $100 per person admission deductible which applies to inpatient hospital expenses and a separate $100 per admission deductible per person per calendar year which applies to all covered inpatient treatment of mental conditions and substance abuse services.

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

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

- **Coinsurance**

Coinsurance is the percentage of our allowance that you must pay for your care. Coinsurance doesn't begin until you meet your $200 per calendar year deductible.

Example: You pay 20% of our allowance for office visits.

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 charges $100 for a service, but routinely waives your 20% coinsurance, the actual charge is $80. We will pay $64.

- **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, page 56.

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.

- **Participating providers (Par),** agree to limit what they will bill you. Because of that, when you use a participating provider, your share of covered charges consists only of your deductible and coinsurance. Here is an example: You see a Participating 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 — 20% of our $100 allowance ($20). Because of the agreement, your Participating physician will not bill you for the $50 difference between our allowance and his bill.

- **Non-Participating providers (Non-Par),** on the other hand, have no agreement to limit what they will bill you. When you use a Non-Par 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-Par 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 20% of our $100 allowance ($20). Plus, because there is no agreement between the non-Par physician and us, he 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 Par physician vs. a non-Par physician. 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	Par physician	Non-Par physician
Physician's charge	$150	$150
Our allowance	We set it at: 100	We set it at: 100
We pay	80% of our allowance: 80	80% of our allowance: 80
You owe: Coinsurance	20% of our allowance: 20	20% of our allowance: 20
+Difference up to charge?	No: 0	Yes: 50
TOTAL YOU PAY	$20	$70

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

For those services with coinsurance, the Plan pays 100% of the Carrier allowance charges for the remainder of the calendar year after the calendar year deductible is met, if out-of-pocket expenses for the deductible and the coinsurance in that calendar year exceed $1000 per member or $2000 per family.

Out-of-Pocket expenses for the purposes of this benefit are:

- The calendar year deductible;
- The 20% you pay for Surgical Benefits;
- The 20% you pay for Maternity Benefits; and
- The 20% you pay for Other Medical Benefits.

The following cannot be counted toward out-of-pocket expenses:

- Expenses for Inpatient Hospital Benefits;
- Expenses in excess of the Carrier allowance or maximum benefit limitations;
- Expenses for mental conditions, substance abuse or dental care;
- Any amounts you pay if benefits have been reduced because of non-compliance with this Plan's cost containment requirements;
- Expenses for prescription drugs purchase through retail or mail program.

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to the plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you received in January before the effective date of your coverage in this Plan.

If you have already met the covered out-of-pocket maximum expense level in full, your old plan's catastrophic protection benefit will continue to apply until the effective date of your coverage in this plan.

If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expense until the prior year's catastrophic level is reached and then apply the catastrophic benefit to covered out-of-pocket expenses incurred from that point until the effective date. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

When government facilities bill us

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

If we overpay you

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

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 or coinsurance 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	your deductibles, coinsurance, and copayments;
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 have the Original Medicare Plan (Part A, Part B, or both)

We limit our payment to an amount that supplements the benefits that Medicare would pay under Medicare Part A (Hospital insurance) and Medicare Part B (Medical insurance), regardless of whether Medicare pays. Note: We pay our regular benefits for emergency services to 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 that both Medicare Part B and we cover depend on whether your physician accepts Medicare assignment for the claim.

- If your physician accepts Medicare assignment, then you pay our deductible and coinsurance.

- If your physician does not accept Medicare assignment, then you pay the difference between the charge and 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 your physician to reduce the charges. If the physician does not, 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 with a Physician

A physician may ask you to sign a private contract agreeing that you can be billed directly for service ordinarily covered by 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 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 7 for how our benefits changed this year and page 63 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 800-424-7474 extension 6039 or 202-479-6039 or at our website at www.CareFirst.com.

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

IMPORTANT

Here are some important things 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: $200 per person ($400 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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 say "(No deductible)" when it does not apply.	
Diagnostic and treatment services	
• Professional services of physicians • In physician's office	Par Doctor: 20% of the Plan allowance Non-Par doctor: Any difference between the plan allowance and the provider's charge
Professional services of physicians • In an urgent care center • During a hospital stay • In a skilled nursing facility • Initial examination of a newborn child covered under a family enrollment • Office medical consultations • Second surgical opinion • At home	Par Doctor: 20% of the Plan allowance Non-Par doctor: Any difference between the plan allowance and the provider's charge
Not covered: Routine physical check-ups and related test.	*All charges*

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	Par doctor: 20% of the Plan allowance Non-Par doctor: Any difference between the plan allowance and the provider's charge
Preventive care, adult	
Routine screenings, limited to: • Total Blood Cholesterol – once every three years • Chlamydial infection • Colorectal Cancer Screening, including – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50	Par doctor: Nothing "No deductible" Non-Par doctor: Any difference between the plan allowance and the provider's charge. "No deductible"
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	Par doctor: Nothing "No deductible" Non-Par doctor: Any difference between the plan allowance and the provider's charge. "No deductible"
Routine pap test Note: The office visit is covered if pap test is received on the same day; see Diagnosis and Treatment, above.	Par doctor: Nothing "No deductible" Non-Par doctor: Any difference between the plan allowance and the provider's charge. "No deductible"
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years	Par doctor: Nothing "No deductible" Non-Par doctor: Any difference between the plan allowance and the provider's charge. "No deductible"
Routine immunizations, limited to: • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over	Par doctor: Nothing "No deductible" Non-Par doctor: 100% of Plan allowance and any difference between the plan allowance and the provider's charge. "No deductible"

Preventive care, children	You pay
• For well-child care charges for routine examinations, immunizations and care (to age 3)	Par doctor: Nothing "No deductible" Non-Par doctor: Any difference between the plan allowance and the provider's charge. "No deductible"
• Examinations, limited to: – Examinations for amblyopia and strabismus – limited to one screening examination (ages 2 through 6) – Examinations done on the day of immunizations (ages 3 through 22)	Par doctor: Nothing "No deductible" Non-Par doctor: Any difference between the plan allowance and the provider's charge. "No deductible"
Maternity care	
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; see pages 10-11 for other circumstances, such as extended stays for you or your baby. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will cover an extended stay if medically necessary, but you, your representative, your doctor, or your hospital must precertify.	Par doctor: 20% of plan allowance after $200 deductible Non-Par doctor: Any difference between the plan allowance and the provider's charge.
• 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 5c) and Surgery benefits (Section 5b).	*(see above)*
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	
A broad range of voluntary family planning services, limited to: • Voluntary sterilization • Surgically implanted contraceptives (such as Norplant) • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit in Section 5(f).	Par doctor: 20% of Plan allowance. Non-Par doctor: Any difference between the plan allowance and the provider's charge.
Not covered: reversal of voluntary surgical sterilization, genetic counseling	*All charges.*

Infertility services	You pay
Diagnosis and treatment of infertility, except as shown in Not covered.	Par doctor: 20% of the Plan allowance. Non-Par doctor: Any difference between the plan allowance and the provider's charge.
Not covered: • *Infertility services after voluntary sterilization* • *Fertility drugs* • *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 eggs*	*All charges.*
Allergy care	
Testing and treatment, including materials such as allergy serum and injections.	Par doctor: 20% of the Plan allowance Non-Par doctor: Any difference between the plan allowance and the provider's charge.
Allergy injections	Par doctor: 20% of the Plan allowance Non-Par doctor: Any difference between the plan allowance and the provider's charge.
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*

Treatment therapies	You pay
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed on page 29. • Dialysis - Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy - Home IV and antibiotic therapy • Growth hormone therapy (GHT) Note: Growth hormone is covered under the prescription drug benefit Note: – We only cover GHT when we preauthorize the treatment. Call 800-553-8700 or 202-479-6718 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. • Respiratory and inhalation therapies	Par doctor: 20% of the Plan allowance Non-Par doctor: Any difference between the plan allowance and the provider's charge.
Physical and occupational therapies	
• 90 visits per calendar year for the services of each of the following: • qualified physical therapists; • occupational therapists. Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury and when a physician: 1) orders the care; 2) identifies the specific professional skills the patient requires and the medical necessity for skilled services; and 3) indicates the length of time the services are needed.	Par doctor: 20% of the Plan allowance Non-Par doctor: Any difference between the plan allowance and the provider's charge. See above
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges.*

Speech therapy	You pay
• 90 visits per calendar year	Par doctor: 20% of the Plan allowance Non-Par doctor: any difference between the plan allowance and the provider's charge.
Not Covered:	*All Charges*
Hearing services (testing, treatment, and supplies)	
First hearing aid and testing only when necessitated by accidental injury	Par doctor: 20% of the Plan allowance Non-Par doctor: Any difference between the plan allowance and the provider's charge.
Not covered: • *hearing testing* • *hearing aids, testing and examinations for them, except for accidental injury*	*All charges.*
Vision services (testing, treatment, and supplies)	
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) Note: See Preventive care, children for eye exams for children	Par doctor: 20% of the Plan allowance Non-Par doctor: Any difference between the plan allowance and the provider's charge.
Not covered: • *Eyeglasses or contact lenses and examinations for them* • *Eye exercises and orthoptics* • *Radial keratotomy and other refractive surgery.*	*All charges.*
Foot care	
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.	Par doctor: 20% of the Plan allowance Non-Par doctor: Any difference between the plan allowance and the provider's charge.
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*

Orthopedic and prosthetic devices	You pay
• Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: See 5(b) for coverage of the surgery to insert the device.	Par doctor: 20% of the Plan allowance Non-Par doctor: Any difference between the plan allowance and the provider's charge.
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Foot orthotics* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided less than 3 years after the last one we covered*	*All charges.*
Durable medical equipment (DME)	
Durable medical equipment (DME) is equipment and supplies that: 1. Are prescribed by your attending physician (i.e., the physician who is treating your illness or injury); 2. Are medically necessary; 3. Are primarily and customarily used only for a medical purpose; 4. Are generally useful only to a person with an illness or injury; 5. Are designed for prolonged use; and 6. Serve a specific therapeutic purpose in the treatment of an illness or injury. We cover rental or purchase, at our option, including repair and adjustment, of durable medical equipment, such as oxygen and dialysis equipment. Under this benefit, we also cover: • Hospital beds; • Wheelchairs; • Apnea Monitors • Respirators • Commodes • Suction Machines • Crutches; and • Walkers.	Par doctor: 20% of the Plan allowance Non-Par doctor: Any difference between the plan allowance and the provider's charge.
Not covered: • *Wigs* • *Orthotics*	*All charges*

Home health services	You pay
90 days per calendar year up to a maximum plan payment of 100% of Plan allowance per day when: • A registered nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.) provides the services; • 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.	Par: Nothing "No deductible" Non-Par: Any difference between the plan allowance and the provider's charge. "No deductible"
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family;* • *Home care primarily for personal assistnce that does not include a medical component and is not diagnostic, therapeutic or rehabilitative.*	*All charges.*
Chiropractic	
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application	Par doctor: 20% of the Plan allowance Non-Par doctor: Any difference between the plan allowance and the provider's charge.
Not covered	*All charges*
Alternative treatments	
• Acupuncture – by a doctor of medicine or osteopathy for: anesthesia	Par doctor: 20% of the Plan allowance Non-Par doctor: Any difference between the plan allowance and the provider's charge.
Not covered: • *naturopathic services* (Note: benefits of certain alternative treatment providers may be covered in medically underserved areas; see page 8)	*All charges*
Educational classes and programs	
Coverage is limited to: • Smoking Cessation – Up to $100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs. • Diabetes self management	Par doctor: Nothing Non-Par doctor: Any difference between the plan allowance and the provider's charge.

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 is: $200 per person ($400 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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. Any costs associated with the facility charge (i.e. hospital, surgical center, etc.) are in Section 5 (c).
- **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 After the calendar year deductible…
NOTE: The calendar year deductible does not apply to benefits in this Section. We say "(No deductible)" when it does not apply.	
Surgical procedures	
A comprehensive range of services such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Electroconvulsive therapy • Removal of tumors and cysts • Correction of congenital anomalies (see Reconstructive surgery) • Surgical treatment of morbid obesity — a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over.	Par doctor: 20% of the Plan allowance Non-Par doctor: Any difference between the plan allowance and the provider's charge.

Surgical procedures — *Continued on next page*

Surgical procedures *(Continued)*	
• Insertion of internal prostethic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information • Voluntary sterilization, Norplant (a surgically implanted contraceptive), and intrauterine devices (IUDs) • Treatment of burns • Assistant surgeons – we cover up to 80% of our allowance for the surgeon's charge	Par doctor: 20% of the Plan allowance for the primary procedure and 20% of one-half of the Plan allowance for the secondary procedure(s) Non Par doctor: 20% of the Plan allowance for the primary procedure and 20% of one-half of the Plan allowance for the secondary procedure(s); and any difference between our payment and the billed amount
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: – Par: 80% of the Plan allowance or – Non-Par: 80% of the Plan allowance • For the secondary procedure(s): – Par: 80% of one-half of the Plan allowance or – Non-Par: 80% of one-half of the reasonable and customary charge 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.	Par: 20% of the Plan allowance for the primary procedure and 20% of one-half of the Plan allowance for the secondary procedure(s) Non-Par doctor: 20% of the Plan allowance for the primary procedure and 20% 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; see Foot care*	*All charges.*

Reconstructive surgery	You pay
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: – the condition produced a major effect on the member's appearance and – the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformaties; 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)	Par: 20% of the Plan allowance Non-Par: Any difference between the plan allowance and the provider's charge.
Note: We may pay for internal breast prostheses as hospital benefits. 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 if repair is initiated from the effective date of the contract.* • *Surgeries related to sex transformation or sexual dysfunction*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Other surgical procedures that do not involve the teeth or their supporting structures	Par doctor: 20% of the Plan allowance Non-Par doctor: Any difference between the plan allowance and the provider's charge.
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*

Organ/tissue transplants	You pay
Limited to: • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single – only for the following end-stage pulmonary diseases: pulmonary fibrosis, primary pulmonary hypertension, or emphysema; Double – only for patients with cystic fibrosis • Pancreas • Allogeneic bone marrow transplants – only for patients with acute leukemia, advanced Hodgkins disease • Intestinal transplant (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas • Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support, limited to patients with acute lymphocytic, or nonlymphocytic leukemia; advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advance neuroblastoma (limited to children over age one): testicular, mediastinal, retroperitoneal and ovarian germ cell tumors, breast cancer; multiple myeloma, epithelial ovarian cancer National Transplant Program (NTP) – SSEHA does not have a NTP. Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols. Note: We cover related medical and hospital expenses of the donor when we cover the recipient.	Par doctor: 20% of the Plan allowance. Non-Par doctor: Any difference between the plan allowance and the provider's charge.
Not covered: • *Donor screening tests and donor search expenses, except those performed for the actual donor* • *Implants of artificial organs* • *Transplants not listed as covered*	*All charges*
Anesthesia	
Professional services provided in – • Hospital (inpatient)	Par doctor: 20% of the Plan allowance. Non-Par doctor: Any difference between the plan allowance and the provider's charge.
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Par doctor: 20% of the Plan allowance. Non-Par doctor: Any difference between the plan allowance and the provider's charge.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Unlike Sections 5(a) and 5(b), in this section 5(c) the calendar year deductible applies to only a few benefits. In that case, we added "(calendar year deductible applies)". The calendar year deductible is: $200 per person ($400 per family).
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works, 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 Sections 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: The calendar year deductible applies ONLY when we say below: "(calendar year deductible applies)".	
Inpatient hospital	
Room and board, such as • ward, 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.	Participating hospital: $100 per admission deductible. Non-Participating hospital: $100 per admission. Note: If you use a Participating provider and a Participating facility, we may still pay non-Participating benefits if you receive treatment from a radiologist, pathologist, or anesthesiologist who is not a Participating provider.

Inpatient hospital – *Continued on next page*

Inpatient hospital *(continued)*	**You pay**
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home (Note: calendar year deductible applies.) NOTE: We base payment on whether the facility or a health care professional bills for the services or supplies. For example, when the hospital bills for its nurse anesthetists' services, we pay Hospital benefits and when the anesthesiologist bills, we pay Surgery benefits.	Par hospital: $100 per admission deductible. Non-Par hospital: Any difference between the plan allowance and the provider's charge, the $100 per admission deductible.
Not covered: • *Any part of a hospital admission that is not medically necessary (see definition), such as when you do not need acute hospital inpatient (overnight) care, but could receive care in some other setting without adversely affecting your condition or the quality of your medical care. Note: In this event, we pay benefits for services and supplies other than room and board and in-hospital physician care at the level they would have been covered if provided in an alternative setting* • *Custodial care; see definition.* • *Non-covered facilities, such as nursing homes, schools,* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges.*
Outpatient hospital or ambulatory surgical center	
• Operating, recovery, and other treatment room • Prescribed drugs • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	Par hospital: Nothing "No deductible" Non-Par hospital: Any difference between the plan allowance and the provider's charge. "No deductible"

Extended care benefits/Skilled nursing care facility benefits	You pay
Skilled nursing facility (SNF): We cover semiprivate room, board, services and supplies in a SNF for up to 365 days per confinement when: 1) you are admitted directly from a precertified hospital stay of at least 3 consecutive days; and 2) you are admitted for the same condition as the hospital stay; and 3) your skilled nursing care is supervised by a physician and provided by an R.N., L.P.N., or L.V.N.; and 4) SNF care is medically appropriate.	Par SNF: Nothing "No deductible" Non-Par SNF: Any difference between the plan allowance and the provider's charge. "No deductible"
Extended care benefit: We cover semiprivate room, board, services and supplies for up to 365 days per confinement when: 1) If you are admitted directly from a percertified hospital stay of at least 3 consecutive days; and 2) ECF confinements follow and are related to a hospital admission; therefore, ECF admissions are not subject to the per admission inpatient hospital benefits deductible Note: Each day a patient receives benefits in a hospital reduces by two days the number of ECF benefit days available for the confinement. Note: ECF benefits are not provided for admissions for mental conditions or substance abuse.	Par ECF: Nothing "No deductible" Non-Par ECF: Any difference between the plan allowance and the provider's charge. "No deductible"
Not covered: Custodial care	*All charges.*
Hospice care	
Hospice is a coordinated 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. We cover: • services provided to terminally ill patients with a life expectancy of 6 months or less for whom no further curative therapy is indicated; • condition management services provided at home or as an inpatient; • palliative care delivered by a team of hospice professionals and volunteers with family members participating as active members of that team; • inpatient hospice care when the patient requires 24-hour-a-day care or when the proper care cannot be provided in the home; and • up to 180 day per lifetime, 60 of which can be used for inpatient hospital care. Note: If a patient requires hospice care benefits beyond the 6 months life expectancy period and has exhausted 180 hospice benefit days 45 reserve days are available.	Par hospital: Nothing "No deductible" Non-Par hospital: Any difference between the plan allowance and the provider's charge. "No deductible"
Not covered: Independent nursing, homemaker	*All charges.*
Ambulance	
• Local professional ambulance service when medically appropriate	After $200 deductible, 20% of the Plan Allowance

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: $200 per person ($400 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- 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 a medical emergency?

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

What is an accidental injury?

An accidental injury is a bodily injury sustained solely through violent, external, and accidental means, such as broken bones, animal bites, and poisonings. We do cover dental care for accidental injury.

Benefit Description	You pay After the calendar year deductible…
NOTE: The calendar year deductible applies to almost all benefits in this Section. We say "(No deductible)" when it does not apply.	
Accidental injury	
If you receive care for your accidental injury within 72 hours, we cover: • Non-surgical physician services and supplies • Related outpatient hospital services 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.	Par hospital: Nothing "No deductible" Non-Par hospital: Any difference between the plan allowance and the provider's charge. "No deductible"
If you receive care for your accidental injury after 72 hours, we cover: • Non-surgical physician services and supplies • Surgical care Note: We pay Hospital benefits if you are admitted.	Par hospital: Nothing "No deductible" Non-Par hospital: 20% of Plan allowance and any difference between our allowance and the billed amount "No deductible"

Medical emergency	
If you receive care for your medical emergency within 72 hours, we cover: • Non surgical physician services and supplies • Related outpatient hospital services	Par hospital: Nothing for initial care 72 within hours. "No deductible" Non-Par Hospital: Any difference between the plan allowance and the provider's charge. "No deductible"
If you receive care for you medical emergency after 72 hours, we cover • Non surgical physician services and supplies • Surgical care Note: We pay Hospital benefits if you are admitted Outpatient medical or surgical services and supplies	Par hospital: 20% of the Plan allowance. Non-Par hospital: Any difference between the plan allowance and the provider's charge.
Ambulance	
Professional ambulance service Note: See 5(c) for non-emergency service.	After $200 deductible, 20% of the Plan Allowance
Not covered: air ambulance	*All charges*

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

IMPORTANT

You may choose to get care Out-of-Network or In-Network. When you receive In-Network care, you must get our approval for services and follow a treatment plan we approve. If you do, cost-sharing and limitations for In-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 or, for facility care, the inpatient deductible apply to almost all benefits in this Section. We added "(No deductible)" to show when a deductible does not 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.
- **YOU MUST GET PREAUTHORIZATION OF THESE SERVICES.** See the instructions after the benefits descriptions below.
- In-Network mental health and substance abuse benefits are below, then Out-of-Network benefits begin on page 37.

IMPORTANT

Description	You pay
NOTE: The calendar year deductible applies to almost all benefits in this Section.	
In-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: In-Network benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as a part of the treatment plan that we approve.	**Your cost sharing responsibilities are no greater than for other illness or conditions.**

In-Network benefits – *Continued on next page*

In-Network Benefits *(Continued)*	You pay
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	Inpatient Visits: Par doctor – After the $200 deductible, any difference between the plan allowance and the provider's charge. Inpatient Visits: Non-Par – Any difference between the plan allowance and the provider's charge. Outpatient Visits: Par doctor – After the $200 deductible, any difference between the plan allowance and the provider's charge. Outpatient Visits: Non-Par doctor – Any difference between the plan allowance and the provider's charge.
• Diagnostic Tests	Par doctor: After $200 deductible, 20% of the Plan allowance Non-Par doctor: After $200 deductible, any difference between the plan allowance and the provider's charge.
• Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full day hospitalization, facility based intensive outpatient treatment	Par doctor: After $200 deductible, 20% of the Plan allowance Non-Par doctor: After $200 deductible, any difference between the plan allowance and the provider's charge.
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges.*

Preauthorization	To be eligible to receive these enhanced mental health and substance abuse benefits you must obtain a treatment plan and follow all of the following network authorization processes: You, your representative, your doctor, or your hospital must call CareFirst BlueCross Blue Shield for medical admissions, at least two days prior to admission. The toll free number is 800-553-8700 or 202-479-6718 in the Washington, DC area. For mental health and substance abuse admissions call Health Management Strategies International, Inc. at 800-999-9849 or at 703-836-6365.
Network limitation	If you do not obtain an approved treatment plan, we will provide only Out-of-Network benefits

Out-of-Network benefits	You pay
Professional services to treat mental conditions and substance abuse	After $200 mental conditions/substance abuse calendar year deductible, any difference between the plan allowance and the provider's charge.
Inpatient care to treat mental conditions includes ward or semiprivate accommodations and other hospital charges	After a $200 deductible per admission to a non-Par hospital, any difference between the plan allowance and the provider's charge.
Inpatient care to treat substance abuse includes room and board and ancillary charges for confinements in a treatment facility for rehabilitative treatment of alcoholism or substance abuse	After $200 inpatient substance abuse calendar year deductible, any difference between the plan allowance and the provider's charge.
Not covered out-of-network; • *Services by pastoral, marital,drug/alcohol and other counselors* • *Treatment for learning disabilities and mental retardation* • *Services rendered or billed by schools, residential treatment centers or halfway houses or members of their staff*	*All charges*

Lifetime Maximum	Out-of-network inpatient care for the treatment of alcoholism and drug abuse is limited to one treatment program (28-day maximum) per lifetime.
Precertification	The medical necessity of your admission to a hospital or covered facility must be precertified for you to receive these Out-of-Network benefits. Emergency admissions must be reported within two business days following the days of admission even if you have been discharges. Otherwise the benefits payable will be reduced by $500. See Section 3 for details. Call Health Management Strategies International, Inc for precertification at 800-999-9849 or locally at 703-836-6365.

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 more information about submitting 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 in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is $200 per person ($400 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No Deductible)" to show when the calendar year deductible does not apply.
- 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

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

- **Who can write your prescription.** A licensed physician must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a pharmacy that participates with Advance Paradigm, Inc, a non-network pharmacy, or by mail. We pay a higher level of benefits when you use a network pharmacy.
- **These are the dispensing limitations:**
  - You will receive an AdvanceRx Prescription identification card. In most cases, you simply present the card together with the prescription to the pharmacist. Under the Prescription Drug Card Program, you may only obtain a 30-day supply and one refill. For the initial 30-day supply and the one refill, you pay $20 for brand name and $10 for generic drugs. You may fill your prescription at a participating pharmacy. You may obtain the names of participating pharmacies by calling AdvancePCS Member Services at 1-800-241-3371.
  - Through the AdvancePCS Mail Order Service you may receive up to a 90-day supply of maintenance medications for drugs which require a prescription, diabetic supplies, and insulin (including syringes) and oral contraceptives. You may receive refills of the original prescription for up to one year. You must pay a copayment of $40 for brand name drugs and $20 for generic drugs

    The Carrier will send you information on the Mail Order Program. To use the Program:

    1) Complete the Mail Order Form. Complete the information on the back of the pre-addressed envelope.
    2) Enclose your prescription and your $20 or $40 copayment.
    3) Mail your order in the pre-addressed envelope to AdvancePCS, P.O. Box 830070, Birmingham, AL 35283-0070.
    4) Allow approximately two weeks for delivery.

    You will receive forms for refills and future prescription orders each time you receive drugs or supplies under this Program. In the meantime, if you have any questions about a particular drug or a prescription, and to request your first order forms, you may call toll free: 1-800-241-3371 form 8 a.m. to 11 p.m. Monday through Friday, 8 a.m. to 7 p.m. on Saturday, and 8 a.m. to 5:30 p.m. on Sunday, EST. Emergency consultation is available seven days a week, 24 hours per day.

Prescription drugs *(Continued)*

- A generic equivalent will be dispensed if it is available, unless our physician specifically requires a name brand. If you receive a name brand drug when a Federally approved generic drug is available, and your physician has not specified "Dispense as Written" for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic.

- **Why use generic drugs?** A generic drug is a prescription drug that by law must have the same chemical composition as a specific brand-name prescription drug. Generic medications that are recommended for use by CareFirst members have been thoroughly evaluated and certified by the FDA as bioequivalent to their brand-name counterparts. Using generics saves you money, yet provides the same quality.

When you have to file a prescription drug claim. Use a claim form to claim benefits for prescription drugs and supplies you purchased (without your AdvanceRx drug card). You may obtain these forms by calling 1-800-241-3371. Follow instructions on the form and mail it to the address referenced on this page. If a participating pharmacy is not available where you reside or you do not use your identification card, you must submit your claim to:

AdvancePCS
P.O. Box 830070
Birmingham Al 35283-0070

Your claim will be reimbursed subject to the copayment level shown above and based on SSEHA's cost for the drug had a participating pharmacy been used.

Claims must be filed within 12 months of the date of service.

Note: If you are enrolled in a Medicare Part B, the Plan will waive the $20 or $40 copayment ONLY through the Mail Order Program. The copayment WILL NOT be waived under the Prescription Drug Card Program. Any copayment or coinsurance for drugs purchased at retail are not waived.

Covered medications and supplies	You pay
Each new enrollee will receive a description of our prescription drug program, a combined prescription drug/Plan identification card, a mail order form/patient profile and a preaddressed reply envelope. You may purchase the following medications and supplies prescribed by a physician from either a pharmacy or by mail: • Drugs for which a prescription is required by Federal law • Oral contraception drugs; diaphragms • Insulin and the following injectables; Heparin, Glucagon, Initrex, EpiPen and Anakit • Smoking deterrents, limited to one series per member per lifetime. • Diabetic supplies, including insulin syringes, needles, glucose test strips, lancets and alcohol swabs • Implantable drugs (such as Norplant), some injectable drugs (such as Depo Provera), and IUDs are covered under Section (5a-Family planning) • Drugs to treat sexual dysfunctions are limited to drugs for male impotence (i.e., Viagra) limited to 6 pills per 30 days • Allergy serum and intravenous fluids and medication for home use under Section (5a-Allergy care) • Drugs and medicines (including those administered during a non-covered admission or in a non-covered facility) that by Federal law of the United States require a physician's prescription for their purchase, those listed as not covered • Needles and syringes for the administration of covered medications	• Network Retail: $10 generic/$20 brand name • Network Retail Medicare: $10generic/$20 brand (No deductible) • Non-Network Retail: Copayment – Average wholesale price • Non-Network Retail Medicare: 40% of cost (No deductible) • Network Mail Order: $20 generic/$40 brand • Network Mail Order Medicare: Copay is waived Copayment – Average wholesale price Note: If there is no generic equivalent available, you will still have to pay the brand name copay.
Not covered: • *Drugs and supplies for cosmetic purposes* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Nonprescription medicines* • *Drugs available without a prescription* • *Nutritional supplements and vitamins (except injectable B12 for treatment of pernicious anemia).* • *Drugs to aid in smoking cessation except those limited to $100 lifetime maximum as a part of the smoking cessation benefit (see page 25).*	*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 1-800-622-6252 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	TDD Telecommunications Device for the deaf 202-479-3546
Travel benefit/ services overseas	BlueCard Worldwide enables Blue Cross and Blue Shield Plan members traveling or living abroad to receive impatient, outpatient and professional services from healthcare providers worldwide. **Provider Referral** • If a member is traveling or living outside the United States and requires medical attention, the member calls the Bluecard Access line at 800-810-BLUE (2583). A medical assistance coordinator, in conjuction with a nurse, will facilitate hospitalization or make an appointment with a physician. • The member presents his or her Blue Cross Blue Shield Plan ID card to the provider. The provider will verify the member's eligibility and coverage by calling the BlueCard Worldwide Service Center. • In emergency cases, members should go directly to the nearest hospital. **Claims Processing** • Inpatient Participating Hospital Care – the provider files the claim. The member is not required to pay up front and is only responsible for deductibles, coinsurance and non-covered services. • Outpatient Hospital or Professional Care – The member pays the provider, and completes and sends an international claim form to the BlueCard Worldwide Service Center.

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.
- There is no calendar year deductible for dental services
- 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: We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. We do not cover the dental procedure.

IMPORTANT

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	**Par doctor: After $200 deductible, 20% of the Plan allowance** Non-Par doctor: After $200 deductible, any difference between the plan allowance and the provider's charge

Dental benefits

Service	We pay (scheduled allowance)	You pay
• Routine cleaning including scaling and polishing • Two oral examinations per person, per calendar year • Two topical flouride applications per calendar year (children up to the age of 16) • Regular x-rays • Palliative emergency services • Space maintainers (for deciduous teeth only) • Pulp vitality tests • Consultation by a dental consultant • Panoramic X-rays (1 every 3 years)	100% up to $1000 per person, per calendar year	Par doctor: Any balances in excess of the $1000 per person maximum per calendar year. Non-par: Any balances in excess of the $1000 per person maximum per calendar year and difference up to the provider's charges.

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

My CareFirst.com is a health resource guide for members. CareFirst BlueCross BlueShield makes this Web site available for the sole purposes of providing education health related issues and providing access to health-related resources for care that patients receive from their physician. This Web site's health related resources are not intended to be a substitute for professional medical advice. Please review the Terms of Use before using this Web site. Your use this Web site indicates your agreement to be bound by the Terms of Use. This Web site includes the following types of information.

- Customized Personal Health Assessments
- Disease and conditions information
- Health News
- Fitness Information

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;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Expenses you incurred while you were not enrolled in this Plan;
- Services and supplies furnished without charge (except as described on page 14; 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 and supplies furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption;
- Services and supplies furnished or billed by a non-covered facility, except that medically necessary prescription drugs are covered;
- Services and supplies not specifically listed as covered;
- Any portion of a provider's fee or charge that is ordinarily due from the enrollee but has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived;
- Charges the enrollee or Plan has no legal obligation to pay, such as; excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see pages 44-52), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge; see page 16), or State premium taxes however applied;
- Rest, institutional, or rehabilitation care not specifically stated as covered;
- Treatment of obesity; weight reduction, except surgery for morbid obesity;
- Biofeedback;
- Charges for stand-by services;
- Any portion of a charge which is determined by the Carrier to be in excess of the carrier allowance;
- Charges for completion of claim forms or similar charges;
- Charges for services rendered to a patient after the date of death; or
- Travel, even if prescribed by a doctor.

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 800-424-7474 ext. 6039or 202-479-6039, or at our website at www.CareFirst.com.

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 1-800-424-7474 or 202-479-6039.

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. Bills and receipts should be itemized and show:

- 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.

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.
- Claims for rental or purchase of durable medical equipment; private duty nursing; and physical, occupational, and speech therapy require a written statement from the physician specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs and supplies that are not ordered through the Mail Service Prescription Drug Program must include receipts that include the prescription number, name of drug or supply, prescribing physician's name, date, and charge.
- We will not provide translation and currency conversion for claims overseas (foreign) services.

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 by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. 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 US and Puerto Rico and performed by physicians outside the United States send a completed claim form and the itemized bill 550 12th Street, SW, Washington, DC 20065. Obtain Overseas Claim forms and send any written inquiries concerning the processing of overseas claims to this address.

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: Write to us within 6 months from the date of our decision; and (a) Send your request to us at: Member Services, 550 12th St. S.W., Washington D.C. 20065 and (b) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and (c) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: (a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or (b) Write to you and maintain our denial — go to step 4; or (c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request-go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us — if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436, Washington, DC 20044-0436.

The Disputed Claims process *(Continued)*

Send OPM the following information:

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

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

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must 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 their disputed claim decision. This information will become part of the court record.

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

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

(a) We haven't responded yet to your initial request for care or preauthorization/prior approval, then call us at 800-553-8700 or 202-479-6718 and we will expedite our review; or

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

- If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
- You can call OPM's Health Benefits Contracts Division II at 202/606-3818 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

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

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

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

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

- **What is Medicare?**

Medicare is a Health Insurance Program for:

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

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. 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 information.
- Part B (Medical Insurance). Most 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 choice in how you get your healthcare. Medicare+Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare+Choice Plan you have.

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

The Original Medicare Plan (Original Medicare is a Medicare+Choice plan that 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. Your care must continue to be pre-certified by the Plan.

Claims process when you have 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 800-424-7474 extension 6039 toll free outside the Washington, DC area; or 202-479-6039. (You may also contact the carrier at its web site at http://www.carefirst.com.)

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:

- Medical services and supplies provided by physician and other healthcare professionals.

- If you are enrolled in Medicare Part B, we will waive the $5 or $12 Mail order Copayment.

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

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

- **Private Contract with your physician**

A physician may ask you to sign a private contract agreeing that you can be billed directly for services ordinarily covered by 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 no 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

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.

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 rendered safely and reasonably by a person not medically skilled, or that 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 and 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 companion or sitter;

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

6) treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

The Carrier determines which services are custodial care.

Deductible

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

Experimental or investigational services

A medical treatment or procedure, or a drug, device or biological product is experimental or investigational if 1) reliable evidence shows that it is the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or 2) reliable evidence shows that the consensus of opinion among experts regarding the drug, device or biological product, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with 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, or medical treatment or procedure. If you desire additional information concerning the experimental/investigational determination process, please contact the Plan

Group health coverage

Health care coverage that a member is 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 services or supplies, including extension of any of these benefits through COBRA. Group health coverage also includes coverage that pays a specific amount for each day or period of hospitalization if the specified amount exceeds $100 per day. The Carrier will coordinate benefits against the amount that exceeds $100 per day.

Medical necessity

Services, supplies or equipment provided by a hospital or covered provider of the health care services that the Carrier determines:

1) are appropriate to diagnose or treat the patient's 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 or convenience 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 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 or equipment does not, in itself, make it medically necessary.

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:

For claims in the Washington D.C. area, Resource Based Relative Value Scale (RBRVS) is the methodology we use for paying physicians based on a schedule of relative procedure values which reflect the resource costs and effort used to perform each procedure.

Us/We

Us and we refer to SSEHA

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

NOTE: 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 January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time of 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 ex-spouse's employing or retirement office to get RI 70-5, the Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees, or other information about your coverage choices.

- **TCC**

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

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

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

- **Converting to individual coverage**

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 72-27, 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 contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

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

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

What is long term care (LTC) insurance?

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

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

- 76% of Americans believe they will never need long term, 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 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 you should have a plan just in case. LTC insurance to be vital to your financial and retirement planning.

Is long term care expensive?

- Yes. A year in a nursing home can exceed $50,000 and only three 8-hours shifts a week can exceed $20,000 a year, that's before inflation !
- LTC can easily exhaust your savings but LTC insurance can protect it.

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

- Not FEHB. Look at the "Not covered" in sections 5(a) and 5(c) of your FEHB brochure. Custodial care, asisted living, or continuing home health care for activities of daily living are not covered. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care after a hospitalization with a 100 day limit.
- Medicaid covers LTC for those who meet their state's guidelines, but restricts covered services and where they can be received.

LTC insurance can provide choices of care and preserve your independence.

When will I get more information?

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

How can I find out more about the program NOW?

- A toll-free telephone number will begin in mid-2002. You can learn more about the program now at www.opm.gov/insure/ltc.

Index

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

Notes

Summary of benefits for the U.S. Secret Service Employees Health Association – 2002

- **Do not rely on this chart alone.** All benefits are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- Below, an asterisk (*) means the item is subject to the $200 calendar year deductible. And, after we pay, you generally pay any difference between our allowance and the billed amount if you use a Non-PPO physician or other health care professional.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office....	Par doctor: 20% of the Plan allowance Non-Par doctor: 20% of Plan allowance and any difference up to the billed amount.	18-19
Services provided by a hospital: • Inpatient ..... • Outpatient	Par hospital: $100 per admission deductible. Non-Par hospital: 20% of the Plan allowance and any difference between our allowance, the $100 per admission deductible and the billed amount. Par hospital: Nothing Non-Par hospital: 20% of the Plan allowance and any difference between our allowance and the billed amount.	30-31
Emergency benefits • Accidental injury ..... • Medical emergency	Par hospital: Nothing Non-Par hospital: Any difference between our allowance and the billed amount	34
Mental health and substance abuse treatment	Regular benefits	35-37
Prescription drugs	$10 generic/$20 brand name	38-40
Special features:		41
Dental Preventive Care.....	Nothing	42
Protection against catastrophic costs (your out-of-pocket maximum)	Nothing after $1,000/Self Only or $2,000/Family enrollment per year Some costs do not count toward this protection	13-14

2002 Rate Information for
U.S. Secret Service Employees Health Association

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

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

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	Y71	$92.51	$30.83	$200.43	$66.81	$109.46	$13.88
Self and Family	Y72	$219.24	$73.08	$475.02	$158.34	$259.43	$32.89