Blue Shield of California

Blue Shield of California
An Independent Member of the Blue Shield Association

Access+ 2002

http://www.mylifepath.com

A Health Maintenance Organization

Serving: Most of California

Enrollment in this plan is limited. You must live or work in our geographic service area to enroll. See page 7 for requirements.

For changes in benefits, see page 8.

This plan has been granted Commendable Accreditation from the NCQA.
See the 2002 Guide for more information on accreditation.

Enrollment codes for this plan:

SJ1 Self Only
SJ2 Self and Family

Authorized for distribution by the:

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

FEHB
Federal Employees
Health Benefits Program

RI 73-574

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Introduction

Blue Shield of California
Access+ HMO[sm]
50 Beale Street
San Francisco, CA 94105

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

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

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

Plain Language

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

Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member; "we" means Blue Shield of California.

We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.

Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to 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 800-334-5847 and explain the situation.

If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202-418-3300

The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

Penalties for Fraud

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

Section 1. Facts about this HMO plan

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

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

When you receive services from plan providers, you will not have to submit claim forms except for your annual eye exam. You only pay the copayments and coinsurance described in this brochure. When you receive emergency services from non-plan providers, you may have to submit claim forms.

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

How we pay providers

We contract with physicians, medical groups, and hospitals to provide the benefits in this brochure. These plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about your health plan, its networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

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

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

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

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

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

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

Service Area

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

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

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will normally pay only for emergency or urgent care. We will not pay for any other health care service, except those that are specifically listed on page 34 under the heading “Medical Care for Vacations, Business Travel and College Students.”

If you or a covered family member move outside the service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO like ours that has agreements with affiliates in other states. See page 34 for details about our HMO Medical care available for vacations, business travel and college students coverage. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we change for 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)

Changes to this Plan

- Your share of the non-Postal premium will increase by 24.3% for Self Only or 24.3% for Self and Family.
- The following counties are no longer a part of our service area: Napa, Shasta and San Luis Obispo.
- We no longer limit total blood cholesterol tests to certain age groups. (Section 5(a))
- We now cover routine screening for chlamydial infection. (Section 5(a))
- We now cover certain intestinal transplants. (Section 5(b))
- The copayments for prescription drugs have changed. Members can now obtain non-formulary drugs for $25 per retail plan pharmacy prescription/ $50 per plan mail service prescription. The charge for a generic formulary retail plan pharmacy prescription has been reduced from $6 per prescription to $5 per prescription. Other copayment changes are: $10 per brand name formulary plan pharmacy prescriptions; $10 per generic formulary plan mail service prescription; and $20 per brand name formulary plan mail service prescription. As before, a generic equivalent will be dispensed if it is available, unless your physician specifically requires a brand name. If you receive a brand name drug when a federally-approved generic drug is available and your physician has not specified "Dispense as Written" for the brand name drug, you will pay the difference in the cost between the brand name drug and the generic plus the appropriate copayment.
- Smoking cessation medications requiring a prescription are covered at the appropriate prescription copayment but are limited to one 12-week course of treatment per calendar year.
- We have clarified that the coordination of benefits provision does not apply to the Prescription Drug Benefit.
- We have clarified that treatment of damage to natural teeth caused solely by an accidental injury is covered.
- We have clarified that a member can self-refer for mental health and substance abuse care using the Access+ feature as long as the specialist is an USBHPC provider.
- We have also clarified that OB/GYN services obtained within the same Medical Group/IPA as the primary care physician; services for which the Medical Group or IPA routinely allows the Member to self-refer without authorization from the primary care physician; and internet consultants are not covered Access+ visits. (Section 5(g))
- We have clarified that home testing devices are not covered except as specifically listed in the covered section.

Section 3. How you get care

Identification cards

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

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 800-334-5847.

Where you get covered care

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

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. All plan providers are credentialed, according to national standards.

We list plan providers in the provider directory, which we update periodically. The list is also on our website, http://www.mylifepath.com.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website, http://www.mylifepath.com

What you must do to get covered care

It depends on the type of care you need. First, you and each family member must choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. You must complete a Primary Care Physician Selection Form.

- **Primary care**

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

If you want to change primary care physicians or if your primary care physician leaves the plan, call us at 800-334-5847. We will help you select a new one.

- **Specialty care**

Your primary care physician will refer you to a specialist for needed care. When you receive a referral from your primary care physician, you must return to the primary care physician after the consultation, unless your primary care physician authorized a certain number of visits without additional referrals.

The primary care physician must provide or authorize all follow-up care. Do not go to the specialist for return visits unless your primary care physician gives you a referral.

The exceptions to this are:

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

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

Here are other things you should know about specialty care:

If you need to see a specialist frequently because of a chronic, complex or serious medical condition, your primary care physician will develop a treatment plan with you that allows an adequate number of direct access visits with that specialist. Your primary care physician will use our criteria when creating your treatment plan.

If you are seeing a specialist when you enroll in our plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. We will not pay for you to see a specialist who does not participate with our plan, unless your primary care physician refers you to a non-plan specialist for a second opinion.

If you are seeing a specialist and your specialist leaves the plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.

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

- terminate our contract with your specialist for other than cause;
- drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB plan; or
- reduce our service area and you enroll in another FEHB plan;

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

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

- **Second Opinions**

If there is a question about your diagnosis or if additional information concerning your condition would be helpful in determining the most appropriate plan of treatment, your primary care physician will, upon request, refer you to another physician for a second medical opinion. If you are requesting a second opinion about care you received from your primary care physician, a physician within the same Medical Group\IPA as your primary care physician will provide the second opinion. If you are requesting a second opinion about care received from a specialist, any plan specialist of the same equivalent specialty may provide the second opinion. All second consultations must be authorized by us.

- **Hospital care**

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

If you are in the hospital when your enrollment in our plan begins, call our member service department immediately at 800-334-5847. If you are new to the FEHB Program, we will arrange for you to receive care.

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

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

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

Circumstances beyond our control

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

Services requiring our prior approval

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

Your primary care physician must obtain a preauthorization from us for; (1) selected drugs and drug dosages which require prior authorization for medical necessity, (2) growth hormone therapy (GHT) (3) organ transplants and (4) bone marrow transplants.

See page 23 in Section 5(b) for the preauthorization process for organ and bone marrow transplants.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

- **Copayments**

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

Example: When you see your primary care physician you pay a copayment of $10 per office visit.

- **Coinsurance**

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

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

Your out-of-pocket maximum for coinsurance and copayments

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

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

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

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

Section 5. Benefits -- OVERVIEW

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms for annual eye exams, or more information about our benefits, contact us at 800-334-5847 or at our website at http://www.mylifepath.com.

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians	
• During a hospital stay • In a skilled nursing facility • Vaccines for pediatric and adult immunizations • Inpatient non-dental treatment of temporomandibular joint (TMJ) syndrome	Nothing
• Office visits • Office medical consultations • Second opinions	$10 per office visit
Home visit by physician	$25 per visit
Self-referral to a plan specialist under Access+ option	$30 per office visit
In an urgent care center	$50 per visit
Home visit by nurse or health aide	$5 per visit
Lab, x-ray and other diagnostic tests	
Tests, such as: • Blood tests • Urinalysis • Pathology • X-rays • CAT scans/MRI • Ultrasound • Electrocardiogram and EEG	Nothing
• Non-routine Pap tests • Non-routine mammograms	$10 per test

Preventive care, adult	You Pay
Routine screenings, such as: • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including – Fecal occult blood test – Sigmoidoscopy, screening – every five years starting at age 50	Nothing
Prostate Specific Antigen (PSA test) – one annually for men age 40 and older	Nothing
Routine Pap test	Nothing
Routine mammogram – covered for women age 35 and older, as follows: • From age 35 through 39, one during this five year period • From age 40 through 49, one every one or two years • From age 50 through 64, one every year • At age 65 and older, one every two years	Nothing
Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*
Routine immunizations as recommended by the United States Public Health Service • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza vaccines, annually, age 50 and older • Pneumococcal vaccine for adults 65 and older • Recommended travel immunizations • Hepatitis A, hepatitis B and lyme disease immunization for individuals at high risk	Nothing
Preventive care, children	
Childhood immunizations recommended by the American Academy of Pediatrics	Nothing
Well-child care charges for routine examinations, immunizations and care (through age 17) Examinations, such as: • Eye screenings through age 17 to determine the need for vision correction • Ear screenings through age 17 to determine the need for hearing correction • Examinations done on the day of immunizations (through age 17)	Nothing

Maternity care	You Pay
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care	Nothing
Note: Here are some things to keep in mind: • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section (5c)) and Surgery benefits (Section 5(b)).	
Not covered: Routine sonograms to determine fetal age, size or sex	*All charges*
Family planning	
A broad range of voluntary family planning services, such as: • Physician office visit for fitting a diaphragm.	Nothing
• 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.	$10 per item
Voluntary Sterilization • Vasectomy • Tubal ligation	 $75 $100
Not covered: reversal of voluntary surgical sterilization	*All charges*
Infertility services	
Diagnosis and treatment of infertility, such as: • Artificial insemination: – intravaginal insemination (IVI) – intracervical insemination (ICI) – intrauterine insemination (IUI) • Covered injectable fertility drugs	50% of allowable charges
Oral fertility drugs (See *Prescription Drug Benefits*)	Regular cost sharing

Infertility services *(continued)*	**You pay**
Not covered: • *Infertility services after voluntary sterilization* • *Assisted reproductive technology (ART) procedures, such as:* – *in vitro fertilization* – *embryo transfer, gamete GIFT and zygote ZIFT* • *Services and supplies related to excluded ART procedures* • *Cost of donor sperm, eggs and frozen embryos and their collection and storage*	*All charges*
Allergy care	
• Allergy serum	Nothing
• Testing and treatment • Allergy injection	$10 per office visit
• Customized antigens	50% of allowable charges
Not covered: provocative food testing and sublingual allergy desensitization	*All charges*
Treatment therapies	
• Growth hormone therapy (GHT) Note: We will only cover GHT for medically necessary conditions when we have preauthorized the treatment. Such authorization must be obtained through your primary care physician. • Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 23. • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy and antibiotic therapy	$10 per office visit
Physical and occupational therapies	
These are covered benefits when determined by us to be medically necessary and it is demonstrated that the member's condition will significantly improve as a result of the services. – qualified physical therapists; and – occupational therapists. Note: Occupational therapy is limited to services that assist the member to achieve and maintain self-care and improved functioning in other activities of daily living.	$10 per visit
Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction, is provided at a plan facility, if medically necessary with the appropriate treatment plan.	$10 per visit
Not covered: • *long-term rehabilitative therapy* • *exercise programs*	*All charges*

Speech therapy	You Pay
Speech therapy by a qualified speech therapist is covered when it is determined by us to be medically necessary and it is demonstrated that the member's condition will significantly improve as a result of the services.	$10 per visit
Hearing services (testing, treatment, and supplies)	
Hearing screening for children through age 17 (see *Preventive care, children*)	Nothing
Not covered: • *all other hearing testing* • *hearing aids, testing and examinations for them*	*All charges*
Vision services (testing, treatment, and supplies)	
Contact lenses, if medically necessary to treat eye conditions such as keratoconus and keratitis sicca or when required as a result of cataract surgery when no intraocular lens has been implanted, are covered.	$10 per office visit
Annual eye refraction; in addition to the medical and surgical benefits provided for diagnosis and treatment of disease of the eye, an annual eye refraction (to provide a written lens prescription) may be obtained from Medical Eye Services (MES) providers. MES directories can be ordered by calling 800-334-5847. Note: See *Preventive care, children* for eye screenings for children.	$10 per office visit
Not covered: • *Eyeglasses or contact lenses (See page 34 for details about eyewear discounts)* • *Eye exercises and orthoptics* • *Radial keratotomy, refractive keratoplasty and other refractive surgery*	*All charges*
Foot care	
Not covered: Routine foot care	*All charges*
Orthopedic and prosthetic devices	
Surgically implanted breast implant following mastectomy	Nothing
Surgically implanted prosthetic devices, such as artificial joints, pacemakers: • Inpatient Hospital • Outpatient Hospital	 Nothing $50 per surgery
• Orthopedic devices (and their repair) such as braces and functional foot orthoses • Prosthetic devices (and their repair) such as artificial limbs, Blom-Singer prostheses and contact lenses necessary to treat certain medical eye conditions. Contact us for details. • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy	50% of allowable charges

Orthopedic and prosthetic devices *(continued)*	**You Pay**
Not covered: • *Orthopedic and corrective shoes* • *Arch supports* • *Heel pads and heel cups* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Penile prostheses*	*All charges*
Durable medical equipment (DME)	
Purchase or rental up to the purchase price, including repair and adjustment, of durable medical equipment prescribed by your plan physician. Under this benefit, we cover: • Colostomy/ostomy supplies • Hospital beds • Wheelchairs • Crutches • Walkers • Canes • Traction equipment • Peak flow monitor for self-management of asthma • Glucose monitor for self-management of diabetes • Apnea monitor for management of newborns Note: Call us at 800-334-5847 as soon as your plan physician prescribes this equipment. We have contracted with health care providers to rent or sell you durable medical equipment at discounted rates and we will tell you more about this service when you call.	50% of allowable charges
Not covered: • *Exercise equipment* • *Disposable medical supplies for home use* • *Speech/language assistance devices except as listed under prosthetic devices* • *Self-monitoring equipment and home testing devices, except as listed in the covered section* • *Wigs*	*All charges*
Home health services	
• Home health care ordered by a plan physician and provided by a registered nurse (R.N.), Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (ST), Respiratory Therapist (RT), licensed vocational nurse (L.V.N.), or home health aide • Services include oxygen therapy, intravenous therapy and medications	$5 per visit
• Home visit by physician	$25 per visit

Home health services *(continued)*	**You pay**
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Services primarily for hygiene, feeding, exercising, moving the patient, homemaking, companionship or giving oral medication*	*All charges*
Chiropractic/Alternative treatments	
Chiropractic services (with an annual limit of 20 visits per year)	$10 per office visit
Each member is allowed a pre-authorized appliance benefit of up to $50 per year. Appliance benefits that are pre-authorized such as: • Elbow supports • Back supports (Thoracic) • Cervical collars	All charges above $50 per year
Not covered: • *All charges after the 20 visit annual maximum* • *Naturopathic services* • *Hypnotherapy* • *Services for or related to acupuncture (see page 34 for Non-FEHB discount information.)* *Note: See page 34 Non-FEHB benefits available to plan members. Significant discounts through the mylifepath[sm] Alternative Health Services Discount Program - acupuncture, massage & more*	*All charges*
Educational classes and programs	
Coverage is limited to: • Health education newsletter • Health Resource Directory; provides information about health education classes and support groups offered by Blue Shield providers and community organizations • Healthwise Handbooks for new members • First Steps[sm] prenatal education program • Preventative health reminders	Nothing

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

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5 (c) for charges associated with the facility charge (i.e. hospital, surgical center, etc.).

IMPORTANT

Benefit Description	You pay
Surgical procedures	
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, when medically necessary • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity – for members who meet Blue Shield Medical Policy and clinical criteria for defined procedures and services that have been approved by their Primary care physicians • Treatment of burns	Nothing in hospital
Insertion of internal prosthetic devices. See Section 5(a) – Orthopedic and prosthetic devices for device coverage information.	$10 per procedure
Outpatient hospital surgery and supplies	$50 per surgery
Voluntary Sterilization • Vasectomy • Tubal ligation	 $75 $100
Not covered: • *Reversal of voluntary sterilization* • *Routine treatment of conditions of the foot*	*All charges*

Reconstructive surgery	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 congenial anomalies are: protruding ear deformities, cleft lip, cleft palate, birth marks, webbed fingers, and webbed toes	Nothing as an inpatient
• All stages of breast reconstruction surgery following a mastectomy, such as: – surgery to produce a symmetrical appearance on the other breast – treatment of any physical complications, such as lymphedemas Note: If you need a mastectomy, you may choose to have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	See above
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*
Oral and maxillofacial surgery	
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones • Surgical correction of cleft lip, cleft palate or severe functional malocclusion • Removal of stones from salivary ducts • Excision of leukoplakia or malignancies • Excision of cysts and incision of abscesses when done as independent procedures • Surgical and anthroscopic treatment of TMJ is covered if prior history shows conservative medical treatment has failed. Splint therapy and physical therapy is covered, see Section 5(a) • Other surgical procedures that do not involve the teeth or their supporting structures	Nothing as an inpatient
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*

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

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

IMPORTANT

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a plan facility.
- We have no calendar year deductible.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).

IMPORTANT

Benefit Description	You pay
Inpatient hospital	
Room and board, such as: • semiprivate or intensive care accommodations • general nursing care • meals and special diets when medically necessary • special duty nursing when medically necessary • private rooms when medically necessary NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	Nothing
Other hospital services and supplies, such as: • Operating, recovery, delivery room, newborn nursery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and x-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home • Radiation therapy, chemotherapy, and renal dialysis	Nothing
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, convalescent care facilities, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care*	*All charges*

Outpatient hospital or ambulatory surgical center	You pay
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, x-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Pre-surgical testing • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service NOTE: – We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover dental procedures for non-accidental injury to natural teeth. See page 33.	$50 per treatment or surgery including necessary supplies
Not covered: blood and blood derivatives if replaced by the member	*All charges*
Extended care benefits/skilled nursing care facility benefits	
We provide benefits up to 100 days each calendar year when full time skilled nursing care is necessary and confinement in a skilled nursing facility is medically appropriate as determined by your plan physician and approved by us. Admissions to a sub-acute care setting require prior approval and are limited to 100 days each calendar year. All necessary services are covered, including: • Bed, board and general nursing care • Drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a plan physician	Nothing
Not covered: custodial care, rest cures, domiciliary or convalescent care and comfort items such as a telephone and television. All charges after the 100 day annual maximum.	*All charges*
Hospice care	
Supportive and palliative care for a terminally ill member is covered in the home or a hospice facility. Care received in the home is limited to 100 visits per year. Care received in a hospice facility provides for 100 days of service, applied against the Extended Care Day Limits, without copayment. Services include inpatient and outpatient care, and family counseling; these services provided under the direction of a plan physician who certifies that the patient is in the terminal stages of illness, with a life expectancy of approximately six months or less.	Nothing in a hospice facility $10 copayment per home physician visit $5 copayment per visit of other health care providers
Not covered: Independent nursing, homemaker services	*All charges*
Ambulance	
Local professional ambulance service when ordered or authorized by a plan physician.	Nothing

Section 5(d). Emergency services/accidents

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

What is a medical emergency?

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

What to do in case of emergency:

Emergencies within our service area

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

If you need to be hospitalized, we must be notified immediately following your admission, unless it was not reasonably possible to notify us within that time. If you are hospitalized in non-plan facilities and a plan physician believes care can be better provided in a plan hospital, you will be transferred when medically feasible with any ambulance charges covered in full.

Benefits are available for care from non-plan providers in a medical emergency only if delay in reaching a plan provider would result in death, disability or significant jeopardy to your condition. Any follow-up care recommended by non-plan providers must be approved by us or provided by plan providers.

We pay reasonable charges for emergency services to the extent the services would have been covered if received from plan providers. If the emergency results in admission to a hospital, any applicable copayment is waived.

Benefit Description	You pay
Emergency within our service area	
Emergency care at a doctor's office	$10 per visit
• Emergency care at an urgent care center • Emergency care as an outpatient or inpatient at a hospital, including doctors' services Note: If the emergency results in admission to a hospital, the copayment is waived.	$50 per visit
Not covered: Elective care or non-emergency care	*All charges*

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

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

Network Benefit

IMPORTANT

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

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

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

IMPORTANT

Benefit Description	You pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by plan providers and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
• Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management	$10 per visit
• Diagnostic tests	Nothing
• Services provided by a hospital or other facility • Services approved in alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility based intensive outpatient treatment	Nothing
Not covered: Services we have not approved. *Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.*	*All charges*

Mental health and substance abuse benefits *(continued)*

Preauthorization

To be eligible to receive these benefits you must follow your treatment plan and all the following authorization processes:

To obtain an authorization, call 877-263-8827. You should continue to identify yourself as a Blue Shield member and use your Blue Shield identification card and identification numbers when contacting USBHPC or its participating providers.

Your health care provider should contact USBHPC at 877-263-9870 to obtain information about joining the USBHPC network, obtaining an authorization for your treatment, or to speak with a member of USBHPC's clinical staff about issues related to this benefit or your care.

If you would like a copy of a provider directory, you can contact the Blue Shield Member Services Department at 800-334-5847.

Out-of-Network Benefit

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- See page 28 for In-Network benefits.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

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

Section 5(f). Prescription drug benefits

IMPORTANT

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

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works..

IMPORTANT

There are important features you should know about your prescription drug benefit. These include:

Who can write your prescription? A licensed physician, or other covered provider acting within the scope of their license.

Where can you obtain your prescriptions? You must fill the prescription at a retail plan pharmacy, or plan mail service pharmacy for a maintenance medication.

Mail Service Drug Program. Prescriptions are available by mail for up to a 90-day supply. Generic drugs will be dispensed in lieu of brand name drugs when substitution is permissible by the physician. Call Member Services at 800-334-5847 to receive a packet for ordering prescriptions through the mail.

We use a formulary. Prescription drug coverage is based on the use of the prescription drug formulary, a copy of which is available to you. Non-formulary drugs are always covered at the non-formulary copayment, unless excluded from prescription drug benefit. Selected drugs and drug dosages, require prior authorization for medical necessity. You should not become directly involved with us for this pre-authorization process. Your physician is responsible for obtaining prior authorization and documenting medical necessity. If all necessary documentation is available from your physician, prior authorization approval or denial will be provided to your physician within two working days of the request.

Medications are selected for inclusion in Blue Shield's Outpatient Prescription Drug Formulary based on safety, efficacy, and FDA bio-equivalency data. The Blue Shield Pharmacy and Therapeutics Committee reviews new drugs and clinical data four times a year.

Members may call Blue Shield Member Services at 800-334-5847 to find out if a specific drug is included in the Formulary. New members receive a printed copy of the formulary with their welcome kits. Formulary information is also available on Blue Shield's website at http://www.mylifepath.com.

In lieu of brand name drugs, generic drugs will be dispensed when substitution is permissible by the physician. If you request a brand name drug when a generic drug is available, you pay the difference between the cost of the brand name drug and its equivalent generic drug, plus the appropriate copayment.

Prescription Days Supply Covered: Present your Access+ ID card at the participating pharmacy. A retail plan pharmacy may dispense up to a 30-day supply for the appropriate copayment. You will pay the appropriate copayment per prescription for out-of-state emergencies. Maintenance drugs are available for up to a 90-day supply at the appropriate copayment per prescription through the plan mail service pharmacy.

Why use generic drugs? Generic drugs offer a safe and economic way to meet your prescription drug needs. The generic name of a drug is its chemical name; the brand name is the name under which the manufacturer advertises and sells a drug. Under federal law, generic and brand name drugs must meet the same standards for safety, purity, strength, and effectiveness. A generic prescription costs you -- and us -- less than a brand name prescription.

Benefit Description	You pay
Covered medications and supplies	
We cover the following medications and supplies prescribed by a plan physician and obtained from a retail plan pharmacy or through our mail service pharmacy: • Diabetic supplies limited to disposable insulin syringes, needles, pen delivery systems for the administration of insulin as determined by Blue Shield to be medically necessary and glucose testing tablets and strips • Smoking cessation medication requiring a prescription (limited to one 12-week course of treatment per calendar year) • Formulary and non-formulary drugs for sexual dysfunction or sexual inadequacies will be covered when the dysfunction is caused by medically documented organic disease. Prior plan approval is required and the maximum dosage dispensed will be limited by the protocols established by us. Certain drugs for these conditions are not available through the Mail Service option. • Formulary and non-formulary drugs and medicines that by federal law of the United States require a physician's prescription for their purchase, except as excluded below. • Insulin • Disposable needles and syringes for the administration of covered medications • Formulary and non-formulary oral contraceptive drugs and diaphragms.	$5 per generic formulary retail plan pharmacy prescription $10 per brand name formulary retail plan pharmacy prescription $25 per non-formulary retail plan pharmacy prescription $10 per generic formulary mail service prescription $20 per brand name formulary mail service prescription $50 per non-formulary mail service prescription
Here are some things to keep in mind about our prescription drug program: • A generic equivalent will be dispensed if it is available, unless your physician specifically requires a brand name. If your receive a brand name drug when a federally-approved generic drug is available and your physician has not specified "Dispense as Written" for the brand name drug, you will pay the difference in the cost between the brand name drug and the generic plus the copayment.	Appropriate copayment plus the difference in price of brand name and generic drugs
Not covered: • *Drugs available without a prescription or for which there is a nonprescription equivalent available* • *Drugs obtained at a non-plan pharmacy except for out-of-area emergencies* • *Compounded medication with formulary alternatives or those with no FDA approved indications* • *Medical supplies such as dressings and antiseptics* • *Drugs for cosmetic purposes* • *Drugs to enhance athletic performance* • *Drugs for weight loss* • *Smoking cessation drugs without a prescription or for which there is a nonprescription equivalent available* • *Vitamins and nutritional substances that can be purchased without a prescription* • *Intravenous fluids and medications for home use and some injectable drugs, such as Depo Provera, are covered under Sections 5(a) or 5(b) Medical or Surgical services, not the Prescription Drug Benefit.* *Note: IUDs and Norplant dispensed by your physician are covered under Section 5(b) Surgical Services, not the Prescription Drug Benefit.*	*All Charges*

Section 5 (g). Special Features

Feature	Description
High risk pregnancies	We cover the prenatal diagnosis of genetic disorders of the fetus in high-risk pregnancy cases.
Self-referral to Specialty services	Access+ allows you to arrange office visits with plan specialists in the same Medical Group or IPA as your primary care physician without a referral. A few physicians are not Access+ providers. You are advised to refer to the *Access+ 2002 Provider Directory for Federal Employees* to determine if your physician participates in the Access+ self-referral option. Members who use this convenient feature are subject to a $30 copayment per specialty office visit. If the medical condition requires follow-up care to the same specialist, you are encouraged to request that the specialist receive prior authorization from your primary care physicians for additional visits at the regular office copayment of $10 per visit. **The Access+ specialist includes:** • Examinations and consultations; • Conventional x-rays of the chest and abdomen; • X-rays of bones to diagnose suspected fractures; • Laboratory services; • Diagnostic or treatment procedures that would normally be provided with a referral; and • Vaccines and antibiotics. **The Access+ specialist visit does not include:** • Diagnostic imaging such as CAT Scans, MRI or bone density measurements; • Services that are not covered benefits or that are not medically necessary; • Services of a provider not in the Access+ or USBHPC network (see section 5(e)); • Allergy testing; • Endoscopic procedures; • Injectables, chemotherapy or other infusion drugs (not listed above); • Infertility services; • Emergency services; • Urgent care services; • Inpatient services or facility charges; • Services for which the Medical Group or IPA routinely allows the Member to self-refer without authorization from the Personal Physician; • OB/GYN services by an obstetrician/gynecologist or family practice Physician within the same Medical Group/IPA as the Personal Physician; and • Internet based consultations.

Section 5(h). Dental benefits

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan providers must provide or arrange your care.
- We have no calendar year deductible.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

IMPORTANT

Accidental injury benefit

Hospital and professional services provided for conditions of the teeth, gums, or jaw joints and jawbones, including adjacent tissues are a benefit only to the extent that they are provided for the treatment of damage to natural teeth caused solely by an accidental injury is covered by this plan. Prosthodontics, orthodontia, and cosmetic services are not covered. This benefit does not include damage to the natural teeth that is not accidental; e.g., resulting from chewing or biting

Dental benefits

We have no other FEHB dental benefits. Please refer to page 34 for details about a comprehensive, non-FEHB optional Blue Shield Dental Plan.

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

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

Blue Shield Dental Option -- Comprehensive and Affordable

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

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

	Biweekly Dues	Monthly Dues	Quarterly Dues
Self only	$8.14	$17.63	$52.89
Two party	$15.69	$33.99	$101.97
Family	$23.10	$50.05	$150.15

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

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

Receive Discounts from Vision One Eyecare Program on Frames and Lenses

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

For coverage of eye refractions see page 18.

Receive Discounts through the mylifepath[sm] Alternative Health Services Discount Program - Acupuncture, Massage & More

Access+ offers you participation in the mylifepath discount program, which entitles you to discounts of 10%-25% off certain health and wellness services. When you see a participating practitioner or visit a facility in the mylifepath alternative health services discount network, you'll experience savings on acupuncture, chiropractic, massage therapy and somatic education, fitness centers and athletic clubs, health spas, and wellness programs. You will be responsible for all charges remaining after the discounts are applied. For more details on all features, please call 888-999-9452 or visit our website at http://www.mylifepath.com for health information and news about value-added features.

Medical Care for Vacations, Business Travel and College Students

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

Blue Shield 65 Plus, A Medicare+Choice Prepaid Plan

This Plan offers Medicare recipients the opportunity to enroll in the plan through Medicare. As indicated on page 41, annuitants and former spouses with FEHB coverage and Medicare Part B may elect to drop their FEHB coverage and enroll in a Medicare prepaid plan if one is available in their area. They may then later reenroll in the FEHB Program. Most federal annuitants have Medicare Part A. Those without Medicare Part A may join this Medicare prepaid plan but will have to pay for hospital coverage in certain instances in addition to the Part B premium. Before you join the plan, ask whether the plan covers hospital benefits and, if so, what you will have to pay. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan. Contact us at 888-713-0000 for information on the Medicare prepaid plan and the cost of that enrollment. Blue Shield 65 Plus is now available in Kern, Los Angeles, Orange, Riverside, San Bernardino, San Diego, and Ventura counties.

Benefits on this page are not part of the FEHB Contract

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

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

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see Emergency Benefits);
- Services, drugs, or supplies you receive while you are not enrolled in this plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or mental health practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs or supplies related to sexual dysfunction or sexual inadequacies (including penile prostheses) except as provided for medically documented treatment of organically based conditions; or
- Services performed by a close relative (the spouse, child, brother, sister, or parent of a member) or a person who ordinarily resides in the member's home.

Section 7. Filing a claim for covered services

When you see plan physicians, receive services at plan hospitals and facilities, or obtain your prescription drugs at plan pharmacies, you will not have to file claims except for your annual eye examination. Just present your identification card and pay your copayment or coinsurance.

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

Medical, hospital and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form CMS-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call us at 800-334-5847.

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

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

Submit your claims to:

Blue Shield of California
Access+ Member Services
P.O. Box 272550
Chico, CA 95927

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

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

Section 8. The disputed claims process

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

Step	Description
1	You may appeal by either calling or writing the Member Services Department requesting Blue Shield of California to reconsider our initial decision. You must: a) Write or call us within 6 months from the date of our decision; b) Send your written request to us at: Blue Shield of California, Appeals & Grievance Department, P.O. Box 92945, Los Angeles, CA 90009-2945. You may call our member service department at 800-334-5847 and request a Grievance Form. We will mail or fax the form to you. c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	We have 30 days from the date we receive your request to: a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or b) Write to you and maintain our denial -- go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
4	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, 1900 E Street, NW, Washington, DC 20415-3620 Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. Note: • If you want OPM to review different claims, you must clearly identify which documents apply to which claim. • 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. • The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

(continued on next page)

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 800-334-5847 and we will expedite our review; or
b) We denied your initial request for care or preauthorization/prior approval, then:
   - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
   - You can call OPM's Health Benefits Contracts Division II at 202-606-3818 between 8 a.m. and 5 p.m. Eastern Standard 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.

The coordination of benefits provision does not apply to the Prescription Drug Benefit

- **What is Medicare?**

Medicare is a Health Insurance Program for:

– People 65 years of age and older.

– Some people with disabilities, under 65 years of age.

– People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

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

– Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

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

- **The Original Medicare Plan**

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

When you are enrolled in Original Medicare along with this plan, you still need to follow the rules in this brochure for us to cover your care. Your care must continue to be authorized by your plan primary care physician.

We will not waive any of our copayments or coinsurances.

(Primary payer chart begins on next page.)

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

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

- **Medicare managed care plan**

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

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

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

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will nor require you to enroll in Medicare Part B and, if you can't get premium free Part A, we will not ask you to enroll in it.

TRICARE

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

Workers' Compensation

We do not cover services that:

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

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

Medicaid

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

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, state, or federal government agency directly or indirectly pays for them

When others are responsible for injuries

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

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us at 530-666-2238 for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year

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

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See page 12.

Coinsurance

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

Covered services

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

Experimental or investigational services

Access+ covers drugs, devices that are medically indicated and biological products no longer considers to be investigational by the Food and Drug Administration. Coverage for other procedures are reviewed by and decided by the Blue Shield of California Medical Policy Committee. The primary criteria are that the proposed new procedures are safe and effective.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. These are negotiated lower provider rates and savings are passed on to you.

Us/We

Us and we refer to *Blue Shield of California Access+ or USBHPC* for mental health and substance abuse coverage.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

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

Where you can get information about enrolling in the FEHB Program

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

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

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

Types of coverage available for you and your family

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

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

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

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

When benefits and premiums start

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

Your medical and claims records are confidential

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

OPM, this plan, and subcontractors when they administer this contract;

This plan and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;

Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;

OPM and the General Accounting Office when conducting audits;

Individuals involved in bona fide medical research or education that does not disclose your identity; or

OPM, when reviewing a disputed claim or defending litigation about a claim.

When you retire

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

When you lose benefits

- **When FEHB coverage ends**

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

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

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

- **Spouse equity coverage**

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

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

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

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

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

Converting to individual coverage

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

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

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

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

Getting a Certificate of Group Health Plan Coverage

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

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

Long Term Care Insurance Is Coming Later in 2002!

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

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

What is long term care (LTC) insurance?

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

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

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

Is long term care expensive?

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

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

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

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

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

How can I find out more about the program NOW?

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

Department of Defense/FEHB Demonstration Project

What is it?

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

Who is eligible

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

- You are an active or retired uniformed service member and are eligible for Medicare;
- You are a dependent of an active or retired uniformed service member and are eligible for Medicare;
- You are a qualified former spouse of an active or retired uniformed service member and you have not remarried; or
- You are a survivor dependent of a deceased active or retired uniformed service member; and
- You live in one of the geographic demonstration areas.

If you are eligible to enroll in a plan under the regular Federal Employees Health Benefits Program, you are not eligible to enroll under the DoD/FEHBP Demonstration Project.

The demonstration areas

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

When you can join

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

You may select coverage for yourself (Self Only) or for you and your family (Self and Family) during the 2001 open season. Your coverage will begin January 1, 2002.

If you become eligible for the DoD/FEHB Demonstration Project outside of open season, contact the IPC to find out how to enroll and when your coverage will begin.

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

Temporary Continuation of Coverage (TCC)

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

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

Other features

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

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

Summary of Benefits for the Access+ 2002

Do not rely on this chart alone. All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.

If you want to enroll or change your enrollment in this plan, be sure to put the correct enrollment code from the cover on your enrollment form.

We only cover services provided or arranged by plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians: • Preventive diagnostic and treatment services provided in the office	Office visit copayment: $10 primary care; $10 specialist; $30 Access+ self-referral	14
Services provided by a hospital: • Inpatient • Outpatient	 Nothing $50 per treatment or surgery	24
Emergency benefits: • In-area or out-of-area	 $50 copayment per visit	26
Mental health and substance abuse treatment • In-Network • Out-of-Network	 Regular cost sharing No benefit	28
Prescription Drugs	$5 per generic formulary retail plan pharmacy prescription $10 per brand name formulary retail plan pharmacy prescription $25 per non-formulary retail plan pharmacy prescription $10 per generic formulary mail service prescription $20 per brand name formulary mail service prescription $50 per non-formulary mail service prescription	30
Dental Care Accidental injury benefit	 $10 per office visit, or $50 per treatment or surgery	33
Optional Non-FEHB Dental Plan	You pay total premiums plus various copayments	34
Vision Care	$10 per office visit	18
Special Features: High risk pregnancy program, Access+ self-referral		32
Protection against catastrophic costs • Surgical and medical • Mental health and substance abuse Note: There are separate catastrophic cost for mental health and substance abuse services.	Nothing after $1,000/Self Only or $2,000/Family enrollment per year Some costs do not count toward this protection	12

Notes

2002 Rate Information for
Blue Shield of California Access+

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

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

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	**Code**	**Gov't Share**	**Your Share**	**Gov't Share**	**Your Share**	**Gov't Share**	**Your Share**
High Option Self Only	**SJ1**	**$84.05**	**$28.02**	**$182.12**	**$60.70**	**$99.46**	**$12.61**
High Option Self and Family	**SJ2**	**$208.51**	**$69.50**	**$451.77**	**$150.59**	**$246.73**	**$31.28**