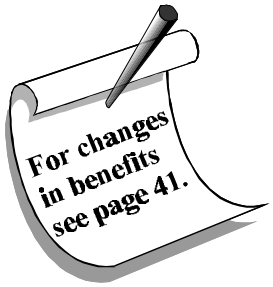
APWU Health Plan 1999

A Managed Fee-for-Service Plan
with Preferred Provider Organizations



Sponsored by the American Postal Workers Union, AFL-CIO

Who may enroll in this Plan:

All Federal and Postal Service employees and annuitants who are eligible to enroll in the FEHB Program may become members of this Plan. To enroll, you must be, or must become, a member of the American Postal Workers Union, AFL-CIO. Annuitants (retirees) may enroll in this Plan.

To become a member or associate member:

All active Postal Service bargaining unit employees must be, or must become, dues-paying members of the APWU, except where exempt by law. In item 1 of Part B of your registration form, enter the number of your APWU Local immediately after the name of this Plan.

If you are a non-postal employee/annuitant, you will automatically become an associate member of APWU upon enrollment in the APWU Health Plan.

Membership dues: $35 per year for associate members. New associate members will be billed for annual dues when the Plan receives notice of enrollment. Continuing associate members will be billed by the Plan for the annual membership. Billing usually takes place at the end of March. Please do not send money to the Health Plan; APWU headquarters will bill you for the dues.

Enrollment code for this Plan:

471 Self only
472 Self and family

Visit the OPM website at http://www.opm.gov/insure
and
this Plan's Web site at http://www.apwuhp.com

Authorized for distribution by the:

United States Office of Personnel Management

Federal Employees Health Benefits Program

RI 71-004

American Postal Workers Union Health Plan

The American Postal Workers Union, Washington, DC, (Carrier) has entered into Contract No. CS 1370 with the Office of Personnel Management (OPM) to provide a health benefits plan (Plan) authorized by the Federal Employees Health Benefits (FEHB) law. The FEHB contract specifies the manner in which it may be modified or terminated.

This brochure is the official statement of benefits on which you can rely. It describes the benefits, exclusions, limitations, and maximums of the APWU Health Plan for 1999 and until amended by future benefit negotiations between OPM and the Carrier. It also describes procedures for obtaining benefits. You should use this brochure to determine your entitlement to benefits. Oral statements cannot modify the benefits described in this brochure.

An enrollee does not have a vested right to receive the benefits in this brochure in 2000 or later years, and does not have a right to benefits available prior to 1999 unless those benefits are contained in this brochure.

Inspector General Advisory: Stop Health Care Fraud!

Fraud increases the cost of health care for everyone. Anyone who intentionally makes a false statement or a false claim in order to obtain FEHB benefits or increase the amount of FEHB benefits is subject to prosecution for FRAUD which may result in CRIMINAL PENALTIES.

Please review all medical bills, medical records and claims statements carefully. If you find that a provider, such as a doctor, hospital, pharmacy, etc., charged your Plan for services you did not receive, billed for the same service twice, or misrepresented any other information, take the following actions:

- Call the provider (doctor, hospital, etc.) and ask for an explanation - sometimes the problem is a simple error.
- If the provider does not resolve the matter, or if you remain concerned, call your Carrier at 1-800/222-APWU and explain the situation.
- If the matter is not resolved after speaking to your Carrier (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300
The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

The inappropriate use of membership identification cards, e.g., to obtain benefits for a person who is not an eligible family member or after you are no longer enrolled in the Plan, is also subject to review by the Inspector General and may result in an adverse administrative action by your agency.

When you need help with Plan benefits, or getting your ID card, call your Plan at 1-800/222-APWU. The Fraud Hotline cannot help you with these.

Using This Brochure

The **Table of Contents** will help you find the information you need to make the best use of your benefits. To get the best value for your money, you should read **Facilities and Other Providers**. It will help you understand how your choice of doctors and hospitals will affect how much you pay for services under this Plan.

This brochure explains all of your benefits. It's important that you read about your benefits so you will know what to expect when a claim is filed. Most of the benefit headings are self-explanatory. **Other Medical Benefits** and **Additional Benefits**, on the other hand, both include a variety of unrelated benefits. What is different about these benefits is how they are paid: **Other Medical Benefits** are paid after you satisfy the calendar year deductible and **Additional Benefits** are generally not subject to the calendar year deductible.

You will find that some benefits are listed in more than one section of the brochure. This is because how they are paid depends on which provider bills for the service. For example, physical therapy is paid one way if it is billed by an inpatient facility and paid another way when it is billed by a doctor, physical therapist or outpatient facility.

The last part of the brochure contains information useful to you under certain circumstances. For example, if you have to go to the hospital you need to read **Precertification**; hospital stays **must** be precertified for all payable benefits to apply. If you are enrolled in Medicare, take a look at **This Plan and Medicare**. And, the **Enrollment Information** section tells you about several FEHB enrollment requirements that could affect your future coverage.

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How This Plan Works

Help Contain Costs

You can help

FEHB plans are expected to manage their costs prudently. All FEHB plans have cost containment measures in place. All fee-for-service plans include two specific provisions in their benefits packages: precertification of all inpatient admissions and the flexible benefits option. Some include managed care options, such as PPO's, to help contain costs.

As a result of your cooperative efforts, the FEHB Program has been able to control premium costs. Please keep up the good work and continue to help keep costs down.

Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of hospital days required to treat your condition. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with your Plan before being admitted to the hospital. If that doesn't happen, your Plan will reduce benefits by $500. Be a responsible consumer. Be aware of your Plan's cost containment provisions. You can avoid penalties and help keep premiums under control by following the procedures specified on page 30 of this brochure.

Flexible benefits option

Under the flexible benefits option, the Carrier has the authority to determine the most effective way to provide services. The Carrier may identify medically appropriate alternatives to traditional care and coordinate the provision of Plan benefits as a less costly alternative benefit. Alternative benefits are subject to ongoing review. The Carrier may decide to resume regular contract benefits at its sole discretion. Approval of an alternative benefit is not a guarantee of any future alternative benefits. The decision to offer an alternative benefit is solely the Carrier's and may be withdrawn at any time. It is not subject to OPM review under the disputed claims process.

PPO

This Plan offers most of its members the opportunity to reduce out-of-pocket expenses by choosing providers who participate in the Plan's preferred provider organization (PPO). Consider the PPO cost savings when you review Plan benefits and check with the Carrier to see whether PPO providers are available in your area.

In addition to a preferred provider network, your Plan has discount arrangements with other hospitals around the country. Their terms vary, but the purpose is the same: to reduce your out-of-pocket expenses on covered services.

Facilities and Other Providers

Covered facilities

Freestanding ambulatory facility

An out-of-hospital facility such as a medical, cancer, dialysis, or surgical center or clinic, and licensed outpatient facilities accredited by the Joint Commission on Accreditation of Healthcare Organizations for treatment of substance abuse.

Hospital

1) An institution which is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations, or

2) Any other institution which is operated pursuant to law, under the supervision of a staff of doctors and twenty-four hour a day nursing service, and which is primarily engaged in providing:

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

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

The term "hospital" shall not include a skilled nursing facility, a convalescent nursing home or institution or part thereof which 1) is used principally as a convalescent facility, rest facility, residential treatment center, nursing facility or facility for the aged or 2) furnishes primarily domiciliary or custodial care, including training in the routines of daily living.

Covered providers

For purposes of this Plan, covered providers include:

1) Doctor - A licensed doctor of medicine (M.D.), a licensed doctor of osteopathy (D.O.), a licensed doctor of podiatry (D.P.M.), or, for certain specified services covered by this Plan, a licensed dentist, licensed chiropractor**,** or licensed clinical psychologist practicing within the scope of the license.
2) Alternate Provider - Alternate providers are covered when performing certain specified services covered by this Plan and when such treatment is within the scope of the provider's license. Alternate providers are limited to licensed physical, occupational and speech therapists; licensed physician's assistants; Registered Nurses (R.N.); Licensed Practical Nurses (L.P.N.); Licensed Vocational Nurses (L.V.N.); and Certified Registered Nurse Anesthetists (C.R.N.A.).
3) Other covered providers include a qualified clinical psychologist, clinical social worker, optometrist, nurse midwife, nurse practitioner/clinical specialist, and nursing school administered clinic. For purposes of this FEHB brochure, the term "doctor" includes all of these providers when the services are performed within the scope of their license or certification.

Coverage in medically underserved areas

Within States designated as medically underserved areas, any licensed medical practitioner will be treated as a covered provider for any covered services performed within the scope of that license. For 1999, the States designated as medically underserved are: Alabama, Idaho, Louisiana, Mississippi, New Mexico, North Dakota, South Carolina, South Dakota and Wyoming.

PPO arrangements

Benefits under this Plan are available from facilities, such as hospitals, and from providers, such as pharmacies, doctors and other health care personnel, who provide covered services. This Plan covers two types of facilities and providers: (1) those who participate in a preferred provider organization (PPO) and (2) those who do not. Who these health care providers are, and how benefits are paid for their services, are explained below. In general, it works like this.

PPO facilities and providers have agreed to provide services to Plan members at a lower cost than you'd usually pay a non-PPO provider. Although PPO's are not available in all locations or for all services, when you use these providers you help contain health care costs and reduce what you pay out of pocket. The selection of PPO providers is solely the Carrier's responsibility; continued participation of any specific provider cannot be guaranteed. While PPO providers agree with the Carrier to provide covered services, final decisions about health care are the sole responsibility of the doctor and patient and are independent of the terms of the insurance contract.

PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. The availability of every specialty in all areas cannot be guaranteed. If no PPO provider is available, or you do not use a PPO provider, the standard non-PPO benefits apply.

When you use a PPO hospital, keep in mind that the professionals who provide services to you in the hospital, such as radiologists, anesthesiologists and pathologists, may not all be preferred providers. If they are not, they will be paid by this Plan as non-PPO providers.

Non-PPO facilities and providers do not have special agreements with the Plan. The Plan makes its regular payments toward the bills, and you are responsible for any balance.

This Plan's PPO

The Plan has established a network of doctors and hospitals that have agreed to reduce their charges to members who voluntarily seek them out for covered services. If you are admitted to a PPO hospital, the Plan will pay **90%** of covered Inpatient hospital charges. Precertification of all hospital admissions is still required as outlined on page 30. If you use the services of a PPO doctor, the Plan will pay in full after a $15 copayment for outpatient visits and pay **90%** of other covered reasonable and customary charges.

Enrollees who reside in a PPO area will receive information concerning the PPO in their region. Additional locations may become available throughout 1999. If you need assistance in identifying a participating provider, call the Plan's PPO administrator for your state: Alliance PPO, Inc. 1-800/342-3289 for providers in the District of Columbia, Maryland, Virginia and West Virginia; Beech Street 1-800/923-3248 for providers in California, Florida, Georgia, Ohio, Oklahoma,

Facilities and Other Providers *continued*

This Plan's PPO *(continued)*

Tennessee, Texas and Washington; MultiPlan 1-800/672-2140 for providers in New Jersey and New York; MedNet 1-800/556-1144 for providers in Maine; PreferredOne 1-800/451-9597 for providers in Minnesota; or First Health 1-800/447-1704 for all other states. For mental conditions/substance abuse providers (all states), call ValueOptions toll-free 1-888/700-7965. Including a provider in the PPO does not represent a warranty of services by the Plan nor does it constitute medical advice. When you phone for an appointment, please remember to verify that the physician is still a PPO provider.

Cost Sharing

Deductibles

A deductible is the amount of expense an individual must incur for covered services and supplies before the Plan starts paying benefits for the expense involved. A deductible is not reimbursable by the Plan and benefits paid by the Plan do not count toward the deductible. When a benefit is subject to a deductible, only expenses allowable under that benefit count toward the deductible.

Calendar year

The calendar year deductible is the amount of expense an individual must incur for covered services and supplies each calendar year before the Plan pays certain benefits. The deductible is $250 and applies to Surgical Benefits, Maternity Benefits, and Other Medical Benefits.

Hospital admission

The per admission deductible is the amount of covered room and board expenses an individual must incur during each non-PPO hospital admission before the Plan pays benefits. The per admission deductible is $200.

Prescription drugs

A prescription drug deductible applies to drugs obtained through a retail pharmacy. This deductible is $50 per person each calendar year (maximum $100 per Self and family enrollment per year). Drugs obtained through the mail order drug program are not subject to any deductible.

Mental conditions/ Substance abuse

A separate deductible applies each calendar year to covered services for inpatient and/or outpatient treatment of mental conditions or substance abuse. This deductible is $250 per person for services by a PPO provider or $750 per person for services by a non-PPO provider.

Carryover

If you changed to this Plan during open season from a plan with a deductible and the effective date of the change was after January 1, any expenses that would have applied to that plan's deductible in the prior year will be covered by your old plan if they are for care you got in January **before** the effective date of your coverage in this Plan. If you have already met the deductible in full, your old plan will reimburse these covered expenses. If you have not met it in full, your old plan will first apply your covered expenses to satisfy the rest of the deductible and then reimburse you for any additional covered expenses. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

Family limit

There is a separate calendar year deductible of $250 per person. However, under a family enrollment, when the combined covered expenses applied to the deductible for all family members reach $500 during a calendar year, the family deductible is satisfied and benefits for which the calendar year deductible applies are payable for all family members.

Coinsurance

Coinsurance is the stated percentage of covered charges you must pay after you have met any applicable deductible. The Plan will base this percentage on either the billed charge or the reasonable and customary charge, whichever is less. For instance, when a plan pays 80 percent of reasonable and customary charges for a covered service, you are responsible for 20 percent of the reasonable and customary charges, i.e., the coinsurance. In addition, you may be responsible for any excess charge over the Plan's reasonable and customary allowance. For example, if the provider ordinarily charges $100 for a service but the Plan's reasonable and customary allowance is $95, the Plan will pay 80 percent of the allowance ($76). You must pay the 20 percent coinsurance ($19), plus the difference between the actual charge and the reasonable and customary allowance ($5), for a total member responsibility of $24. Remember, if you use preferred providers, your share of covered charges (after meeting any deductible) is limited to the stated coinsurance amount.

Cost Sharing *continued*

When hospital charges are limited by law

When inpatient claims are paid according to a Diagnostic Related Group (DRG) limit (for instance, for admissions of certain retirees who do not have Medicare - see page 9), the Plan will pay 30 percent of the total covered amount as room and board charges and 70 percent as other charges and will apply your coinsurance accordingly.

Copayments

A copayment is the stated amount the Plan requires you to pay for certain covered services, such as $15 per office visit at a PPO provider.

If provider waives your share

If a provider routinely waives (does not require you to pay) your share of the charge for services rendered, the Plan is not obligated to pay the full percentage of the amount of the provider's original charge it would otherwise have paid. A provider or supplier who routinely waives coinsurance, copayments or deductibles is misstating the actual charge. This practice may be in violation of the law. The Plan will base its percentage on the fee actually charged. For example, if the provider ordinarily charges $100 for a service but routinely waives the 20% coinsurance, the actual charge is $80. The Plan will pay $64 (80% of the actual charge of $80).

Lifetime maximums

For Smoking Cessation Benefit, the Plan will pay up to $100 for enrollment in one smoking cessation program per member per lifetime.

For substance abuse, the Plan will pay up to $3,000 for one treatment program per member per lifetime.

General Limitations

All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable when determined by the Carrier to be medically necessary. Coverage is provided only for services and supplies that are listed in this brochure. **No oral statement of any person shall modify or otherwise affect the benefits, limitations and exclusions of this brochure, convey or void any coverage, increase or reduce any benefits under the Plan or be used in the prosecution or defense of a claim under the Plan.** This brochure is the official statement of benefits on which you can rely.

Other sources of benefits

This section applies when you or your family members are entitled to benefits from a source other than this Plan. You must disclose information about other sources of benefits to the Carrier and complete all necessary documents and authorizations requested by the Carrier.

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B, or Parts A and B of Medicare, the provisions on coordination of benefits with Medicare described on pages 31 - 33 apply.

Group health insurance and automobile insurance

Coordination of benefits (double coverage) applies when a person covered by this Plan also has, or is entitled to benefits from, any other group health coverage, or is entitled to the payment of medical and hospital costs under no-fault or other automobile insurance that pays benefits without regard to fault. Information about the other coverage must be disclosed to this Carrier.

When there is 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. When this Plan is the secondary payer, it will pay the lesser of (1) its benefits in full, or (2) a reduced amount that, when added to the benefits payable by the other coverage, will not exceed 100 % of covered expenses. When this Plan pays secondary, it will only make up the difference between the primary plan's coverage and this Plan's coverage. Thus, the combined payments from both plans may not equal the entire amount billed by the provider.

The determination of which health coverage is primary (pays its benefits first) is made according to guidelines provided by the National Association of Insurance Commissioners (NAIC). When benefits are payable under automobile insurance, including no-fault, the automobile insurer is primary (pays its benefits first) if it is legally obligated to provide benefits for health care expenses without regard to other health benefits coverage the enrollee may have.

This provision applies whether or not a claim is filed under the other coverage. When applicable, authorization must be given this Carrier to obtain information about benefits or services available from the other coverage, or to recover overpayments from other coverages.

CHAMPUS

If you are covered by both this Plan and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), this Plan will pay benefits first.

Medicaid

If you are covered by both this Plan and Medicaid, this Plan will pay benefits first.

Workers' compensation

The Plan will not pay for benefits or services required as the result of occupational disease or injury for which any medical benefits are determined by the Office of Workers Compensation Programs (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, medical benefits may be provided for services or supplies covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for benefits paid by the Plan that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, and Indian Health Service

Facilities of the Department of Veterans Affairs, the Department of Defense, and the Indian Health Service are entitled to seek reimbursement from the Plan for certain services and supplies provided to you or a family member to the extent that reimbursement is required under the Federal statutes governing such facilities.

Other government agencies

The Plan will not provide benefits for services and supplies paid for directly or indirectly by any other local, State, or Federal Government agency.

Liability insurance and third party actions

Subrogation applies when you are sick or injured as a result of the act or omission of another person or party.

If you or your dependent sustains an injury or illness caused by a third party, the Plan will pay benefits for the injury or illness, subject to the conditions that you and your dependents (1) agree to the Plan being subrogated to any recovery or right of recovery you or your dependents have, including the right to bring suit in your name; (2) will not take any action which would prejudice the Plan's subrogation rights; and (3) will cooperate in doing what is reasonably necessary to assist the Plan in any recovery. The Plan will be subrogated only to the extent of Plan benefits paid because of that injury.

This provision means that the Plan must be reimbursed in full for benefits paid in an amount not to exceed the amount you recover, or, if you do not bring suit or recover, that the Plan, to the extent of benefits paid, has a right to bring suit in the name(s) of the injured party or parties. Under this provision all recoveries (whether by lawsuit, settlement or otherwise), no matter how described or designated, must be used to reimburse the Plan in full for benefits paid. This provision does not allow the Plan's share of the recovery to be reduced because you or your covered dependent do not receive the full amount of damages claimed or for your attorney's fees and costs, unless the Plan agrees in writing to a reduction.

Overpayments

The Carrier will make reasonable diligent efforts to recover benefit payments made erroneously but in good faith and may apply subsequent benefits otherwise payable to offset any overpayments.

Vested rights

An enrollee does not have a vested right to receive the benefits in this brochure in 2000 or later years, and does not have a right to benefits available prior to 1999 unless those benefits are contained in this brochure.

Limit on your costs if you are age 65 or older and don't have Medicare

The information in the following paragraphs applies to you when 1) you are **not** covered by either **Medicare Part A** (hospital insurance) or **Part B** (medical insurance), or both, 2) are enrolled in this Plan as an annuitant or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse, and 3) you are not employed in a position which confers FEHB coverage.

Inpatient hospital care

If you are not covered by **Medicare Part A**, are age 65 or older or become age 65 while receiving inpatient hospital services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b)) requires the Plan to base its payment on an amount equivalent to the amount Medicare would have allowed if you had Medicare Part A. This amount is called the equivalent Medicare amount. After the Plan pays, the law prohibits the hospital from charging you for covered services after you have paid any deductibles, coinsurance, or copayments you owe under the Plan. Any coinsurance you owe will be based on the equivalent Medicare amount, not the actual charge. You and the Plan, together, are not legally obligated to pay the hospital more than the equivalent Medicare amount.

The Carrier's explanation of benefits (EOB) will tell you how much the hospital can charge you in addition to what the Plan paid. If you are billed more than the hospital is allowed to charge, ask the hospital to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan at 1-800/222- APWU for assistance.

Physician services

Claims for physician services provided for retired FEHB members age 65 and older who do not have Medicare Part B are also processed in accordance with 5 U.S.C. 8904(b). This law mandates the use of Medicare Part B limits for covered physician services for those members who are not covered by Medicare Part B.

The Plan is required to base its payment on the Medicare-approved amount (which is the Medicare fee schedule for the service), **or** the actual charge, whichever is lower. If your doctor is a member of the Plan's preferred provider organization (PPO) and participates with Medicare, the Plan will base its payment on the lower of these two amounts and you are responsible only for any deductible and the PPO copayment or coinsurance.

If you go to a PPO doctor who does not participate with Medicare, you are responsible for any deductible and the copayment or coinsurance. In addition, unless the doctor's agreement with the Carrier specifies otherwise, you must pay the difference between the Medicare-approved amount and the limiting charge (115% of the Medicare-approved amount).

If your physician is not a Plan PPO doctor that participates with Medicare, the Plan will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's surgery benefit, the Plan will pay 75% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 25% of the Medicare-approved amount.

If your physician does not participate with Medicare, the Plan will still base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, the coinsurance or copayment amount, **and** any balance up to the limiting charge amount (115% of the Medicare-approved amount).

Since a physician who participates with Medicare is only permitted to bill you up to the Medicare fee schedule amount even if you do not have Medicare Part B, it is generally to your financial advantage to use a physician who participates with Medicare.

The Carrier's explanation of benefits (EOB) will tell you how much the physician can charge you in addition to what the Plan paid. If you are billed more than the physician is allowed to charge, ask the physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Plan at 1-800/222-APWU for assistance.

General Exclusions

These exclusions apply to more than one or to all benefits categories. Exclusions that are primarily identified with a single benefit category are listed along with that benefit category, but may apply to other categories. Therefore, please refer to the specific benefit sections as well to assure that you are aware of all benefit exclusions.

Benefits are provided only for services and supplies that are medically necessary (see definition). The Carrier reserves the right to determine medical necessity. The fact that a covered provider has prescribed, recommended, or approved a service or supply does not, in itself, make it medically necessary.

Benefits will not be paid for services and supplies when:

- No charge would be made if the covered individual had no health insurance coverage
- Furnished without charge (except as described on page 9); while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions or (2) during combat
- Furnished by immediate relatives or household members, such as spouse, parent, child, brother, or sister by blood, marriage, or adoption
- Furnished or billed by a provider or facility that has been barred from the FEHB Program
- Furnished or billed by a noncovered facility, except that medically necessary prescription drugs and physical, speech and occupational therapy rendered by a qualified professional therapist on an outpatient basis are covered subject to plan limits
- For or related to sex transformation, sexual dysfunction or sexual inadequacy except for organic impotence as shown on pages 13 and 23
- Not specifically listed as covered
- Investigational or experimental (see pages 37 and 38)
- Not provided in accordance with accepted professional medical standards in the United States
- Furnished or billed by someone other than a covered provider as defined on page 6
- Incurred while not covered by the Plan

Benefits will not be paid for:

- Any portion of a provider's fee or charge ordinarily due from the enrollee but that has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible, copay or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived
- Charges the enrollee or Plan has no legal obligation to pay, such as excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see page 9), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge) (see page 10), or State premium taxes however applied
- Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest
- Biofeedback; nonmedical self care or self help training, such as recreational, educational, or milieu therapy
- Charges that the Plan determines to be in excess of the reasonable and customary charge

Inpatient Hospital Benefits

What is covered

The Plan pays for inpatient hospital services as shown below.

Precertification

The medical necessity of your hospital admission **must** be precertified for you to receive full Plan benefits. Emergency admissions not precertified must be reported within 48 hours of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See pages 30 and 31 for details.

Waiver

This precertification requirement does not apply to persons whose primary coverage is another health insurance policy or when the hospital admission is outside the United States and Puerto Rico. Also, this requirement generally does not apply to persons whose primary coverage is Medicare Part A, however, see page 30 for exceptions. For information on when Medicare is primary, see pages 31, 32 and 33.

Room and board

Benefits for hospital room and board and other hospital expenses for a bed patient (inpatient) in a hospital, include:

- Ward and semiprivate accommodations.
- Intensive care accommodations, when medically appropriate.
- Isolation care accommodations, when medically appropriate to prevent contagion.
- Lab, X-ray and pharmacy services.
- Anesthesia supplies, operating and recovery room.
- Professional ambulance service, when medically appropriate.
- Blood or blood plasma, if not donated or replaced.

PPO benefit

Plan pays room and board and Other charges at **90%** of hospital's negotiated rates.

Non-PPO benefit

After a $200 deductible per admission, Plan pays room and board and Other charges at **70%** of reasonable and customary charges.

Private room

If a private room is used other than for isolation care, the hospital's average charge for semiprivate accommodations will be paid. If the hospital only has private rooms, the average semiprivate rate for comparable hospitals in the area will be allowed.

Related benefits

Pre-surgical testing

Outpatient laboratory tests, pathology, radiology and X-rays related to surgery are paid as Other Medical Benefits (see pages 19, 20 and 21).

Professional charges

Charges for professional services of a doctor, alternate provider or anesthesiologist, even though billed by a hospital as part of hospital services, are covered only as shown on pages 13, 14, 15 and 19.

Take-home items

Appliances, medical equipment and medical supplies that are provided for use outside a hospital are covered as Other Medical Benefits as shown on page 19.

Prescription drugs and medicines dispensed for take-home use are covered as Prescription Drugs as shown on pages 23 and 24.

Inpatient Hospital Benefits *continued*

Hospitalization for dental work

The Plan pays for room and board and other hospital services for hospitalization in connection with dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient.

What is not covered

- A hospital admission that the Carrier determines is not medically appropriate, i.e., the medical services did not require the acute hospital inpatient (overnight) setting, but could have been provided in a doctor's office, the outpatient department of a hospital, or some other less expensive setting without adversely affecting the patient's condition or the quality of medical care.
- Custodial care as defined on page 37.
- Day and evening care centers, nursing homes, skilled nursing facilities, extended care and residential treatment facilities, a place for rest or for the aged, or any other place which does not meet the definition of a hospital as shown on page 5.
- Services of a private duty nurse that would normally be provided by hospital nursing staff.
- Personal comfort items such as radio, television, air conditioners, beauty and barber services, guest meals and beds.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Surgical Benefits

What is covered

The Plan pays for the following services:

PPO benefit

After the $250 calendar year deductible, **90%** of the surgeon's negotiated fee for the inpatient or outpatient surgical procedure.

Non-PPO benefit

After satisfaction of the $250 calendar year deductible; **70%** of reasonable and customary charges.

This Plan will pay charges in or out of a hospital, to the extent shown above, for:

- Charges of a surgeon. Charges for normal postoperative care by the surgeon(s) are considered to be part of the surgical charges.
- Charges of an anesthesiologist.
- Voluntary sterilization procedures.
- Routine circumcision of newborn.
- Recognized surgery for morbid obesity and organic impotence **(only with prior Plan approval.)** To obtain prior Plan approval, call Spectera/CARE Programs at 1-800/580-8771.
- Cosmetic surgery only if necessary:
  - for breast reconstruction following a mastectomy; or
  - for the correction of congenital defects which existed at or from birth (limited to conditions listed on page 37); or
  - for repair of injuries caused by an accident provided the surgery is completed within two years of the accidental injury.

Multiple surgical procedures

When multiple or bilateral surgical procedures that add time or complexity to patient care are performed during the same operative session, the Plan pays 50% of the value of the secondary, lesser or repeat procedure(s).

Incidental procedures

Only the value of the major procedure is allowed when an incidental procedure is performed through the same incision or when an independent procedure is carried out as an integral part of the total service.

Assistant surgeon (inpatient/ outpatient)

The Plan will consider 20% of the surgical allowance to be reasonable and customary for all assistant surgeons combined during the same operative session.

Second opinion (voluntary)

See Other Medical Benefits (page 19).

Anesthesia

Plan allowance is based upon CPT code value multiplied by units of time.

Organ/tissue transplants and donor expenses

Transplant surgery means transfer of body organ(s) from the donor to the recipient (allogeneic) or a bone marrow transplant in which the donor and recipient are the same person (autologous). Donor means a person who undergoes a surgical operation for the purpose of donating a body organ(s) for transplant surgery. Recipient means a person insured by the Plan who undergoes a surgical operation to receive a body organ transplant.

Prior approval

The Plan participates in a National Transplant Program administered by First Health. Before your initial evaluation as a potential candidate for a transplant procedure, you or your doctor must contact First Health at 1-800/447-1704 and ask to speak to a Transplant Case Manager. You will be provided with information about this program and about transplant preferred providers.

The Plan pays reasonable and customary charges for a covered surgical transplant the same as expenses for any other illness or injury as follows (this benefit applies only if recipient is covered by the Plan):

PPO benefit

All reasonable and customary charges for services performed by a provider, specified by the Plan for this benefit, whether incurred by the recipient or donor. If you participate in the National Transplant Program, you may receive prior approval for travel and lodging costs.

Non-PPO benefit

Pretransplant evaluation, organ procurement, inpatient hospital, surgical and medical expenses for covered transplants, whether incurred by the recipient or donor, are limited to a maximum of $100,000 for each listed transplant, including multiple organ transplants.

What is covered

Benefits will be provided for the following transplants:

- Cornea, kidney, pancreas and liver.
- Heart and heart/lung.
- Single or double lung transplants for the following end-stage pulmonary diseases at an approved center: primary fibrosis, primary hypertension, and emphysema; double-lung transplant for cystic fibrosis at an approved center.
- Benefits for allogeneic bone marrow transplants are limited to patients with leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, aplastic anemia, severe combined immuno-deficiency disease or Wiskott-Aldrich syndrome.
- Benefits for autologous bone marrow transplants and autologous peripheral stem cell support are limited to patients with acute leukemia in remission, relapsed non-Hodgkin's lymphomas responding to treatment, resistant or recurrent neuroblastoma, relapsed Hodgkin's disease responding to treatment, testicular cancer, mediastinal cancer, retroperitoneal cancer, ovarian germ cell tumors, epithelial ovarian cancer, breast cancer and multiple myeloma.
- Related medical and hospital expenses of the donor are covered when the recipient is covered by the Plan.

What is not covered

- Transplants not listed as covered.
- Surgical implant of artificial hearts.
- Services or supplies for**,** or related to**,** surgical transplant procedures for artificial or human organ transplants not listed as specifically covered. Related services include administration of high dose chemotherapy when supported by autologous bone marrow transplant.

Oral and maxillofacial surgery

This Plan will pay reasonable and customary charges in or out of a hospital, to the extent shown on page 13, only for:

- Extraction of impacted (unerupted) teeth.
- Alveoplasty, partial ostectomy and radical resection of mandible with bone graft unrelated to tooth structure.
- Fractures of the jaw and/or facial bones and severe malocclusion (protruding or retruding mandible or maxilla) caused by accidental injury.
- Correction of cleft palate and severe malocclusion if caused by congenital malformation.
- Excision of bony cysts of the jaw unrelated to tooth structure.
- Excision of tori, tumors, leukoplakia, premalignant and malignant lesions, and biopsy of hard and soft oral tissues.
- Reduction of dislocations and excision, manipulation, arthrocentesis, aspiration or injection of temporomandibular joints.
- Removal of foreign body, skin, subcutaneous alveolar tissue, reaction-producing foreign bodies in the musculoskeletal system and salivary stones.
- Incision/excision of salivary glands and ducts.
- Repair of traumatic wounds.
- Sinusotomy, including repair of oroantral and oromaxillary fistula and/or root recovery.
- Surgical treatment of trigeminal neuralgia.
- Frenectomy or frenotomy, skin graft or vestibuloplasty-stomatoplasty unrelated to periodontal disease.
- Incision and drainage of cellulitis unrelated to tooth structure.

To determine whether a procedure is covered, it is suggested that prior Carrier approval be obtained by calling 1-800/222-APWU.

Mastectomy Surgery

Women who undergo mastectomies may, at their option, have this procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.

Pre-surgical testing

Outpatient laboratory tests, pathology, radiology and X-rays related to surgery are paid as Other Medical Benefits (see pages 19 and 20).

What is not covered

- Cosmetic surgery and other related expenses, except as described on page 13.
- Sterilization reversal.
- Trimming of toenails or removal of corns and calluses**, except when the patient is under active treatment of metabolic or peripheral vascular disease.
- Eye surgery, such as radial keratotomy, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring).
- Dental bridges, replacement of natural teeth, dental/orthodontic/temporomandibular joint dysfunction appliances and any related expenses.
- Treatment of periodontal disease and gingival tissues, and abscesses.
- Charges related to orthodontic treatment.
- Oral implants or transplants of any kind.

**May be eligible for Wellness benefit (see page 22).

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Maternity Benefits

What is covered

The Plan pays the same benefits for hospital, surgery (delivery), laboratory tests and other medical expenses as for illness or injury. The mother, at her option, may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a caesarean delivery. Inpatient stays will be extended if medically necessary.

Inpatient hospital

Precertification

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Unscheduled or emergency admissions not precertified must be reported within 48 hours of admission even if you have been discharged. Newborn confinements that extend beyond the mother's discharge must also be precertified. If any of the above are not done, the benefits payable will be reduced by $500. See pages 30 and 31 for details.

Waiver

This does not apply when the hospital admission is outside the United States and Puerto Rico.

Room and board and Other charges

Benefits for hospital room and board and other hospital expenses for a bed patient (inpatient) in a hospital, include:

- Ward and semiprivate accommodations.
- Intensive care accommodations, when medically appropriate.
- Isolation care accommodations, when medically appropriate to prevent contagion.
- Lab, X-ray and pharmacy services.
- Anesthesia supplies, operating and recovery room.
- Professional ambulance service, when medically appropriate.
- Blood or blood plasma, if not donated or replaced.

PPO benefit

Plan pays room and board and Other charges at **90%** of hospital's negotiated rates.

Non-PPO benefit

After a $200 deductible per admission, Plan pays room and board and Other charges at **70%** of reasonable and customary charges.

Private room

If a private room is used other than for isolation care, the hospital's average charge for semiprivate accommodations will be paid. If the hospital only has private rooms, the average semiprivate rate for comparable hospitals in the area will be allowed.

Bassinet and nursery

Hospital charges for bassinet and nursery care of the child during the mother's hospital confinement are considered expenses of the mother and not expenses of the child. **Any other expenses incurred by the child will be considered the child's own and will be allowed only if the child is covered by a Self and Family enrollment.**

Outpatient care

Outpatient hospital care for surgery (delivery) including care in freestanding ambulatory facilities, including birthing centers, is covered as described under Other Medical Benefits on pages 19 and 20.

Obstetrical care

- Delivery (paid under Surgical Benefits as shown on page 13), including prenatal and postpartum care (paid as shown on pages 19 and 20).
- Administration of anesthesia, as shown on page 14.
- Services of a licensed midwife.

Tests

Sonograms, amniocentesis (but not for diagnosing multiple births) and other related diagnostic services which are accepted medical practice, paid as shown on pages 19 and 20.

Related benefits

Contraceptive devices and drugs

See *Other Medical Benefits* on page 19 and *Prescription Drugs* on pages 23 and 24.

Diagnosis and treatment of infertility

Diagnosis and treatment of infertility will be covered up to a maximum Plan benefit of $2,500 per member per calendar year.

Voluntary sterilization

See *Surgical Benefits* on page 13.

Well child care

See *Additional Benefits* on page 22.

For whom

Benefits are payable under Self Only enrollments and for family members under Self and Family enrollments.

What is not covered

- Assisted Reproductive Technology (ART) procedures such as artificial insemination, in vitro fertilization, embryo transfer and GIFT, as well as services and supplies related to ART procedures are not covered.
- Reversal of voluntary surgical sterilization.
- Charges related to abortions except when 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.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Mental Conditions/Substance Abuse Benefits

What is covered

The Plan pays for the following Mental conditions/substance abuse services:

Inpatient care

Plan pays for ward or semiprivate accommodations, other hospital charges and professional fees. In lieu of medically appropriate inpatient care, and with prior Plan approval, coverage includes treatment at a licensed day treatment facility which has been accredited by the Joint Commission on Accreditation of Healthcare Organizations. Prior Plan approval may be obtained by calling ValueOptions toll-free at 1-888/700-7965.

Outpatient care

Plan pays for outpatient services by doctors and other covered practitioners for the treatment of mental conditions or substance abuse.

PPO benefit

After a $250 annual deductible per person, the Plan pays:
Inpatient Care - **60%** of provider's negotiated fees for up to 45 days per person each calendar year.
Outpatient Care - **70%** of provider's negotiated fees for up to 30 visits per person each calendar year.

Non-PPO benefit

After a $750 annual deductible per person, the Plan pays:
Inpatient Care - **50%** of reasonable and customary charges up to 30 days per person each calendar year.
Outpatient Care - **50%** of reasonable and customary charges up to 15 visits per person each calendar year.

Benefit limitations

Annual maximum

The specified limits on covered inpatient days are inclusive of any and all days previously used during the year regardless of whether the days were in a PPO or non-PPO facility.

The specified limits on covered outpatient visits are inclusive of any and all visits previously used during the year regardless of whether the visits were with a PPO or non-PPO provider.

Lifetime maximum

The maximum lifetime benefit for inpatient treatment of alcoholism and/or drug abuse is one treatment program per member, not to exceed a maximum Plan payment of $3,000.

Precertification-Inpatient care

The medical necessity of your admission to a hospital or other facility must be precertified at least 48 hours prior to admission for you to receive full Plan benefits. Emergency admissions must be reported within 48 hours of admission even if you have been discharged. Otherwise, the benefits will be reduced by $500. To precertify an admission for mental conditions/substance abuse; you, your representative, your doctor or your hospital must call ValueOptions toll-free at 1-888/700-7965.

Preauthorization-Outpatient care

Outpatient care for mental conditions/substance abuse requires prior Plan approval. Prior approval must be obtained by calling ValueOptions toll-free at 1-888/700-7965 prior to seeking care.

What is not covered

- Treatment for learning disabilities and mental retardation.
- Services rendered or billed by a school or halfway house or a member of its staff.
- Services and supplies that are not medically appropriate.
- Phototherapy for treatment of Seasonal Affective Disorder (SAD).

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Other Medical Benefits

What is covered

Outpatient physician visits

Coverage for home or office visits, outpatient consultations and second surgical opinions are covered as follows:

PPO benefit

Plan pays **in full** after a $15 copayment for each covered outpatient visit charge. The $250 deductible does not apply to this benefit.

Non-PPO benefit

After the $250 calendar year deductible, the Plan pays **70%** of reasonable and customary charges.

Chiropractic treatment

Benefits are limited to 12 chiropractic visits and/or manipulations per person each calendar year.

Other services

PPO benefit

After the $250 calendar year deductible, **90%** of provider's negotiated fees.

Non-PPO benefit

After the $250 calendar year deductible, the Plan pays **70%** of reasonable and customary charges.

Coverage is provided for the following services when prescribed by a doctor:

- Hospital visits and inpatient consultations.
- Diagnostic services such as X-rays, electrocardiograms, laboratory tests, allergy tests and pre-admission testing.
- Durable medical equipment (as defined on page 37), such as a wheelchair, kidney machine and oxygen, rented or purchased at the Plan's option.*****
- Established outpatient cardiac and pulmonary rehabilitation programs.
- Radiation therapy.
- Chemotherapy for cancer.
- Renal dialysis.
- Necessary supplies and accessories for use in connection with home dialysis, hyperalimentation and intravenous therapy.*****
- Artificial limbs, joints and eyes; pacemakers; and leg, arm, neck, and back braces; but not replacement, adjustment, or repair of braces, unless replacement is necessary due to the growth of a child.*****
- Stump hose for artificial limbs.
- Internal (implant) and the first external breast prosthesis, and the first bra for use with the external prosthesis following mastectomy.
- Internal (implant) ocular lenses and/or the first contact lenses required to correct an impairment caused by trauma or disease. The services of an optometrist are limited to the testing, evaluation and fitting of the first contact lenses required to correct an impairment caused by trauma or disease.
- Catheters, permanent tracheotomy tubes, ostomy bags and supplies and accessories required for attachment.*****
- Intra-uterine devices (including the cost of insertion and removal).

* The Plan recommends that prior approval be obtained for these services and supplies. To obtain prior Carrier approval, call Spectera/CARE Programs at 1-800/580-8771.

Home health care and rehabilitative therapy

These benefits must be provided under a treatment plan prescribed by a doctor and **require prior Carrier approval**. To obtain prior Plan approval, call Spectera/CARE Programs at 1-800/580-8771.

- Professional private duty intermittent nursing care performed during home visits by a Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocational Nurse (L.V.N.), up to a maximum Plan payment of $90 per day. The patient must have specific needs for which only an R.N., L.P.N., or L.V.N. can provide the necessary services.
- Professional services of a licensed registered therapist performing rehabilitative physical, occupational and speech therapy. These services may be provided in an outpatient setting or in the patient's home.

Outpatient hospital services

Outpatient services and supplies of a hospital or free-standing ambulatory facility the day of a surgical procedure (including change of cast), hemophilia treatment, hyperalimentation, rabies shots, cast or suture removal, oral surgery, dental and foot treatment, chemotherapy for treatment of cancer, and radiation therapy.

Medical emergency

Outpatient services and supplies of a hospital or free-standing ambulatory facility are covered for treatment within 24 hours after onset of a true medical emergency. For Plan purposes, a medical emergency is the sudden and unexpected onset of a serious, possibly life-threatening condition requiring immediate care such as loss of consciousness, loss of breathing, poisoning, severe bleeding or chest pain. If you are unsure of the severity of a condition in terms of this benefit, the Plan recommends that you first call its 24-hour nurse advisory service (1-800/755-2200) or your physician.

The following conditions are **not** generally considered medical emergencies for purposes of this Plan:

- Colds, earaches, sore throats, flu
- Nausea and headaches
- Maternity/term deliveries

If you use an emergency room for other than a recognized medical emergency, facility fees and supplies will not be covered.

Preventive services

In addition to coverage of diagnostic X-ray, laboratory and pathology services and machine diagnostic tests, the following routine (screening) services are covered as preventive care:

Breast cancer screening

Mammograms are covered for women age 35 and older as follows:

- From age 35 through 39, one mammogram screening during this five year period
- From age 40 through 49, one mammogram screening every one or two consecutive calendar years
- From age 50 through 64, one mammogram screening every calendar year
- At age 65 and older, one mammogram screening every two consecutive calendar years

Cervical cancer screening

Annual coverage of one pap smear for women age 18 and older

Colorectal cancer screening

Annual coverage of one fecal occult blood test for members age 40 and older

Prostate cancer screening

Annual coverage of one PSA (Prostate Specific Antigen) test for men age 40 and older

Nonfasting total blood cholesterol test

Covered once annually per covered person from age 19 through 64 years old

Tetanus diphtheria (Td) booster

Covered once every 10 years per covered member or spouse age 19 years and over. (For dependent children through age 22, see Childhood immunizations below.)

Influenza and Pneumococcal vaccines

Covered once annually per covered person age 65 years and over

Limited benefits

Childhood immunizations

Childhood immunizations recommended by the American Academy of Pediatrics are covered for eligible members under age 22.

Smoking cessation benefit

After satisfaction of the calendar year deductible, the Plan will pay up to $100 for enrollment in one smoking cessation program per member per lifetime.

What is not covered

- Routine physical examinations, routine eye examinations, and immunizations.**
- Eyeglasses, contact lenses except as shown above, eye exercises and visual training.**
- Hearing aids and examinations for them.**
- Professional fees for automated lab tests.
- Weight reduction/control and treatment of obesity not caused by an organic condition except as shown on page 13.**
- Orthopedic shoes, foot appliances or any related expenses, elastic stockings, corsets; lumbosacral, neck or joint supports; trusses, air purifiers, whirlpool equipment, sun and heat lamps, light boxes, heating pads, exercise devices, stair glides and elevators.
- Drugs and medicines that can be purchased without a doctor's prescription, even if a doctor has prescribed them or recommended their use.
- Nursing services and rehabilitative therapy without prior Plan approval.
- Speech therapy for developmental delay.
- Services of nurses aides or home health aides.
- Administration of high dose chemotherapy when supported by non-covered autologous bone marrow transplants.
- Maintenance therapies.

**May be eligible for Wellness benefit (see page 22).

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Additional Benefits

The additional benefits described on this page are not subject to any deductibles.

Accidental injury

The Plan pays as follows for outpatient first aid treatment within 24 hours after an accidental injury (an injury resulting from a violent external force). There is no deductible for first aid treatment for an accidental injury rendered within 24 hours after the injury.

PPO benefit

100% of provider's negotiated fees.

Non-PPO benefit

100% of reasonable and customary charges.

24-hour nurse advisory

The Plan offers a 24-hour nurse advisory service for your use. This program is strictly voluntary and confidential. You may call toll-free at 1-800/755-2200 and reach registered nurses to discuss an existing medical concern or to receive information about numerous health care issues.

Hospice care

The Plan pays reasonable and customary charges for hospice care provided by a hospice program subject to the following annual limits:

- Maximum annual outpatient benefit.....$3,000
- Maximum annual inpatient benefit $2,000
- Maximum bereavement benefit per family unit during any one calendar year.....$200

Conditions: 1) Patient's doctor certifies terminal illness and life expectancy of six months or less, and 2) the hospice in- or outpatient services must be ordered by the patient's doctor and charged for by an approved hospice program.

Preventive benefits

The Plan pays for the following preventive benefits (see also Preventive services under Other Medical Benefits on pages 20 and 21):

Well child care

The Plan pays for physical examinations and laboratory tests for children through age 12 covered by a Self and Family enrollment. The Plan also pays for one eye exam for amblyopia (lazy eye) and strabismus (eye muscle imbalance) per covered child between the ages of 2 through 6. Benefits provided are as follows:

PPO benefit

100% for children ages birth through 12.

Non-PPO benefit

100% of reasonable and customary charges not to exceed Plan maximum of $250 per child per year for children birth through age 3. For children ages 4 through 12, the Plan pays a maximum benefit of $150 per child per calendar year.

Childhood immunizations

The Plan will cover childhood immunizations recommended by the American Academy of Pediatrics for dependent children under age 22 as follows:

PPO benefit

100% of provider's negotiated fees.

Non-PPO benefit

100% of reasonable and customary charges.

Wellness benefit

The Plan reimburses up to **$250** per Self Only enrollment and **$350** per Self and Family enrollment per calendar year for non-covered expenses such as vision care, eyeglasses, hearing aids, if received in 1999 and no other benefits for 1999 have been paid. If the Plan paid claims of less than $350 for a Self and Family enrollment, the difference up to $350 will be paid. See page 27 for additional claims information.

Review and reward program

Upon receipt of a corrected hospital billing from the member, the Plan will credit 20% of any hospital charge over $20 for covered services and supplies that were not actually provided to a covered person. The maximum amount payable under this program is $100 per person per calendar year.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Prescription Drug Benefits

What is covered

You may purchase the following medications and supplies prescribed by a doctor from either a pharmacy or by mail:

- Drugs and medicines, including those for smoking cessation, for use at home that are obtainable only upon a doctor's prescription and listed in official formularies
- Insulin and reagent strips for known diabetics
- Needles and syringes for the administration of covered medications
- Elective birth control methods limited to prescription birth control pills and prescription diaphragms
- Approved drugs for organic impotence subject to prior Plan approval and limitations on dosage and quantity

What is not covered

- Medication that does not require a prescription under Federal law even if your doctor prescribes it or a prescription is required under your State law
- Vitamins, minerals, nutritional supplements, and enteral formulas (liquid food supplements)
- Medical supplies such as dressings and antiseptics
- Drugs and supplies for cosmetic purposes

From a pharmacy

Plan pharmacy

After the $50 per person calendar year drug deductible (maximum $100 per family), the Plan pays **80%** of covered charges.

You may obtain up to a 30-day supply plus one 30-day refill for each prescription purchased from a Plan pharmacy. After one 30-day refill, you must obtain a new prescription and submit it to the Mail Order Program. Failure to do so will result in benefits payable at the non-Plan pharmacy benefit level and the waiver below will not apply. Refills for maintenance medications are not considered new prescriptions except when the doctor changes the strength or 180 days have elapsed since the previous purchase.

Call 1-800/841-2734 to locate a Plan network pharmacy in your area.

- To use a Plan pharmacy, you must present an APWU/PAID prescription identification card which the Plan will provide you.
- You will be required to pay only your deductible and coinsurance for the drugs.
- **Do not** submit a claim to the Plan. The Plan pharmacy will automatically submit your claim for you.

Waiver

If you have Medicare Parts A and B as your primary payer and you use a Plan pharmacy, the Plan will waive the deductible and the coinsurance for purchase of generic drugs. For purchase of brand name drugs, only the deductible will be waived. This waiver does not apply beyond the first 30-day supply and the first 30-day refill of each prescription.

Non-Plan pharmacy

If you do not use your identification card, if you elect to use a non-network pharmacy or if a Plan pharmacy is not available, you will need to file a claim and the Plan will reimburse you for covered expenses as follows:

After the $50 per person calendar year deductible (maximum $100 per family), the Plan pays **60%** of covered charges for up to a 30-day supply and unlimited refills.

Waiver

If you have Medicare Parts A and B as your primary payer, the Plan will waive the deductible applicable to prescription drugs.

Prescription Drug Benefits *continued*

To claim benefits

Use a Prescription Drug Claim Form to claim benefits for prescription drugs and supplies you purchased from a non-Plan pharmacy. You may obtain forms by calling 1-800/222-APWU. Your claim must include receipts that show the prescription number, National Drug Code (NDC) number, name of drug, prescribing doctor's name, date and charge. Follow the instructions on the claim form and mail to:

APWU Health Plan
Post Office Box 967
Silver Spring, MD 20910

By mail

If you are currently taking a prescription medication on a regular basis, the Mail order drug program can help you save money on the cost of your prescriptions and refills. Your doctor may prescribe up to a 90-day supply. Merck-Medco Rx Services, which is a licensed pharmacy, will fill your prescription within two weeks of receipt of a prescription received by mail or within two business days of a prescription initiated by physicians over the telephone.

The Plan pays **100%** after a $7 copayment for covered generic drugs and medicines and a $25 copayment for covered brand name drugs when purchased through the Plan's Mail order drug program. **Charges for Mail order drugs are not subject to any deductible.**

Waiver

If you have Medicare Parts A and B as your primary payer, the Plan will waive the copayments applicable to prescription drugs obtained through the Mail order drug program. You do not need to make any payment or submit a claim for Mail order drugs.

To claim benefits

Contact the Plan for an order kit and the address of the Mail order drug program. To use the program:

1) Complete the Patient Profile Questionnaire and complete the information on the back of the pre-addressed envelope.
2) Enclose your prescription and mail to Merck-Medco, who will fill your prescription and mail it to you.
3) Merck-Medco will file your claim with the Plan, then bill you for any outstanding balance. Do not submit a claim to the Plan for mail order drugs.
4) Forms necessary for refills and future prescription orders will be provided each time you receive a supply of medication from the program.

If you have any questions about the Mail order drug program or about a particular drug or prescription, you may call toll-free: 1-800/841-2734.

Purchasing mail order drugs overseas

Use of the Mail order drug program for overseas delivery is restricted to delivery to APO boxes. The prescribing doctor must be licensed to prescribe drugs in the United States.

Drugs from other sources

Prescription drugs and antigens for treatment of allergies provided to you by a doctor or facility are covered as Prescription Drugs as shown on pages 23 and 24.

The non-PPO benefits are the standard benefits of this plan. PPO benefits apply only when you use a PPO provider. When no PPO provider is available, non-PPO benefits apply.

Dental Benefits

What is covered

The services listed under the dental benefits are a complete list of covered services for which the Plan pays the following:

Routine dental care

- Diagnostic and preventive services up to $25 a visit (up to two [2] visits each year), including examinations, prophylaxis (cleaning), X-rays of all types and fluoride treatment.
- Restorative dentistry (fillings): one surface $13; two or more surfaces $18.
- Simple extractions: $13 per tooth.
- Restorative care.

Restorative care

There is no limit to the number of fillings or simple extractions in a calendar year.

ADA code	Amalgam restorations (including polishing)	
2110	Amalgam-one surface	$13
2120	Amalgam-two surfaces	$18
2130	Amalgam-three surfaces	$18
2131	Amalgam-four surfaces	$18
2140	Amalgam-one surface	$13
2150	Amalgam-two surfaces	$18
2160	Amalgam-three surfaces	$18
2161	Amalgam-four surfaces	$18
	Silicate restoration	
2210	Silicate cement per restoration	$13
	Acrylic or plastic or composite resin	
2330	Acrylic or plastic or composite resin-one surface	$13
2331	Acrylic or plastic or composite resin-two surfaces	$18
2332	Acrylic or plastic or composite resin-three surfaces	$18
2335	Acrylic or plastic or composite resin-involving incisal angle or four or more surfaces	$18
	Acrylic or plastic or composite resin	
2380	Resin-one surface, posterior-primary	$13
2381	Resin-two surfaces, posterior-primary	$18
2382	Resin-three or more surfaces, posterior-primary	$18
2385	Resin-one surface, posterior-permanent	$13
2386	Resin-two surfaces, posterior-permanent	$18
2387	Resin-three or more surfaces, posterior-permanent	$18
	Gold foil restorations	
2410	Gold foil-one surface	$13
2420	Gold foil-two surfaces	$18
2430	Gold foil-three surfaces	$18
	Gold inlay restorations	
2510	Gold inlay-one surface	$13
2520	Gold inlay-two surfaces	$18
2530	Gold inlay-three surfaces	$18
	Porcelain restorations	
2610	Porcelain inlay-one surface	$13
2620	Porcelain inlay-two surfaces	$18
2630	Porcelain inlay-three surfaces	$18
2650	Inlay-Composite/Resin-one surface	$13
2651	Inlay-Composite/Resin-two surfaces	$18
2652	Inlay-Composite/Resin-three or more surfaces	$18

Extractions

ADA code	Simple extractions (includes local anesthesia and post-operative care)	
7110	Single tooth	$13
7120	Each additional tooth	$13
7210	Surgical extractions (each)	$13

Related benefits

Accidental injury to natural teeth

The Plan will pay for covered expenses to the same extent as expenses for any other illness or injury for necessary repair of accidental injury to natural teeth due to a blow or fall, including dental X-rays, provided the treatment is performed within two years of the accident and while the patient is still covered by the Plan.

Oral and maxillofacial surgery

For covered oral surgery, see page 15 .

Dental Benefits *continued*

What is not covered

- Services not shown as covered under this benefit.
- Dental bridges, replacement of natural teeth, dental/orthodontic/temporomandibular joint dysfunction appliances and any related expenses.
- Treatment of periodontal disease and gingival tissues, and abscesses.
- Charges related to orthodontic treatment.
- Oral implants or transplants of any kind.

How to Claim Benefits

Claim forms, identification cards and questions

If you do not receive your identification card(s) within 60 days after the effective date of your enrollment, call the Carrier at 1-800/222-APWU; for TDD, use 1-800/622-2511 to report the delay. In the meantime, use your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM as proof of enrollment when you obtain services. This is also the number to call for claim forms or advice on filing claims.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with providers.

If you have a question concerning Plan benefits, contact the Carrier at 800/222-APWU or you may write to the Carrier at PO Box 3279, Silver Spring, MD 20918. You may also contact the Carrier by fax at 301/622-5712, at its website at http://www.apwuhp.com or by email at custser@apwuhp.com.

How to file claims

Claims filed by your doctor that include an assignment of benefits to the doctor are to be filed on the form HCFA-1500, Health Insurance Claim Form. Claims submitted by enrollees may be submitted on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

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

In addition:

- A copy of the explanation of benefits (EOB) from any primary payer (such as Medicare) must be sent with your claim.
- Bills for private duty nurses must show that the nurse is a registered, licensed practical or licensed vocational nurse.
- Claims for rental or purchase of durable medical equipment, private duty nursing, and physical, occupational and speech therapy require a written statement from the doctor specifying the medical necessity for the service or supply and the length of time needed.
- Claims for prescription drugs that are not obtained from a Plan pharmacy or through the Mail order program must include receipts that include the prescription number, the National Drug Code (NDC) number, name of drug, prescribing doctor's name, date and charge.
- Claims for overseas (foreign) services should include an English translation. Charges should be converted to U.S. dollars using the exchange rate applicable at the time the expense was incurred.

Cancelled checks, cash register receipts or balance due statements are not acceptable.

How to file claims *(continued)*

After completing a claim form and attaching proper documentation, send claims to:

APWU Health Plan
Post Office Box 967
Silver Spring, MD 20910
Phone: 1-800/580-8771 (for hospital precertification - see page 30)
Phone: 1-800/222-APWU (benefits verifications)
Phone: 1-301/622-1700 (other business)
FAX: 1-301/622-5712 (not for filing of claims)
TDD line for hearing-impaired: 1-800/622-2511 (TDD equipment required)

Wellness Claims

The Plan notifies members in November of each year if they are eligible for the Wellness benefit. Submit Wellness claims after January 1, 2000. Wellness claims are paid after March 1, 2000. If, after Wellness benefits have been paid, subsequent claims are received for hospital, medical or dental expenses, payments made under the Wellness benefit will be deducted from allowable charges.

Records

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

Submit claims promptly

Claims must be submitted within two years of the date you incur the expense. The Plan encourages timely submission because failure to file within the two-year limit will invalidate your claim, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible. Once benefits have been paid, there is a three year limitation on the reissuance of uncashed checks.

Overseas claims

See Records and How to file claims on pages 26 and 27.

Direct payment to hospital or provider of care

You or your spouse may authorize direct payment to the provider by completing the assignment of benefits payment section of the claim form or the provider's own assignment form. Otherwise, payment will be made to you. The Plan reserves the right to make payment of benefits directly to you.

When more information is needed

Reply promptly when the Carrier requests information in connection with a claim. If you do not respond, the Carrier may delay processing or limit the benefits available.

Confidentiality

Medical and other information provided to the Carrier, including claim files, is kept confidential and will be used: 1) by the Carrier and its subcontractors for internal administration of the Plan, coordination of benefit provisions with other plans, and subrogation of claims; 2) by law enforcement officials with authority to investigate and prosecute alleged civil or criminal actions; 3) by OPM to review a disputed claim or perform its contract administration functions; 4) by OPM and the General Accounting Office when conducting audits as required by the FEHB law; or 5) for bona fide medical research or education. Medical data that does not identify individual members may be disclosed as a result of the bona fide medical research or education. As part of its administration of the prescription drug benefits, the Plan may disclose information about a member's prescription drug utilization, including the names of prescribing physicians, to any treating physicians or dispensing pharmacies.

Disputed claims review

Reconsideration

If a claim for payment is denied by the Carrier, you must ask the Carrier, in writing and within six months of the date of the denial, to reconsider its decision before you request a review by OPM. (This time limit may be extended if you show you were prevented by circumstances beyond your control from making your request within the time limit.) OPM will not review your request unless you demonstrate that you gave the Carrier an opportunity to reconsider your claim. Before you ask the Carrier to reconsider, you should first check with your provider or facility to be sure that the claim was filed correctly.

Reconsideration *(continued)*

For instance, did they use the correct procedure code for the service(s) performed (surgery, laboratory test, X-ray, office visit, etc.)? Indicate any complications of any surgical procedure(s) performed. Include copies of an operative or procedure report, or other documentation that supports your claim. Your written request to the Carrier must state why, based on specific benefit provisions in this brochure, you believe the denied claim for payment should have been paid.

Within 30 days after receipt of your request for reconsideration, the Carrier must affirm the denial in writing to you, pay the claim, or request additional information that is reasonably necessary to make a determination. If the Carrier asks a provider for information it will send you a copy of this request at the same time. The Carrier has 30 days after receiving the information to give its decision. If this information is not supplied within 60 days, the Carrier will base its decision on the information it has on hand.

OPM review

If the Carrier affirms its denial, you have the right to request a review by OPM to determine whether the Carrier's actions are in accordance with the terms of its contract. You must request the review within 90 days after the date of the Carrier's letter affirming its initial denial.

You may also ask OPM for a review if the Carrier fails to respond within 30 days of your written request for reconsideration or 30 days after you have supplied additional information to the Carrier. In this case, OPM must receive a request for review within 120 days of your request to the Carrier for reconsideration or of the date you were notified that the Carrier needed additional information, either from you or from your doctor or hospital.

This right is available only to you or the executor of a deceased claimant's estate. Providers, legal counsel, and other interested parties may act as your representative only with your specific written consent to pursue payment of the disputed claim. OPM must receive a copy of your written consent with their request for review.

Your written request for an OPM review must state why, based on specific benefit provisions in this brochure, you believe the Carrier should have paid the denied claim. If the Carrier has reconsidered and denied more than one unrelated claim, clearly identify the documents for each claim.

Your request must include the following information or it will be returned by OPM:

- A copy of your letter to the Carrier requesting reconsideration;
- A copy of the Carrier's reconsideration decision (if the Carrier failed to respond, provide instead (a) the date of your request to the Carrier, or (b) the dates the Carrier requested and you provided additional information to the Carrier);
- Copies of documents that support your claim (such as doctors' letters, operative reports, bills, medical records, explanation of benefit (EOB) forms); and
- Your daytime phone number.

Medical documentation received from you or the Carrier during the review process becomes a permanent part of the disputed claim file, subject to the provisions of the Freedom of Information Act and the Privacy Act.

Send your request for review to: Office of Personnel Management, Office of Insurance Programs, Contracts Division II, P.O. Box 436, Washington, DC 20044.

You (or a person acting on your behalf) may not bring a lawsuit to recover benefits on a claim for treatment, services, supplies or drugs covered by this Plan until you have exhausted the OPM review procedure, established at section 890.105, title 5, Code of Federal Regulations (CFR). If OPM upholds the Carrier's decision on your claim, and you decide to bring a lawsuit based on the denial, the lawsuit must be brought no later than December 31 of the third year after the year in which the services or supplies upon which the claim is predicated were provided. Pursuant to section 890.107, title 5, CFR, such a lawsuit must be brought against the Office of Personnel Management in Federal court.

Federal law exclusively governs all claims for relief in a lawsuit that relates to this Plan's benefits or coverage or payments with respect to those benefits. Judicial action on such claims is limited to the record that was before OPM when it rendered its decision affirming the Carrier's denial of the benefit. The recovery in such a suit is limited to the amount of benefits in dispute.

Privacy Act statement -- If you ask OPM to review a denial of a claim for payment or service, OPM is authorized by chapter 89 of title 5, U.S.C., to use the information collected from you and the Carrier to determine if the Carrier has acted properly in denying you the payment or service, and the information so collected may be disclosed to you and/or the Carrier in support of OPM's decision on the disputed claim.

Protection Against Catastrophic Costs

Catastrophic protection

For certain services with coinsurance, the Plan pays **100%** of reasonable and customary charges for the remainder of the calendar year after the calendar year deductible is met when out-of-pocket expenses for coinsurance in that calendar year exceed $3,500 for a Self Only enrollment or $3,500 for a Self and Family enrollment. Whether or not you use Preferred providers**,** the $250 individual deductible or the $500 family deductible must be satisfied before the Plan will pay benefits at 100%.

Preferred Providers

When your eligible out-of-pocket expenses from using Preferred providers exceed $2,000 for a Self Only enrollment or $2,000 for a Self and Family enrollment, the Plan pays **100%** of covered expenses for Preferred providers for the remainder of the calendar year.

Out-of-pocket expenses

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

- The 10% you pay for PPO Inpatient hospital charges, Surgical, Maternity and Other Medical Benefits;
- The 30% you pay for non-PPO Inpatient hospital charges, Surgical, Maternity and Other Medical Benefits; and
- The copayment of $15 for outpatient visits to PPO physicians (see page 19).

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

- Expenses in excess of reasonable and customary charges or maximum benefit limitations;
- Expenses for mental conditions, substance abuse or dental care;
- Any amounts you pay because benefits have been reduced for non-compliance with this Plan's cost containment requirements (see pages 5, 6, 7, 8, 30 and 31);
- Covered expenses applied to the $250 calendar year deductible;
- The $200 per admission deductible for non-PPO Inpatient hospital charges;
- Expenses for prescription drugs;
- Expenses incurred in excess of the $90 per day provided under home nursing care (see page 20); and
- Expenses in excess of hospice care and preventive care maximums.

Carryover

If you changed to this Plan during open season from a plan with a catastrophic protection benefit and the effective date of the change was after January 1, any expenses that would have applied to that plan's catastrophic protection benefit during the prior year will be covered by your old plan if they are for care you got in January **before** the effective date of your coverage in this Plan. If you have already met the covered out-of-pocket maximum expense level in full, your old plan's catastrophic protection benefit will continue to apply until the effective date. If you have not met this expense level in full, your old plan will first apply your covered out-of-pocket expenses until the prior year's catastrophic level is reached and then apply the catastrophic protection benefit to covered out-of-pocket expenses incurred from that point until the effective date. The old plan will pay these covered expenses according to this year's benefits; benefit changes are effective on January 1.

Change in enrollment

In case of a change of enrollment within the Plan (i.e., Self Only to Self and Family or Self and Family to Self Only), any benefits paid under the original enrollment will apply toward limitations in the subsequent enrollment during the remainder of the current calendar year. Similarly, deductibles satisfied under the original enrollment will be credited to the subsequent enrollment during the remainder of the current calendar year.

Other Information

Information You Have A Right To Know

All carriers in the FEHB Program must provide certain information to you. If you have questions or need additional information, you can obtain it by calling the Carrier at 800/222-APWU or you may write the Carrier at PO Box 3279, Silver Spring, MD 20918. You may also contact the Carrier by fax at 301/622-5712, at its website at http://www.apwuhp.com or by email at custser@apwuhp.com.

You are entitled to the following information:

- The Plan's 1997 Disenrollment rate was 14.2%
- Spectera, Inc. is the major subcontractor performing hospital precertification and case management for the Plan and is accredited by American Accreditation HealthCare Commission/URAC effective May 24, 1997. PreferredOne Management Company performs hospital precertification and case management for members in the State of Minnesota only and is also URAC accredited effective August 1, 1997.
- The American Postal Workers Union Health Plan is a not-for-profit Voluntary Employee's Beneficiary Association (VEBA) formed in 1972 as the result of a merger between four predecessor union plans.
- The carrier meets applicable State and Federal licensing and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records. Additional information is available from the Plan.

Precertification

Precertify before admission

Precertification is not a guarantee of benefit payments. Precertification of an inpatient admission is a predetermination that, based on the information given, the admission meets the medical necessity requirements of the Plan. **It is your responsibility to ensure that precertification is obtained**. If precertification is not obtained and benefits are otherwise payable, benefits for the admission will be reduced by $500.

To precertify a scheduled admission:

- You, your representative, your doctor, or your hospital must call Spectera/CARE Programs at least 48 hours prior to admission. The toll-free number is 1-800/580-8771 and may be reached 24 hours every day. In Minnesota, call PreferredOne at 1-800/451-9597 to precertify. To precertify an admission for mental conditions/substance abuse, see page 18.
- Provide the following information: enrollee's name and Plan identification number; patient's name, birth date and phone number; reason for hospitalization, proposed treatment or surgery; name of hospital or facility; name and phone number of admitting doctor.

The doctor and/or hospital will be notified telephonically of the number of days of confinement approved initially for the care. Written confirmation of the Carrier's certification decision will be sent to the patient, provider and facility. If the length of stay needs to be extended, follow the procedures below.

Need additional days?

The CARE nurse reviewer will be in contact with the facility and/or physician throughout your hospitalization. If any additional days are required, CARE will obtain clinical information to determine if these days are medically necessary.

If the admission is precertified but you remain confined beyond the number of days certified as medically necessary, the Plan will not pay for charges incurred on any extra days that are determined to not be medically necessary by the Carrier during the claim review.

Precertification *continued*

You don't need to certify an admission when:

- Medicare Part A, or another group health insurance policy, is the primary payer for the hospital confinement (see pages 31 and 32). Precertification is required; however, for members with Medicare Part A prior to the 60th day of a Medicare benefit period, when Medicare hospital benefits are exhausted prior to using lifetime reserve days or if being admitted to a Department of Veterans Affairs or Department of Defense hospital.
- You are confined in a hospital outside the United States and Puerto Rico.

Maternity or emergency admissions

When there is an unscheduled maternity admission or an emergency admission due to a condition that puts the patient's life in danger or could cause serious damage to bodily function, you, your representative, the doctor, or the hospital must telephone the applicable number listed above within 48 hours of admission, even if the patient has been discharged from the hospital. Otherwise, inpatient benefits otherwise payable for the admission will be reduced by $500.

Newborn confinements that extend beyond the mother's discharge date must also be certified. You, your representative, the doctor or hospital must request certification for the newborn's continued confinement within 48 hours of delivery/birth.

Other considerations

An early determination of need for confinement (precertification of the medical necessity of inpatient admission) is binding on the Carrier unless the Carrier is misled by the information given to it. After the claim is received, the Carrier will first determine whether the admission was precertified and then provide benefits according to all of the terms of this brochure.

If you do not precertify

If precertification is not obtained at least 48 hours before admission to the hospital (or within 48 hours of a maternity or emergency admission or, in the case of a newborn, the mother's discharge), a medical necessity determination will be made at the time the claim is filed. If the Carrier determines that the hospitalization was not medically necessary, the inpatient hospital benefits will not be paid. However, medical supplies and services determined to be medically necessary and otherwise payable on an outpatient basis will be paid under applicable outpatient benefits.

If the claim review determines that the admission was medically necessary, any benefits payable according to all of the terms of this brochure will be reduced by $500 for failing to have the admission precertified.

If the admission is determined to be medically necessary, but part of the length of stay was found not to be medically necessary, inpatient hospital benefits will not be paid for the portion of the confinement that was not medically necessary. However, medical services and supplies determined to be medically necessary and otherwise payable on an outpatient basis will be paid under applicable outpatient benefits.

This Plan and Medicare

Coordinating benefits

The following information applies only to enrollees and covered family members who are entitled to benefits from both this Plan and Medicare. You must disclose information about Medicare coverage, including your enrollment in a Medicare prepaid plan, to this Carrier; this applies whether or not you file a claim under Medicare. You must also give this Carrier authorization to obtain information about benefits or services denied or paid by Medicare when they request it. It is also important that you inform the Carrier about other coverage you may have as this coverage may affect the primary/secondary status of this Plan and Medicare (see pages 8 and 9).

This Plan covers most of the same kinds of expenses as Medicare Part A, hospital insurance, and Part B, medical insurance, except that Medicare does not cover prescription drugs.

The following rules apply to enrollees and their family members who are entitled to benefits from both an FEHB plan and Medicare.

This Plan is primary if:

(1) You are age 65 or over, have Medicare Part A (or Parts A and B), and are employed by the Federal Government;

(2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are employed by the Federal Government;

This Plan is primary if: *(continued)*

(3) The patient (you or a covered family member) is within the first 30 months of eligibility to receive Medicare Part A benefits due to End Stage Renal Disease (ESRD) except when Medicare (based on age or disability) was the patient's primary payer on the day before he or she became eligible for Medicare Part A due to ESRD; or

(4) The patient (you or a covered family member) is under age 65 and eligible for Medicare solely on the basis of disability, and you are employed by the Federal Government.

For purposes of this section, "employed by the Federal Government" means that you are eligible for FEHB coverage based on your current employment and that you do not hold an appointment described under Rule 6 of the following "Medicare is primary" section.

Medicare is primary if:

(1) You are an annuitant age 65 or over, covered by Medicare Part A (or Parts A and B) and are not employed by the Federal Government;

(2) Your covered spouse is age 65 or over and has Medicare Part A (or Parts A and B) and you are not employed by the Federal Government;

(3) You are age 65 or over and (a) you are a Federal judge who retired under title 28, U.S.C., (b) you are a Tax Court judge who retired under Section 7447 of title 26, U.S.C., or (c) you are the covered spouse of a retired judge described in (a) or (b);

(4) You are an annuitant not employed by the Federal Government, and either you or a covered family member (who may or may not be employed by the Federal Government) is under age 65 and eligible for Medicare on the basis of disability;

(5) You are enrolled in Part B only, regardless of your employment status;

(6) You are age 65 or over and employed by the Federal Government in an appointment that excludes similarly appointed nonretired employees from FEHB coverage, and have Medicare Part A (or Parts A and B);

(7) You are a former Federal employee receiving workers' compensation and the Office of Workers Compensation has determined that you are unable to return to duty;

(8) The patient (you or a covered family member) has completed the 30-month ESRD coordination period and is still eligible for Medicare due to ESRD; or

(9) The patient (you or a covered family member) becomes eligible for Medicare due to ESRD after Medicare assumed primary payer status for the patient under rules 1) through 7) above.

When Medicare is Primary

When Medicare is primary, all or part of your Plan deductibles and coinsurance will be waived as follows:

Inpatient hospital benefits: If you are enrolled in Medicare Part A, the Plan will waive the deductible and coinsurance.

Surgical Benefits: If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance for services covered by Medicare Part B.

Mental conditions/substance abuse benefits: If you are enrolled in Medicare Part A, the Plan will waive the coinsurance applicable to inpatient hospital charges for services covered by Medicare Part A and this Plan. If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance for services covered by Medicare Part B.

Other Medical Benefits: If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance for services covered by Medicare Part B.

Prescription Drugs: If you are enrolled in Medicare Parts A and B where Medicare is the primary payer, the Plan will waive the coinsurance and deductible applicable to generic prescription drugs (but will waive only the deductible for brand name drugs) obtained from a Plan pharmacy for up to a 30-day supply plus one 30-day refill for each prescription. For subsequent refills from a Plan pharmacy, or for all purchases from a Non-Plan pharmacy; only the deductible is waived; 40% coinsurance applies. If you have Medicare Parts A and B as your primary payer, copayments are waived for purchases made through the Mail Order Program; no deductible applies for mail order purchases.

When Medicare is Primary *(continued)*

When Medicare is the primary payer, this Plan will limit its payment to an amount that supplements the benefits that would be payable by Medicare, regardless of whether or not Medicare benefits are paid. However, the Plan will pay its regular benefits for emergency services to an institutional provider, such as a hospital, that does not participate with Medicare and is not reimbursed by Medicare.

If you are enrolled in Medicare, you may be asked by a physician to sign a private contract agreeing that you can billed directly for services that would ordinarily be covered by Medicare. Should you sign such an agreement, Medicare will not pay any portion of the charges, and you may receive less or no payment for those services under this Plan.

When you also enroll in a Medicare prepaid plan

When you are enrolled in a Medicare prepaid plan while you are a member of this Plan, you may continue to obtain benefits from this Plan. If you submit claims for services covered by this Plan that you receive from providers that are not in the Medicare plan's network, the Plan will not waive any deductibles or coinsurance when paying these claims.

Medicare's payment and this Plan

If you are covered by Medicare Part B and it is primary, you should be aware that your out-of-pocket costs for services covered by both this Plan and Medicare Part B will depend on whether your doctor accepts Medicare assignment for the claim.

Doctors who participate with Medicare accept assignment; that is, they have agreed not to bill you for more than the **Medicare-approved amount** for covered services. Some doctors who do not participate with Medicare accept assignment on certain claims. If you use a doctor who accepts Medicare assignment for the claim, the doctor is permitted to bill you after the Plan has paid only when the Medicare and Plan payments combined do not total the Medicare-approved amount.

Doctors who do not participate with Medicare are not required to accept direct payment, or assignment, from Medicare. Although they can bill you for more than the amount Medicare would pay, Medicare law (the Social Security Act, 42 U.S.C.) sets a limit on how much you are obligated to pay. This amount, called the **limiting charge**, is 115 percent of the Medicare-approved amount. Under this law, if you use a doctor who does not accept assignment for the claim, the doctor is permitted to bill you after the Plan has paid **only** if the Medicare and Plan payments combined do not total the limiting charge. Neither you nor your FEHB Plan is liable for any amount in excess of the Medicare limiting charge for charges of a doctor who does not participate with Medicare. The Medicare Summary Notice (MSN) form will have more information about this limit.

If your doctor does not participate with Medicare, asks you to pay more than the limiting charge and he or she is under contract with this Plan, call the Plan. If your doctor is not a Plan doctor, ask the doctor to reduce the charge or report him or her to the Medicare carrier that sent you the Medicare MSN form. In any case, a doctor who does not participate with Medicare is not entitled to payment of more than 115 percent of the Medicare-approved amount.

How to claim benefits

In most cases, when services are covered by both Medicare and this Plan, Medicare is the primary payer if you are an annuitant and this Plan is the primary payer if you are an employee. When Medicare is the primary payer, your claims should first be submitted to Medicare. After Medicare has paid its benefits, the Carrier will consider the balance of any covered expenses. The Carrier has contracted with most Medicare Part B claims processors to receive electronic copies of your claims after Medicare has paid their benefits, thus eliminating the necessity for you to submit your Part B claims to this Plan. If you completed and returned to this Plan the Authorization Form sent you, you are included in this program. You may call the Carrier at 1-800/222-APWU to obtain information about your status in this program, or to obtain an Authorization Form. If your claims are not being electronically filed, you must submit the MSN form from Medicare and duplicates of all bills along with a completed claim form. The Carrier will not process your claim without knowing whether you have Medicare and, if you do, without receiving the Medicare MSN.

Enrollment information

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Carrier. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Carrier. See "How

If you are a new member *(continued)*

to claim benefits" on page 26.

If you made your open season change by using Employee Express and have not received your new ID card by the effective date of your enrollment, call the Employee Express HELP number to request a confirmation letter. Use that letter to confirm your new coverage with Plan providers.

If you are a new member of this Plan, benefits begin on the effective date of your enrollment, as set by your employing office or retirement system (see *Effective date* on page 37). Coverage under your new plan for a hospitalized member may be delayed if you are currently enrolled in another FEHB plan and you or a covered family member are hospitalized on the effective date of your enrollment; see "If you are hospitalized" below.

No FEHB plan may refuse to provide benefits for any condition you or a covered family member may have solely on the basis that it was a condition that existed before you enrolled in a plan under the FEHB Program.

If you are hospitalized

If you change plans or options, benefits under your prior plan or option cease on the effective date of your enrollment in your new plan or option unless you or a covered family member are confined in a hospital or other covered facility or are receiving medical care in an alternative care setting on the last day of your enrollment under the prior plan or option. In that case, the confined person will continue to receive benefits under the former plan or option until the earliest of (1) the day the person is discharged from the hospital or other covered facility (a move to an alternative care setting does not constitute a discharge under this provision), or (2) the day after the day all inpatient benefits have been exhausted under the prior plan or option, or (3) the 92nd day after the last day of coverage under the prior plan or option. However, benefits for other family members under the new plan will begin on the effective date. If your plan terminates participation in the FEHB Program in whole or in part, or if the Associate Director for Retirement and Insurance orders an enrollment change, this continuation of coverage provision does not apply; in such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Your responsibility

It is your responsibility to be informed about your health benefits. Your employing office or retirement system can provide information about when you may change your enrollment; who "family members" are; what happens when you transfer, go on leave without pay, enter military service, or retire; when your enrollment terminates; and the next open season for enrollment. Your employing office or retirement system will also make available to you an FEHB Guide, brochures and other materials you need to make an informed decision.

Things to keep in mind

- The benefits in this brochure are effective on January 1 for those already enrolled in this Plan. If you changed plans or plan options, see "If you are a new member" above. In both cases, however, the Plan's new rates are effective the first day of the enrollee's first full pay period that begins on or after January 1 (January 1 for all annuitants).
- Generally, you must be continuously enrolled in the FEHB Program for the last five years before you retire to continue your enrollment for you and any eligible family members after you retire.
- The FEHB Program provides Self Only coverage for the enrollee alone or Self and Family coverage for the enrollee, his or her spouse, and unmarried dependent children under age 22. Under certain circumstances, coverage will also be provided under a family enrollment for a disabled child 22 years of age or older who is incapable of self-support.
- An enrollee with Self Only coverage who is expecting a baby or the addition of a child may change to a Self and Family enrollment up to 60 days after the birth or addition. The effective date of the enrollment change is the first day of the pay period in which the child was born or became an eligible family member. The enrollee is responsible for his or her share of the Self and Family premium for that time period.
- You will not be informed by your employing office (or your retirement system) or your Carrier when a family member loses eligibility.

You must direct questions about enrollment and eligibility, including whether a dependent age 22 or older is eligible for coverage, to your employing office or retirement system. The Carrier does not determine eligibility and cannot change an enrollment status without the necessary information from the employing agency or retirement system.

Things to keep in mind *(continued)*

- An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.
- Report additions and deletions (including divorces) of covered family members to the Carrier promptly.
- If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to reenroll in FEHB, you may do so at the next open season, or whenever you involuntarily lose coverage in the Medicare prepaid plan or move out of the area it serves.

  Most Federal annuitants have Medicare Part A. If you do not have Medicare Part A, you may enroll in a Medicare prepaid plan, but you will probably have to pay for hospital coverage in addition to the Part B premium. **Before** you join the plan, ask whether they will provide hospital benefits and, if so, what you will have to pay.

  You may also remain enrolled in this Plan when you join a Medicare prepaid plan. See page 33 for how this Plan's benefits are affected when you are enrolled in a Medicare prepaid plan.

  Contact your local Social Security Administration (SSA) office for information on local Medicare plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800/638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.
- Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

When an employee's enrollment terminates because of separation from Federal service or when a family member is no longer eligible for coverage under an employee or annuitant enrollment, and the person is not otherwise eligible for FEHB coverage, he or she will generally be eligible for a free 31-day extension of coverage. The employee or family member may also be eligible for one of the following:

Former spouse coverage

When a Federal employee or annuitant divorces, the former spouse may be eligible to elect coverage under the spouse equity law. If you are recently divorced or anticipate divorcing, contact the employee's employing office (personnel office) or retiree's retirement system to get more facts about electing coverage.

Certification of Creditable Coverage

Under Federal law, if you lose coverage under the FEHB Program, you should automatically receive a Certificate of Group Health Plan Coverage from the last FEHB Plan to cover you. This certificate, along with any certificates you receive from other FEHB plans you may have been enrolled in, may reduce or eliminate the length of time a preexisting condition clause can be applied to you by a new non-FEHB insurer. If you do not receive a certificate automatically, you must be given one on request.

Temporary continuation of coverage (TCC)

If you are an employee whose enrollment is terminated because you separate from service, you may be eligible to temporarily continue your health benefits coverage under the FEHB Program in any plan for which you are eligible. Ask your employing office for RI 79-27, which describes TCC, and for RI 70-5, the FEHB Guide for individuals eligible for TCC. Unless you are separated for gross misconduct, TCC is available to you if you are not otherwise eligible for continued coverage under the Program. For example, you are eligible for TCC when you retire if you are unable to meet the five-year enrollment requirement for continuation of enrollment after retirement.

Your TCC begins after the initial free 31-day extension of coverage ends and continues for up to 18 months after your separation from service (that is, if you use TCC until it expires 18 months following separation, you will only pay for 17 months of coverage). Generally, you must pay the total premium (both the Government and employee shares) plus a 2 percent administrative charge. If you use your TCC until it expires, you are entitled to another free 31-day extension of coverage when you may convert to nongroup coverage. If you cancel your TCC or stop paying premiums, the free 31-day extension of coverage and conversion option are not available.

Children or former spouses who lose eligibility for coverage because they no longer qualify as family members (and who are not eligible for benefits under the FEHB Program as employees or under the spouse equity law) also may qualify for TCC. They also must pay the total premium plus the 2 percent administrative charge. TCC for former family members continues for up to 36 months after

Temporary continuation of coverage (TCC) *(continued)*

the qualifying event occurs, for example, the child reaches age 22 or the date of the divorce. This includes the free 31-day extension of coverage. When their TCC ends (except by cancellation or nonpayment of premium), they are entitled to another free 31-day extension of coverage when they may convert to nongroup coverage.

NOTE: If there is a delay in processing the TCC enrollment, the effective date of the enrollment is still the 32nd day after regular coverage ends. The TCC enrollee is responsible for premium payments retroactive to the effective date and coverage may not exceed the 18 or 36 month period noted above.

Notification and election requirements

Separating employees -- Within 61 days after an employee's enrollment terminates because of separation from service, his or her employing office must notify the employee of the opportunity to elect TCC. The employee has 60 days after separation (or after receiving the notice from the employing office, if later) to elect TCC.

Children -- You must notify your employing office or retirement system when a child becomes eligible for TCC within 60 days after the qualifying event occurs, for example, the child reaches age 22 or marries.

Former spouses -- You or your former spouse must notify the employing office or retirement system of the former spouse's eligibility for TCC within 60 days after the termination of the marriage. A former spouse may also qualify for TCC if, during the 36-month period of TCC eligibility, he or she loses spouse equity eligibility because of remarriage before age 55 or loss of the qualifying court order. This applies even if he or she did not elect TCC while waiting for spouse equity coverage to begin. The former spouse must contact the employing office within 60 days of losing spouse equity eligibility to apply for the remaining months of TCC to which he or she is entitled.

The employing office or retirement system has 14 days after receiving notice from you or the former spouse to notify the child or the former spouse of his or her rights under TCC. If a child wants TCC, he or she must elect it within 60 days after the date of the qualifying event (or after receiving the notice, if later). If a former spouse wants TCC, he or she must elect it within 60 days after any of the following events: the date of the qualifying event or the date he or she receives the notice, whichever is later; or the date he or she loses coverage under the spouse equity law because of remarriage before age 55 or loss of the qualifying court order.

Important: The employing office or retirement system must be notified of a child's or former spouse's eligibility for TCC within the 60-day time limit. If the employing office or retirement system is not notified, the opportunity to elect TCC ends 60 days after the qualifying event in the case of a child and 60 days after the change in status in the case of a former spouse.

Conversion to individual coverage

When none of the above choices is available — or chosen —, when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, nongroup contract. You will not be required to provide evidence of good health and the plan is not permitted to impose a waiting period or limit coverage for preexisting conditions. If you wish to convert to an individual contract, you must apply in writing to the carrier of the plan in which you are enrolled within 31 days after receiving notice of the conversion right from your employing agency. A family member must apply to convert within the 31-day free extension of coverage that follows the event that terminates coverage, e.g., divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Definitions

Accidental injury An injury resulting from a violent external force.

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

Assignment An authorization by an enrollee or spouse for the Carrier to issue payment of benefits directly to the provider. The Carrier reserves the right to pay the member directly for all covered services.

Calendar year

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

Congenital anomaly

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

Cosmetic surgery

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

Custodial care

Treatment or services, regardless of who recommends them or where they are provided, that could be rendered safely and reasonably by a person not medically skilled, or that are designed mainly to help the patient with daily living activities. These activities include but are not limited to:

1) personal care such as help in: walking; getting in and out of bed; bathing; eating by spoon, tube or gastrostomy; exercising; dressing;
2) homemaking, such as preparing meals or special diets;
3) moving the patient;
4) acting as a companion or sitter;
5) supervising medication that can usually be self administered; or
6) treatment or services that any person may be able to perform with minimal instruction, including but not limited to recording temperature, pulse, and respirations, or administration and monitoring of feeding systems.

The Carrier determines which services are custodial care.

Durable medical equipment

Equipment and supplies that:

1) are prescribed by your attending doctor;
2) are medically necessary;
3) are primarily and customarily used only for a medical purpose;
4) are generally necessary only to a person with an illness or injury;
5) are designed for prolonged use; and
6) serve a specific therapeutic purpose in the treatment of an illness or injury.

Effective date

Benefits described in this brochure are effective January 1 for continuing enrollments. For new enrollees in this Plan the effective date of enrollment is determined by the employing office or retirement system of the enrollee.

Experimental or investigational

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

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

Experimental or investigational *(continued)*

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

Determination of experimental/investigational status may require review by a specialty appropriate board-certified health care provider or appropriate government publication(s) such as those of the National Institute of Health, National Cancer Institute, Food and Drug Administration, Agency of Health Care Policy & Research, and the National Library of Medicine.

Group health coverage

Health care coverage that a member is eligible for because of employment by, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies, or that pays a specific amount for each day or period of hospitalization if that specified amount exceeds $200 per day, including extension of any of these benefits through COBRA.

Home health care agency

An agency which meets all of the following:

- Is primarily engaged in providing, and is duly licensed or certified to provide, skilled nursing care and therapeutic services;
- Has policies established by a professional group associated with the agency or organization. This professional group must include at least one registered nurse (R.N.) to direct the services provided and it must provide for full-time supervision of each service by a physician or registered nurse;
- Maintains a complete medical record on each individual;
- Has a full-time administrator.

Hospice care program

A coordinated program of home and inpatient palliative and supportive care for the terminally ill patient and the patient's family provided by a medically supervised specialized team under the direction of a duly licensed or certified Hospice Care Program.

Maintenance therapy

Includes but is not limited to physical, occupational, or speech therapy where continued therapy is not expected to result in significant restoration of a bodily function but is utilized to maintain the current status.

Medically necessary

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

1) are appropriate to diagnose or treat the patient's condition, illness or injury;
2) are consistent with standards of good medical practice in the United States;
3) are not primarily for the personal comfort or convenience of the patient, the family, or the provider;
4) are not a part of or associated with the scholastic education or vocational training of the patient; and
5) in the case of inpatient care, cannot be provided safely on an outpatient basis.

The fact that a covered provider has prescribed, recommended, or approved a service, supply, drug or equipment does not, in itself, make it medically necessary.

Mental conditions/ Substance abuse

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

Precertification

Precertification is a preliminary determination that the services in question are appropriately performed on an inpatient basis. It does not constitute medical advice (see pages 30 and 31).

Reasonable and customary

Those charges which are comparable with charges from other providers for similar services and supplies under comparable circumstances in the same geographical area and which meet the Plan's established guidelines for that area. This is generally determined by the use of prevailing health care charges guides such as that prepared by the Health Insurance Association of America (HIAA) and is updated at least annually. HIAA guides are applied at the 90th percentile to surgery, doctor's services, therapy (physical, speech and occupational), X-ray and lab expenses.

When there are exceptions to this general method of determining the reasonable and customary charge, such as when HIAA data is unavailable or services occur infrequently, the Plan may determine the reasonable and customary charge based on other credible data sources available, such as charge guides prepared by Medical Data Research (MDR), applied at a comparable percentile level, and statistically derived charges developed by the Plan. When a PPO provider is used, the fee that has been negotiated between the Plan and the PPO provider is used instead of the reasonable and customary charge.

You can call the Plan to determine if proposed fees are within the reasonable and customary limits. If not, this can lead to further discussion with your doctor, or perhaps, obtaining the services of another doctor.

Rehabilitative care

Treatment that reasonably can be expected to restore and/or substantially restore a bodily function that was impaired as a result of trauma or disease.

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How APWU Health Plan Changes January 1999

Do not rely on this page; it is not an official statement of benefits.

Program-wide Changes:

- Several changes have been made in compliance with the President's mandate to implement the recommendations of the Patient Bill of Rights.

- The medical management of mental conditions will be covered under this Plan's Other Medical Benefits provisions. Related drug costs will be covered under this Plan's Prescription Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits. Office visits for the medical aspects of treatment do not count toward the 30 visit PPO or 15 visit non-PPO outpatient Mental Conditions visit limits.

- If you are enrolled in Medicare, you may be asked by a physician to sign a private contract agreeing that you can be billed directly for services that would ordinarily be covered by Medicare. Should you sign such an agreement, Medicare will not pay any portion of the charges, and you may receive less or no payment for those services under this Plan.

- The definition of experimental or investigational now applies to biological products.

Changes to this Plan:

- All inpatient and outpatient services provided by non-PPO providers will be paid at 70% of reasonable and customary charges. Previously, these charges were paid at 75%.

- The Plan has changed Preferred Provider Organizations (PPO) for members in New York and New Jersey. MultiPlan will replace First Health and Ethix respectively as the PPO for those states.

- Mail order prescription drug benefit structure is changed to a copay structure of $7 for a 90-day supply of generic drugs and $25 for a 90-day supply of brand name drugs. Previously, non-Medicare members paid nothing for generic drugs at mail order and 15% coinsurance for brand name drugs. Copays for members who have Medicare Parts A and B as the primary payer, will continue to be waived in 1999.

- Under Surgical Benefits, the Plan now specifies that non-PPO benefits for multiple organ transplants are subject to the $100,000 maximum.

- For clarification, the Plan now specifies that approved drugs for organic impotence are covered subject to prior Plan approval and limitations on dosage and quantity.

- For clarification, the Plan now specifies that skilled nursing facilities are not considered a hospital and services furnished or billed by such facilities are not covered expenses.

- For clarification under Other Medical Benefits, the Plan now specifies that joint supports are not covered expenses.

- Under General Limitations, the Plan has revised its subrogation provision to make the Plan's subrogation rights more clear to covered individuals.

- Coverage of drugs for sexual dysfunction is shown under the Prescription Drug Benefit.

Summary of Benefits for the APWU Health Plan --1999

Do not rely on this chart alone**.** All benefits are subject to the definitions, limitations, and exclusions set forth in the brochure. This chart merely summarizes certain important expenses covered by the Plan. If you wish to enroll or change your enrollment in this Plan, be sure to indicate the correct enrollment code on your enrollment form (codes appear on the cover of this brochure). All items below with an asterisk (*) are subject to the $250 calendar year deductible.

	Benefits	Plan pays/provides	Page
Inpatient care	**Hospital**	**PPO benefit: 90%** of room and board and other charges, no deductible **Non-PPO benefit:** After a $200 deductible per admission, **70%** of room and board and other charges	12-13
	Surgical	**PPO benefit: 90%*** of the physician's negotiated fee **Non-PPO benefit: 70%*** of reasonable and customary charges	13-15
	Medical	Same as Surgical Inpatient Benefit	19-21
	Maternity	Same benefits as for illness or injury	16-17
	Mental Conditions	**PPO benefit:** After a $250 annual deductible, **60%** up to 45 days per year **Non-PPO benefit:** After a $750 annual deductible, **50%** up to 30 days per year	18
	Substance Abuse	Same as Mental Conditions limited to one treatment program per member per lifetime up to a maximum Plan payment of $3,000	18
Outpatient care	**Hospital**	**PPO benefit: 90%*** of covered hospital charges **Non-PPO benefit: 70%*** of reasonable and customary charges	19-21
	Surgical	**PPO benefit: 90%*** of the physician's negotiated fee **Non-PPO benefit: 70%*** of reasonable and customary charges	13-15
	Medical	**PPO benefit**: $15 copay per covered visit; **90%*** of physician's negotiated fee for other covered services **Non-PPO benefit: 70%*** of reasonable and customary charges	19-21
	Maternity	Same benefits as for illness or injury	16-17
	Home Health Care	**70%*** of reasonable and customary charges	20
	Mental Conditions/ Substance Abuse	**PPO benefit:** After a $250 annual deductible, **70%** of provider's negotiated fees up to 30 visits per year **Non-PPO benefit:** After a $750 annual deductible, **50%** of reasonable and customary charges up to 15 visits per year	18
Emergency care (accidental injury)		**PPO benefit: 100%** of providers' negotiated fees (no deductible) within 24 hours **Non-PPO benefit: 100%** of reasonable and customary charges (no deductible)	22
Prescription drug benefits		Pharmacy: **80%** of drug charges purchased from a Plan pharmacy (**60%** from a non-Plan pharmacy) after $50 per person/ $100 per family prescription drug deductible Mail order: **$7 copay** for generic drugs, **$25 copay** for brand name drugs (no deductible)	23-24 23-24
Dental care		Actual charges up to amounts shown for listed procedures	24-26
Additional benefits		Hospice Care, Childhood Immunizations, Well Child, Wellness, Review and Reward Program**,** 24-hour nurse advisory service	22
Protection against catastrophic costs		**100%** of covered charges when applicable coinsurance in a calendar year exceeds $2,000 per Self Only or Self and Family enrollment when PPO providers are used and $3,500 per Self Only or Self and Family enrollment when they are not	29

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United States Office of Personnel Management

1999 Rate Information for

American Postal Workers Union Health Plan

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

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
Self Only	**471**	**72.06**	**36.70**	**156.13**	**79.52**	**84.98**	**23.78**
Self and Family	**472**	**160.39**	**78.29**	**347.51**	**169.63**	**183.29**	**55.39**