A PLAN FOR THE FUTURE

Association Benefit Plan 1999

A Managed Fee-for-Service Plan
with a Preferred Provider Organization

Sponsored by the Association

Who may enroll in this Plan: Members of the Association

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

Enrollment code for this Plan:

421 Self Only
422 Self and Family

Visit the OPM website at http://www.opm.gov/insure

Authorized for distribution by the:

United States Office of Personnel Management

FEHB
Federal Employees
Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Federal Employees Health Benefits Program

1999 Rate Information for

Association Benefit Plan

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

The 1999 rates for this Plan follow:

Type of Enrollment	Code	Premium			
		Biweekly		Monthly	
		Gov't Share	Your Share	Gov't Share	Your Share
Self Only	**421**	**$72.06**	**$26.47**	**$156.13**	**$57.35**
Self and Family	**422**	**$163.40**	**$63.54**	**$354.03**	**$137.67**

Association Benefit Plan

The Government Employees Health Association has entered into Contract No. CS 1065 with the Office of Personnel Management (OPM) to provide a health benefits plan authorized by the Federal Employees Health Benefits (FEHB) law. The Plan is underwritten by Mutual of Omaha Insurance Company which administers this Plan on behalf of the Carrier and is referred to as Carrier in this brochure. 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 Association Benefit Plan for 1999 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 1-800/634-0069 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, DC 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 1-800/634-0069. 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 that 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 now 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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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 days required to treat your condition. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with Mutual of Omaha's Care Review Unit before being admitted to the hospital. If that doesn't happen, your Plan will reduce benefits by $500, except for Hospice Care, Skilled Nursing Facility Care, and Home Health Care where failure to precertify will result in disqualification of higher paid benefit levels. 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 33 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

The Plan has entered into an agreement with Mutual of Omaha's Preferred Provider Organization (PPO). This is a group of doctors and hospitals that has contracted with Mutual to provide medical services at reduced costs. Each time you need medical care by a doctor or hospital you have the choice to use a health care provider who participates in the network or one who does not. Regardless of the provider you choose, benefits will be subject to all terms, conditions and limitations of the Plan. In addition, the Carrier does not supervise, control or guarantee the health care services of any preferred provider or other provider.

Facilities and Other Providers

Covered facilities

Birthing center

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

Day care center

A facility licensed as a day care center and that provides a planned program of psychiatric services for patients with mental conditions who must spend their days, but not nights, under psychiatric supervision, and that is not for schooling, custodial, recreational, or training services.

Hospice

A facility that meets all of the following:

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

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

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

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

5) provides an ongoing quality assurance program.

Hospital

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

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

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

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

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

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

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

3) is operated as a school.

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

Skilled nursing facility

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

Covered providers

For purposes of this Plan, covered providers include:

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

Other covered providers include:

- Qualified Clinical Psychologist—An individual who has earned either a Doctoral or Masters degree in psychology or an allied discipline and who is licensed or certified in the state where services are performed. This presumes a licensed individual has demonstrated to the satisfaction of state licensing officials that he/she by virtue of academic and clinical experience is qualified to provide psychological services in that state.
- Nurse Midwife—A person who is certified by the American College of Nurse Midwives or is licensed or certified as a nurse midwife in states requiring licensure or certification.
- Nurse Practitioner/Clinical Specialist—A person who 1) has an active R.N. license in the United States, 2) has a baccalaureate or higher degree in nursing, and 3) is licensed or certified as a nurse practitioner or clinical nurse specialist in states requiring licensure or certification.

- Clinical Social Worker—A social worker who 1) has a master's or doctoral degree in social work, 2) has at least two years of clinical social work practice and, 3) in states requiring licensure, certification or registration, is licensed, certified or registered as a social worker where the services are rendered.
- Nursing School Administered Clinic—A clinic that is: 1) licensed or certified in the state where the services are performed and 2) provides ambulatory care in an outpatient setting—primarily in rural or inner-city areas where there is a shortage of physicians. Services billed for by these clinics are considered outpatient 'office' services rather than facility charges.
- Physician Assistant—A person who is licensed, registered or certified in the state where services are performed.
- Licensed Professional Counselor or Masters Level Counselor—A person who is licensed, registered or certified in the state where services are performed.
- 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 of license. For 1999, the States designated as medically underserved are: Alabama, Idaho, Louisiana, Mississippi, New Mexico, North Dakota, South Dakota, South Carolina, and Wyoming.

Christian Science practitioners

Charges of a **Christian Science** practitioner are allowable expenses if the practitioner's services are elected instead of a doctor. This election must be made separately for each individual the first time a claim is filed each calendar year and will apply to expenses incurred during that year. This election may be changed the following year if desired. The practitioner must be listed as such in the Christian Science Journal current at the time the service is provided. This election will not apply to, nor prevent payment of, a doctor's charges under Maternity Benefits.

PPO arrangements

PPO facilities agree to provide service to Plan members at a lesser cost than for the same services from a non-PPO provider. Although they are not available in all locations, your use of them whenever possible helps contain health care costs and reduces your out-of-pocket costs. The selection of PPO providers is solely the Carrier's responsibility; continued participation of any specific provider cannot be guaranteed.

PPO benefits apply only when you use a PPO provider. Provider networks may be more extensive in some areas than others. The avalibility of every speciality 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.

This Plan's PPO

In the PPO Network Area, this Plan covers two types of providers: 1) those that participate in a preferred provider organization (PPO) and (2) those that do not.

When you use a PPO Provider

Enrollees living in the PPO Network Area, as defined below, will receive a directory of PPO providers. Providers who belong to the network must meet specific criteria including location, medical specialty, professional skill and proper credentials. The Carrier will publish an updated list of preferred providers periodically. For the most current list of preferred providers, you may contact your Plan Administrator. The list will show when a preferred provider's participation in the Carrier's preferred provider option is limited to:

1) a part of a health care facility; or

2) the furnishing of certain covered services.

Facilities and Other Providers *continued*

Enrollees who reside in the PPO Network Area, as defined below, may utilize the Preferred Provider Organization network when they get local doctor and/or hospital care. Subject to the Plan's definitions, limitations and exclusions, the Plan pays 100% of covered charges for a semi-private room and other covered hospital charges with no deductible for members who are admitted to a PPO provider facility, 90% of covered charges for surgical services of a PPO doctor and 100% for covered charges in excess of the $10 co-payment for specified services of a PPO doctor other than for surgery. If you reside in Washington, D.C. or in one of the cities or counties listed below, call 1-800/634-0069 for information concerning the PPO. When you phone for an appointment, please remember to verify that the physician is still a PPO provider.

When you use a non-PPO Provider

Enrollees who reside in the PPO Network Area who elect to use the services of a non-PPO provider will be required to pay a $100 per admission per person deductible if confined in a non-PPO facility. The Plan will then pay 80% of covered charges for a semi-private room and board rate and other hospital charges until the member's out-of-pocket costs equal $2,000, as defined on page 32. The Plan will then pay these charges at 100%.

If you elect to use the services of a non-PPO doctor, the Plan will pay 80% of covered services of a doctor.

PPO Network Area

The PPO Network Area for 1999 consists of Washington, D.C. and the following counties and cities in Maryland and Virginia:

Maryland: Anne Arundel, Baltimore, Carroll, Cecil, Charles, Frederick, Harford, Howard, Montgomery, Prince Georges, Queen Annes, St. Marys.

Virginia: Counties—Accomack, Albemarle, Amelia, Arlington, Charles City, Chesterfield, Cumberland, Dinwiddie, Essex, Fairfax, Fauquier, Fluvanna, Gloucester, Goochland, Greene, Greenville, Hanover, Henrico, Isle of Wight, James City, King and Queen, King William, Lancaster, Loudoun, Louisa, Lunenburg, Madison, Mathews, Mecklenburg, Middlesex, Nelson, New Kent, Northumberland, Nottoway, Orange, Powhatan, Prince Edward, Prince George, Prince William, Richmond, Southampton, Spotsylvania, Stafford, Surry, Sussex, Westmoreland, York. Cities—Alexandria, Charlottesville, Chesapeake, Fairfax, Falls Church, Hampton, Manassas, Newport News, Norfolk, Portsmouth, Richmond, Suffolk, Virginia Beach, Williamsburg.

If you reside in this area and receive inpatient services or supplies from any non-PPO hospital provider or physician, it will result in higher out-of-pocket costs to you. You must utilize PPO providers to receive maximum Plan benefits.

Outside the Network area

Enrollees who reside outside the PPO Network Area will be required to pay a $100 per admission per person deductible if confined in a hospital. The Plan will then pay 100% of covered hospital charges.

The Plan will pay 85% of covered physician charges.

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 a 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 $250 in covered charges you must pay each year before the Plan starts paying Other Medical Benefits. Other charges also apply to this deductible: covered inpatient and outpatient visits for the treatment of mental conditions and visits for extended dental treatment of accidental dental injuries. You are responsible for the payment of all charges that are applied to the calendar year deductible. There is a separate calendar year deductible for each member of your family.

Cost Sharing *continued*

Family limit

There is a separate calendar year deductible of $250 per person. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the expenses applied to the calendar year deductible for all family members reach $500. Furthermore, if two or more covered members of your family are injured in the same accident, you need to meet only one calendar year deductible for those members in that calendar year for all expenses related to the accident.

Hospital admission

There is a separate hospital deductible of $100 per person per admission for inpatient hospital expenses for non-PPO admissions in the PPO Network Area and for all admissions elsewhere.

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.

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 usual, reasonable and customary charge, whichever is less. For instance, when a Plan pays 80% of reasonable and customary charges for a covered service, you are responsible for 20% 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% of the allowance ($76). You must pay the 20% coinsurance ($19), plus the difference between the actual charge and the reasonable and customary allowance ($5), for a total member responsibility of $24.

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 charge it would otherwise have paid of the provider's original charge. 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 waives the 20% coinsurance, the actual charge is $80. The Plan will pay $64 (80% of the actual charge of $80).

Copayment

A copayment is the stated amount the Plan may request you to pay for a covered service; such as $10 copay per prescription by mail.

Lifetime maximums

Substance abuse coverage is limited to three inpatient or outpatient treatment programs (including aftercare) per person per lifetime. See page 20.

Hospice care has a lifetime maximum benefit of $7,500 per person, if precertified. If not precertified the maximum allowable benefit is $4,500. See page 25.

One smoking cessation program per person is covered per lifetime. See page 23.

Diagnosis and treatment of infertility has a lifetime maximum benefit of $5,000. See page 22.

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 35-36 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 plan 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.

TRICARE

If you are covered by both this Plan and TRICARE, the Department of Defense's health benefits program for the Uniformed Forces (previously known as "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 laws. 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).

General Limitations *continued*

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. Subrogation means the Plan's right to recover any benefit payments made to you or your dependent by a third party's insurer because of the injury or illness caused by a third-party.

Overpayments

The Carrier will make reasonably 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're age 65 or older and don't have Medicare

The information in the following paragraph applies to you when 1) you are not covered by either Medicare Part A (hospital insurance) or Part B (medical insurance), or both, 2) you 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 service, 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 1-800/634-0069 for assistance.

Physician services

The Carrier's explanation of benefits (EOB) will tell you how much the hospital or physician can charge you in addition to what the Plan paid. If you are billed more than the hospital or physician is allowed to charge, ask the hospital or 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 1-800/634-0069 for assistance.

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, the Plan will base its payment on the lower of these two amounts and you are responsible for any deductible.

If your physician does not participate with Medicare, the Plan will base its payment on the Medicare-approved amount. However, in most cases you will be responsible for any deductible, and any balance up to the limiting charge amount that a provider who does not participate with Medicare is legally permitted to bill under Medicare law (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 hospital or physician can charge you in addition to what the Plan paid. If you are billed more than the hospital or physician is allowed to charge, ask the hospital or 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, ask the Carrier for guidance.

General Exclusions

These exclusions apply to more than one or to all benefit 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 11); 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. Immediate relatives include spouse, parent, child, brother or sister by blood, marriage, or adoption
- Furnished or billed by a provider or facility barred from the FEHB Program
- Furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered
- For or related to sex transformation, sexual dysfunction or sexual inadequacy
- Not specifically listed as covered
- That are investigational or experimental
- That are not provided in accordance with generally accepted professional medical or dental standards in the United States
- Not recommended or approved by a covered provider
- Received before coverage under the Plan begins, or after it ends

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 Part A and/or Part B (see pages 34-36), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge), or State premium taxes however applied
- Acupuncture, except when used as an anesthetic agent for covered surgery
- Eye exercises and visual training (orthoptics)
- Weight control or any treatment of obesity except surgery for morbid obesity (as defined on page 43)
- Custodial care
- Educational training

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 two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See pages 33-34 for details.

Waiver

This precertification requirement does not apply to persons whose primary coverage is Medicare Part A, another insurance policy, or when the hospital admission is outside the continental United States, Alaska and Hawaii. For information on when Medicare is primary, see page 35.

Room and board and other charges

For semiprivate room and other hospital services, including intensive care units, the Plan pays as follows. If a private room is used, the patient pays the cost in excess of the hospital's average semiprivate room rate unless the Plan determines that isolation is medically necessary. If the hospital does not have semiprivate rooms, payment will be based on the average semiprivate room rate in the geographic area.

PPO benefit

100% of covered charges at a PPO Network facility; no deductible applies.

Non-PPO benefit

If your permanent address is inside the PPO Network Area, **80%** of covered charges after the $100 deductible per hospital admission.

If your permanent address is outside the PPO Network Area, **100%** of covered charges after the $100 deductible per hospital admission.

Catastrophic protection

The enrollee's share of covered charges at a non-PPO facility will be covered in full when; 1) that enrollee's calendar year deductible is met, and; 2) applicable expenses of that enrollee and any other family members exceed the $2,000 catastrophic protection limit described on page 32.

Out of Area Emergency Admissions

At the discretion of the plan, benefits equal to those for enrollees residing outside the PPO Network Area may be applied for those individuals who reside in the PPO network area, but are hospital confined for a medical emergency or accident while temporarily traveling outside the network area. The Plan, at its discretion, may require such insured person to be transferred to any Mutual Of Omaha participating facility when such a facility is medically safe.

> Medical Emergency means the sudden and unexpected onset of a condition or injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care, that the covered person secures within 72 hours after the onset. Medical emergencies include deep cuts, broken bones, heart attacks, cardiovascular accidents, poisonings, loss of acute consciousness or respiration, convulsions, and such other acute conditions as may be determined by the Carrier to be medical emergencies.

Limited benefits

Pre-admission testing

100% of reasonable and customary charges for outpatient diagnostic X-ray and laboratory tests when performed within 7 days before a scheduled admission and that:

1) are related to a covered hospital confinement;
2) are accepted by the hospital instead of tests that would have been performed during the confinement; and
3) are repeated only if the patient's medical record shows the pre-admission test results and the need for repeated tests upon admission.

Inpatient Hospital Benefits *continued*

Hospitalization for dental work

100% for semiprivate room and other hospital charges in connection with dental procedures (even though the dental work itself may not be covered) only when a nondental physical impairment exists that makes hospitalization necessary to safeguard the health of the patient.

Related benefits

Professional charges

Charges for the professional services of a doctor or any other practitioner covered by this Plan, even though billed by a hospital as part of the hospital services, are covered under Surgical Benefits or Other Medical Benefits. See pages 16-17 and 21-24.

Skilled nursing care

See Additional Benefits, page 25.

Take-home items

Drugs, medicines and other medical supplies furnished upon discharge for use at home are covered only under Prescription Drug Benefits. See pages 26-27.

What is not covered

- Confinement in nursing homes, rest homes, places for the aged, convalescent homes, or any place that is not a hospital, skilled nursing facility, or hospice. See definitions on pages 5 and 6.
- Custodial care (as defined on page 41) even when provided by a hospital
- A hospital admission that is not medically necessary, i.e., the medical services did not require the acute hospital inpatient (overnight) setting, but could have been provided in a doctor's office, the outpatient department of a hospital, or some other setting without adversely affecting the patient's condition or quality of medical care rendered
- Inpatient hospital services and supplies for surgery not covered by the Plan
- Inpatient private duty nursing
- Personal comfort services of a luxury nature such as radio, television, telephone, beauty and barber services

Surgical Benefits

What is covered

PPO benefits for enrollees residing in the Network Area

PPO Surgical Benefits

Hospital inpatient

90% of the covered charges for inpatient surgical services and procedures

Outpatient

90% of the covered charges for outpatient surgery performed at a hospital, doctor's office or surgi-center. Directly related services and supplies rendered at the time of the surgery are paid at 100% of the reasonable and customary charge.

Charges for normal post-operative care by the doctor who performed the surgery are considered part of the surgical charge.

Anesthesia

90% of the covered charges (based on CPT code and time)

Non-PPO Surgical Benefits

Hospital inpatient

For enrollees residing in the PPO Network Area: The Plan pays 80% of the reasonable and customary charges for inpatient surgical services and procedures.

For enrollees residing outside the PPO Network Area: The Plan pays 85% of the reasonable and customary charges for inpatient surgical services and procedures.

Outpatient

For enrollees residing in the PPO Network Area: 80% of the reasonable and customary charges for outpatient surgery performed at a hospital, doctor's office or surgicenter. Directly related services and supplies rendered at the time of the surgery are paid at 100% of the reasonable and customary charge.

For enrollees residing outside the PPO Network Area: 85% of the reasonable and customary charges for outpatient surgery performed at a hospital, doctor's office or surgicenter. Directly related services and supplies rendered at the time of the surgery are paid at 100% of the usual and customary charge.

Anesthesia

The applicable percentage of the reasonable and customary charges (based on CPT and time).

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 the value of the major procedure, plus 50% of the value of the lesser procedure(s) at the applicable percentage rate of the covered charges. For certain surgical procedures, a value of less than 50% may be applied for subsequent procedures.

Incidental procedures

When an incidental procedure (e.g., incidental appendectomy, lysis of adhesions, excision of scar) is performed through the same incision, the reasonable and customary allowance will be that of the major procedure only.

Assistant surgeon

Services of an assistant surgeon are payable at the applicable percentage of the covered charges (based on 20% of the covered charges allocated to the surgeon).

Second opinion (voluntary)

Covered under Other Medical Benefits. See page 21.

Organ/tissue transplants and donor expenses

Transplant surgery means transfer of a body organ(s) from the donor to the recipient. Donor means a person who undergoes a surgical operation for the purpose of donating a body organ(s) for transplant surgery. Recipient means an insured person who undergoes a surgical operation to receive a body organ transplant.

What is covered

- Cornea, heart, kidney, liver, pancreas, heart/lung, single lung and double lung transplants
- Bone marrow and stem cell support as follows:
  - —Allogeneic donor bone marrow transplants
  - —Autologous bone marrow transplants (autologous stem cell support and peripheral stem cell support) for acute lymphocytic or non-lymphocytic leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma, breast cancer, multiple myeloma, epithelial ovarian cancer, and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors.
- Related medical and hospital expenses of the donor when the recipient is covered by the Plan. Recipient means an insured person who undergoes an operation to receive an organ transplant. Donor means a person who undergoes an operation for the purpose of donating an organ for transplant surgery.

What is not covered

Transplants not listed as covered.

Oral and maxillofacial surgery

80% of the reasonable and customary charges for:

- Surgery by an oral surgeon for operations that do not involve any tooth structure, alveolar process, abscess or disease of periodontal or gingival tissue or dental implants
- Surgical correction of temporomandibular joint (TMJ) dysfunction
- Surgical removal of impacted teeth

What is not covered

- Cosmetic surgery (as defined on page 41) except for the repair of accidental injuries sustained while covered under the FEHB Program, to correct congenital anomalies as defined on page 41, and the initial reconstruction of a breast that was removed or partially removed for medically necessary reasons
- Radial keratotomy, or similar surgery to treat myopia (except for cornea graft)
- Removal of corns or calluses, or the trimming of toenails and similar routine treatment of conditions of the foot
- Reversal of voluntary surgical sterilization

Maternity Benefits

What is covered

The Plan pays the same benefits as for hospital, surgery (delivery), laboratory tests and other medical expenses as for illness or injury.

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 two business days following the day 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 page 33 for details.

Waiver

See page 33 for instances when precertification is not required.

Room and board and other charges

The Plan pays for semiprivate room and other hospital services as follows. Bassinet or nursery charges for days on which mother and child are both confined are considered maternity expenses of the mother and not expenses of the child.

PPO Benefit

If you reside in the PPO Network Area, **100%** of covered charges at a PPO network facility; no deductible applies.

Non-PPO Benefit

If you reside in the PPO Network Area, 80% of covered charges after the $100 per admission deductible.

If you reside outside the PPO Network Area, 100% of covered charges after the $100 deductible per hospital admission.

Outpatient care

100% of reasonable and customary charges for covered hospital and physician services at the time of delivery (no deductible) when:

- Delivery is on an outpatient basis; or
- Delivery is at a licensed birthing center; or
- Inpatient delivery results in a hospital confinement of one day (overnight) or less and no more than one day's room and board charge applies.

Limitations

If the mother and/or newborn child is transferred from a birthing center to a hospital due to medical complications, the birthing center expenses will be paid as inpatient care.

For a confinement of one day (overnight) or less, if the mother and child leave the hospital against medical advice, this outpatient maternity benefit is not payable.

Obstetrical care

For a confinement of 2 or more days, charges of the doctor and/or State licensed midwife (for delivery, prenatal and postnatal visits, or abortion) and amniocentesis are paid under Surgical Benefits, pages 16 and 17.

Newborn care

PPO benefits—If you reside in the PPO Network Area, 90% of covered charges for the initial, routine, inhospital examination of a newborn infant, not subject to the calendar year deductible. Routine circumcision for an infant covered under a Self and Family enrollment is covered under Surgical Benefits.

Non-PPO benefits—If you reside in the PPO Network Area, 80% of reasonable and customary charges for the initial, routine, inhospital examination of a newborn infant, not subject to the calendar year deductible. Routine circumcision for an infant covered under a Self and Family enrollment is covered under Surgical Benefits.

If you reside outside the PPO Network Area, 85% of reasonable and customary charges for the initial, routine, inhospital examination of a newborn infant, not subject to the calendar year deductible. Routine circumcision for an infant covered under a Self and Family enrollment is covered under Surgical Benefits.

Maternity Benefits *continued*

Related benefits

Diagnosis and treatment of infertility

Services for the diagnosis and treatment of infertility are covered under Other Medical Benefits. See page 22.

Tests

Sonograms, amniocentesis and other related tests on the unborn are covered under Other Medical Benefits.

Voluntary sterilization

Covered under Surgical Benefits; see page 16.

Contraceptive Drugs

Oral contraceptives dispensed by a retail pharmacy or obtained through the Mail Service Program are covered as prescription drugs (see page 26)

For whom

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

What is not covered

- Assisted Reproductive Technology (ART) such as artificial insemination, in vitro fertilization, embryo transfer and GIFT. Services and supplies related to ART procedures are not covered.
- Contraceptive injectable and implanted drugs (such as Norplant) and devices.
- Services received before enrollment begins or after enrollment ends.

Mental Conditions/Substance Abuse Benefits

What is covered

The Plan pays for the following services:

Mental conditions inpatient care

Precertification

The medical necessity of your admission to a hospital or other covered facility must be precertified for you to receive full Plan benefits. Emergency admissions must be reported within two business days following the day of admission even if you have been discharged. Otherwise, the benefits payable will be reduced by $500. See page 33 for details.

Waiver

See page 33 for when precertification is not required.

PPO benefit

100% of covered hospital charges at a PPO Network facility; no deductible applies.

Non-PPO benefit

If you reside in the PPO Network Area, 80% of covered hospital charges after the $100 deductible per admission. Catastrophic protection applies; see page 32.

If you reside outside the PPO Network Area, after the $100 per person per admission hospital deductible, 100% of covered hospital charges for up to 60 days per confinement and 80% for the 61st day and thereafter.

Mental conditions Inpatient and Outpatient psychiatric treatment sessions

After the $250 calendar year deductible, the Plan will consider charges for psychiatric treatment sessions (including group sessions) up to 90% of covered charges for PPO Providers and up to 50% of reasonable and customary charges for Non-PPO Providers for a maximum of 50 visits per person per calendar year. The medical management of mental conditions will be covered under this Plan's Other Medical Benefits provision. Related drug costs will be covered under this Plan's Prescription Drug Benefits. Office visits for the medical aspects of this treatment do not count toward the 50 visits per person per year calendar maximum.

Mental conditions outpatient care

50% of reasonable and customary charges for treatment in a qualified day care center as determined by the Plan. A qualified day care center is one that provides a planned program of psychiatric care for patients who are at the center for only a part of each day. Doctors' offices, facilities operating principally as schools or recreational or training centers, and facilities primarily providing custodial services will not be recognized as qualified day care centers.

Substance abuse

Up to $10,500 per calendar year for a 28-day inpatient treatment program (including detoxification and aftercare) or up to $4,000 per year for an outpatient treatment program (and aftercare) in a facility as defined on pages 5 and 6. Inpatient confinements must be precertified by the Plan. For precertification, contact the Plan at 1-800/634-0069.

Lifetime maximum

Coverage is limited to three treatment programs per person per lifetime. Withdrawal from a treatment program prior to completion constitutes use of one program. No other benefits of the Plan are payable for the treatment of substance abuse and no deductibles apply.

What is not covered

Counseling or therapy for marital, educational or behavioral problems, or related to mental retardation or learning disabilities

All charges for chemical aversion therapy, conditioned reflex treatments, narcotherapy or any similar aversion treatments and all related charges (including room and board)

Any provider not specifically listed as covered.

Other Medical Benefits

What is covered

PPO Benefits

Subject to the following conditions, enrollees will pay a $10 copayment for a physician's professional fee for each visit, not subject to the $250 calendar year deductible nor counted toward the maximum annual out-of-pocket limit.

—Conditions

1. No more than one copayment will be applied per day per person.
2. The copayment applies to the following, but is not limited to:
   a. Services such as:
      1) office visits
      2) consultations
      3) ophthalmology exam
      4) physical therapy
      5) post-operative follow-up
      6) services after hours
      7) emergency office visits
   b. Injections (including allergy injections)
   c. Allergy testing
   d. Radiation therapy, and
   e. X-ray and laboratory services in the physician's office.

This PPO copayment feature does not apply to all services. The Plan pays 90% of covered charges, subject to the $250 calendar year deductible, for the following:

a. Supplies or drugs provided by the physician.
b. Services received outside the physician's office.

Non-PPO Benefits

For enrollees residing in the Network Area: After the $250 calendar year deductible has been met, the Plan pays 80% of the reasonable and customary charges for services and supplies listed below, to the extent they are not paid under any other benefit of the Plan.

For enrollees residing outside the Network Area: After the $250 calendar year deductible has been met, the Plan pays 85% of reasonable and customary charges of services and supplies listed below, to the extent, they are not paid under any other benefit of the Plan.

Other Benefits

After the $250 calender year deductible has been met, the Plan pays applicable percentages for the following services and supplies listed below, to the extent they are not paid under any other benefit of the Plan:

—Outpatient and out-of-hospital X-ray and laboratory services performed by or under the supervision of a doctor. See page 25 for coverage of emergency treatment of accidental injury.

—Doctors' visits (inhospital, home, office) that are unrelated to surgery or maternity, including a second surgical opinion by an independent consulting doctor other than the surgeon

—Private duty nursing out-of-hospital. Charges for full-time nursing or visits by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.) are covered only when:

- the care is ordered by the attending doctor, and
- the doctor identifies the specific professional nursing skills that the patient requires, as well as the length of time needed.

—Services and supplies, either in or out of a hospital, that are recommended by the attending doctor:

- Orthopedic braces, canes, casts, cervix collars, cervical traction kits, crutches, splints and trusses
- Services and supplies for renal dialysis and chemotherapy

- Two wigs per lifetime, up to a maximum of $150 each and not subject to the deductible, when required due to hair loss in connection with chemo or radiation therapy
- Radium, radioactive isotopes, and X-ray therapy
- Oxygen and rental of equipment for its administration
- Local ambulance service (above the $50 covered under Additional Benefits) or, if a special and unique hospital treatment is required that is not available locally, transportation by professional ambulance, railroad or commercial airline on a regularly scheduled flight, within the United States or Canada, to the nearest hospital equipped to furnish the treatment. This benefit does not apply to transportation necessary to obtain the services of a specific doctor or any other practitioner.
- Rental (up to the purchase price, at the option of the Plan) or purchase of durable medical equipment; including items such as wheelchairs, hospital beds, respirators and other items that the Plan determines are durable medical equipment. See definition on page 41. **Durable medical equipment must be preapproved by the Plan before purchase or rental in excess of 30 days.**
- Services of a registered physical therapist or a registered occupational therapist, practicing within the scope of the license, for administration of therapy in accordance with a doctor's specific instructions as to type, frequency, and duration
- Speech therapy provided by a licensed speech therapist practicing within the scope of the license, but only when necessary to restore speech when there has been a functional loss of speech due to illness or injury, and when therapy is rendered in accordance with a doctor's specific instructions as to type and duration
- Artificial eyes and limbs required to replace natural eyes and limbs.
- One pair of eyeglasses or contact lenses per lifetime, and examination for them, if required to correct an impairment directly caused by accidental eye injury or eye surgery. The services must be received within one year of the date of accident or surgery.
- One hearing aid and examination per lifetime if required to correct an impairment directly caused by accidental injury or intra-aural surgery. The expenses must be incurred within one year of the date of the accident or surgery.
- Two external breast prostheses, and two bras per calendar year following mastectomy and designed exclusively for use with an external prosthesis
- Blood or blood plasma (not donated or replaced) and its administration
- One tetanus-diphtheria (TD) booster every 10 years for patients over 19 years of age; one pneumococcal (pneumonia) vaccine per year for patients age 65 years and over; and one influenza (flu) vaccine per year per person.

Limited benefits

Diagnosis and treatment of infertility

After the $250 calendar year deductible, the Plan pays charges in the same manner as any other covered benefit up to $5,000 per person per lifetime, for the diagnosis and treatment of infertility as defined below:

1) the initial diagnostic test and procedures done solely to identify the cause or causes of the inability to conceive;

2) hormone therapy, FDA-approved drugs and related services; and

3) medical or surgical services performed solely to create or enhance the ability to conceive.

Other Medical Benefits *continued*

Smoking cessation benefit

After the $250 calendar year deductible has been met, the Plan will pay up to $100 for enrollment in one smoking cessation program per person per lifetime. This benefit includes FDA-approved drugs and medicines that are intended to aid in smoking cessation. Smoking cessation drugs and medicines are not covered under any other Plan provisions.

Well child care

After the $250 calendar year deductible has been met, the Plan will pay reasonable and customary charges for all routine inhospital visits and all routine office visits for the child's first 24 months. Coverage for immunizations is described on page 25.

Preventative Services

Routine Physical examination

One annual routine physical examination per person to include a history and physical, chest X-ray, urinalysis, blood tests, proctosigmoidoscopy (for men over 40 years of age) and EKG (electrocardiogram). Also included are:

Cervical cancer screening: Annual pap smear for women age 18 and older.

Prostate cancer screening: Annual PSA (Prostate Specific Antigen) test for males age 40 and older.

Colorectal cancer screening: Annual fecal occult blood test for members age 40 and older.

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

- From age 35 through 39, one baseline mammogram during this five year period.
- From age 40-45, one mammogram screening every other calendar year.
- From age 45+, one mammogram every calendar year.

Benefits levels are indicated below:

PPO Benefits

For enrollees residing in the Network area: $10 copayment for a physician's professional fee and services provided in the physician's office. 90% of covered charges for services provided outside physician's office, subject to the $250 deductible.

Non-PPO Benefits

For enrollees residing in the Network Area: 80% of reasonable and customary charges, subject to the $250 deductible.

For enrollees residing outside the Network Area: 85% of reasonable and customary charges, not subject to the $250 deductible.

What is not covered

- Services of a private duty nurse whose duties consist primarily of custodial care
- Sun or heat lamps, whirlpool baths, heating pads, air purifiers, humidifiers, air conditioners, exercise devices and other items that do not meet the definition of durable medical equipment
- Orthopedic shoes, orthotics, and other supportive devices for the feet
- Provocative food testing, end point titration techniques, hair analysis, and sublingual allergy desensitization
- Preventive medical care and services (including periodic checkups and immunizations such as polio, flu, mumps, and smallpox shots), except as provided under the Routine physical exam and Childhood immunizations benefits on page 25, and under the Well child care benefit on this page.
- Eyeglasses, contact lenses, or examinations for them (except as specified on page 22) and eye refractions.
- Hearing aids or examinations for them (except as specified on page 22)
- Weight control or any treatment of obesity except surgery for morbid obesity (as defined on page 43)

- Services and supplies for cosmetic purposes except for wigs as described on page 22
- Services of a chiropractor
- Chelation therapy except for acute arsenic, gold, mercury, or lead poisoning
- Speech therapy for congenital disorders or loss/impairment due to mental, psychoneurotic and personality disorders
- Assisted Reproductive Technology (ART) procedures that enable a woman with otherwise untreatable infertility to become pregnant through any artificial conception procedures such as artificial insemination, in vitro fertilization, embryo transfer and GIFT, including services and supplies related to ART procedures

Additional Benefits

Accidental injury

100% of reasonable and customary charges for outpatient hospital or outpatient doctors' expenses for emergency treatment of accidental bodily injury, and associated X-ray and laboratory expenses, are covered if rendered within 96 hours of the injury. Follow-up doctors' visits incurred up to 30 days after the injury are also covered at **100%** if initial treatment was received within 96 hours. Prescriptions and durable medical equipment related to the injury, as well as all charges related to the accidental injury incurred 30 days or more after the accident, are payable as Other Medical Benefits.

Ambulance

Up to $50 for local ambulance service to and from a hospital in conjunction with either hospital inpatient or outpatient treatment when ambulance use is due to an emergency or when prescribed by a doctor. Reasonable and customary charges over $50 are covered under Other Medical Benefits.

Childhood immunizations

100% of reasonable and customary charges for childhood immunizations recommended by the American Academy of Pediatrics, for covered members under age 22.

Home health care

If precertified, as defined on page 33, the Plan will pay up to $80 per visit for up to 90 home health care visits in a calendar year.

If not precertified, the Plan will pay up to $40 per visit for up to 40 home health care visits in a calendar year.

A home health care visit consists of one of the following: 1) less than an 8-hour shift of nursing care, or 2) one therapy session, or 3) less than an 8-hour shift by a home health aide. The following services are covered:

- Nursing care provided on a part-time basis (less than an 8-hour shift) by a registered nurse (R.N.) or licensed practical nurse (L.P.N.);
- Physical, occupational or speech therapy provided by a licensed therapist; and
- Home health aide services provided on a part-time basis (less than an 8-hour shift) that: 1) are performed by a home health aide under the supervision of a registered nurse (R.N.); and 2) consist mainly of medical care and therapy provided solely for the care of the patient.

The above home health care services must be furnished: 1) by a home health care agency (or by visiting nurses when services of a home health care agency are not available); 2) in accordance with a home health care plan (as defined on page 42); and 3) in the patient's home.

Hospice care

If precertified, as defined on page 33, the Plan pays **100%** of reasonable and customary charges for covered medical expenses up to a lifetime maximum of $7,500, for care provided by an independent hospice administration to a terminally ill patient in the final stage of illness when a hospice care program, as defined on page 42, is recommended by a doctor.

If not precertified, as defined on page 33, the maximum allowable benefit is $4,500 for care as described above.

This benefit does not apply to services shown as covered under any other provisions of this Plan.

Skilled nursing facilities

If precertified, as defined on page 33, the Plan will pay **100%** of reasonable and customary charges for medically necessary inpatient services, for a maximum of 60 days, when the confinement is under the supervision of a doctor.

If not precertified the Plan will pay **80%** of reasonable and customary charges up to a maximum of 30 days per confinement.

Skilled nursing facility benefits shown above will be restored for each new period of confinement. There is a new period of confinement when at least 60 days have elapsed since the patient was last confined in a skilled nursing facility.

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:

- Diabetic, colostomy, and ostomy supplies
- Drugs, vitamins and minerals that by Federal law of the United States require a doctor's prescription for their purchase.
- Insulin
- Needles and syringes for the administration of covered medications.
- Oral contraceptives when prescribed by a physician.

What is not covered

- Medical supplies such as dressings and antiseptics.
- Contraceptive drugs, other than oral contraceptives, and devices used for the purpose of birth control for which Federal law requires a prescription, including Norplant.
- Drugs and supplies for cosmetic purposes.
- 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.
- Nutritional supplements and vitamins (including prenatal) that do not require a prescription.
- Drugs to aid in smoking cessation are covered only under the Smoking Cessation benefit.
- Fertility drugs are covered only under the Diagnosis and Treatment of Infertility benefit.

From a Pharmacy

Under the prescription drug card program, you may obtain up to a 30 day supply of covered drugs. If purchasing more than a 30 day supply on the same day, any expense exceeding that supply limit will not be covered through the pharmacy arrangement. You may purchase your covered prescription drugs and supplies by presenting your Prescription Drug Card along with your prescription to a preferred prescription drug provider and paying the lesser of the drug cost or:

- copay of $10 per generic drug or brand name, if a generic drug is not available.
- copay of $20 per brand name drug when required by your physician, or if you request, but your doctor does not require, a brand name drug and a generic equivalent is available.
- Prescription refills will be covered when no more than **25%** of the day's supply remains based on your doctor's prescription.

Call 1-800-752-0598 to locate a preferred prescription drug provider in your area.

If your doctor prescribes a medication that will be taken over an extended period of time, you should request two prescriptions—one for immediate use with the local preferred participating pharmacy and the other for up to a 90 day supply from the mail order program.

Waiver

When Medicare Part B is the primary payer, the Plan will waive the copay except when you purchase a brand name drug when a generic is available. The copay of $20 you are required to pay for the election of a brand name drug when a generic is available will not be reimbursed by the Plan.

By mail

If your doctor orders more than a 30-day supply of drugs or covered supplies up to a 90-day supply, you may order your prescription or refill by mail from the Plan's mail order drug program. Diversified Prescription Delivery (DPD) will fill your prescription. All drugs and supplies covered by the Plan are available under this program except drugs to aid in smoking cessation and fertility drugs.

Under the Plan's mail order drug program, if a generic equivalent to the prescribed drug is available, Diversified Prescription Delivery will dispense the generic equivalent instead of the brand name unless you or your doctor specifies that the brand name is required. You pay the cost of the drug up to the following copayment amounts:

- copay of $10 per generic or brand name, if generic drug is not available.
- copay of $20 per brand name drug when required by your physician, or if you request but your doctor does not require, a brand name drug and a generic equivalent is available.

Waiver

When Medicare Part B is the primary payer, the Plan will waive the copay except when you purchase a brand name drug when a generic is available. The copay of $20 you are required to pay for the election of a brand name drug when a generic is available will not be reimbursed by the Plan.

To claim benefits

The Plan will send you information on the mail order drug program. To use the program:

1) Complete the initial mail order form.

2) Enclose your prescription and copayment.

3) Mail your order to:

Diversified Prescription Delivery
P.O. Box 1002
Horsham, PA. 19044-8002

Allow approximately two to three weeks for delivery.

You'll receive forms for refills and future prescription orders each time you receive drugs or supplies under this program. In the meantime, if you have any questions about a particular drug or a prescription, and to request your first order forms, you may call toll-free: 1-800-417-8173.

Purchasing drugs when you are overseas

Only prescription drugs and supplies available in the United States and listed above as covered by the Plan are eligible for reimbursement when purchased in a foreign country. These expenses are reimbursed at **80%** after the $250 deductible has been met.

Drugs from other sources

Prescription drugs are also covered at **80%** after the $250 deductible has been met under this Plan when they are provided to you by a doctor or covered facility, not to include a pharmacy.

Dental Benefits

What is covered

The Plan pays only for the following services:

- Up to $39 for a routine oral examination including X-rays, cleaning, diagnosis, and preparation of a treatment plan. This is limited to two exams per person per calendar year.
- Up to the amounts specified below for dental fillings:

One surface	$12
Two surfaces	$19
Three or more surfaces	$24

Related benefits

Accidental dental injury

The Plan pays **100%** of outpatient hospital or outpatient doctors' reasonable and customary charges for emergency treatment of accidental dental injury to the jaw or sound natural teeth and associated X-ray and laboratory expenses if rendered within 96 hours of injury. (Related follow-up care received after 96 hours is not payable under this benefit.) See page 41for definition of accidental injury and page 43 for definition of sound natural tooth.

Extended dental treatment

After the $250 calendar year deductible, the Plan pays **80%** of reasonable and customary charges for dental services (including initial replacement of sound natural teeth and dental X-rays) as recommended by the attending doctor for repair of accidental injury to the jaw or sound natural teeth occurring while insured under this Plan, if received within 24 months from the date of the accident.

Oral surgery

For covered oral surgery, see page 17.

What is not covered

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

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 1-800/634-0069, 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 have a question concerning Plan benefits, contact the Carrier at 1-800-634-0069 or you may write the Carrier at Mutual of Omaha, P.O. Box 668587, Charlotte, NC 28266. You may also contact the Carrier by fax at 1-704-853-7911.

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 and address 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
- Provider's tax I.D. number

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 or licensed practical nurse and must include nursing notes.
- Claims for rental or purchase of durable medical equipment, private duty nursing, and physical, occupational and speech therapy 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 and medicines must include receipts that include the prescription number, name of drug, prescribing doctor's name, date and charge.
- Use the Plan's standard claim form to file dental claims. Attach the dentist's itemized bill. The dentist's bill must include name of the patient, dates of services, itemized charges and the dentist's tax I.D. number. To speed claim processing, file dental bills separately from other medical bills.
- 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.

After completing a claim form and attaching proper documentation, send claims to this address if not instructed otherwise by the Plan:

Mutual of Omaha
Charlotte Group Claims Processing Center
P.O. Box 668587
Charlotte, NC 28266-8587

Call the center at 1-800/634-0069 if you have questions about your claims.

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 all medical bills including those being accumulated 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

Submit claims promptly as they are incurred. Claims should be filed within 90 days after the expense was incurred for which the claim is being made, but in no event more than two years after the date the expense was incurred, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

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 only: 1) by the Carrier and its subcontractors for internal administration of the Plan coordination of benefit provisions with other plans, 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 in 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 Plan to reconsider, you should first check with your provider or facility to be sure that the claim was filed correctly. 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 Plan 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 should 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, etc.); 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
Insurance Contracts Division 2
P.O Box 436
Washington D.C. 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 those services with coinsurance, the Plan pays 100% of reasonable and customary charges for the remainder of the calendar year if out-of-pocket expenses for the coinsurance in that calendar year exceed $2,000 for you and any covered family members.

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

- The percentage you pay for surgery, anesthesia, and Other Medical Benefits including the percentage you pay for extended medical care after an accidental injury;
- The $100 you pay for the hospital admission deductible;
- The percentage you pay for mental conditions inpatient hospital care;
- The percentage you pay for inpatient and outpatient visits for the treatment of mental conditions; and
- The $250/$500 you pay for the calendar year deductible.

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 treatment of substance abuse or dental care including the 20% you pay for extended dental care after an accidental injury;
- Expenses for non-covered services and supplies;
- Charges in excess of specific Plan allowances, or for services that exceed the number allowed
- PPO copayments; and
- Any amounts you pay if benefits have been reduced because of noncompliance with this Plan's cost containment requirements. See pages 5 and 33-34.

The percentage of covered inhospital charges paid by such an enrollee will be covered in full for the remainder of the calendar year when the following conditions are met: 1) the enrollee has met the calendar year deductible, and 2) applicable expenses of that enrollee and any other family members exceed the above $2,000 catastrophic protection limit.

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.

Information You Have a Right to Know

All carriers in the FEHB Program must provide certain information to you. If you did not receive information about this Plan you can obtain it by calling the Carrier at 1-800-634-0069 or you may write the Carrier at Mutual of Omaha, PO Box 668587, Charlotte, NC 28266. You may also contact the Carrier by fax at 1-704-853-7911.

Information that must be made available to you includes:

Compliance with State and Federal licensing or certification requirements and the dates met. If noncompliant, the reason for noncompliance.

Accreditations by recognized accrediting agencies and the dates received.

Carrier's type of corporate form and years in existance.

Whether the Carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

Precertification

Precertify before admission or receiving specified services

Precertification is not a guarantee of benefit payments. Precertification of an inpatient admission or a specified service (hospice care, skilled nursing facility care, home health care) is a predetermination that, based on the information given, the admission or service 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, except for Hospice Care, Skilled Nursing Facility Care, and Home Health Care where failure to precertify will result in disqualification of higher paid benefit levels.

To precertify a scheduled admission or specified service:

- You, your representative, your doctor, or your hospital must call Mutual of Omaha's Care Review Unit prior to admission. The toll-free number is 1-800/634-0069.
- 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; and number of planned days of confinement.

For hospital confinements, when the above requirements are met, the Care Review Unit will then tell the doctor and hospital the number of approved days of confinement for the care of the patient's condition.

For specified services, when the above requirements are met, the Care Review Unit will notify the patient and the doctor that the service is, or is not, certified as medically necessary.

Written confirmation of the Plan's certification decision will be sent to you, your doctor, and the hospital. If the length of stay needs to be extended, follow the procedures below.

Need additional days?

A review coordinator will contact your doctor before the certified length of stay ends to determine if you will be discharged on time or if additional inpatient 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 be not medically necessary by the Carrier during the claim review.

- 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). Precertification is required, however, when Medicare hospital benefits are exhausted prior to using lifetime reserve days.
- 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 1-800/634-0069 within two business days following the day 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 two business days following the day of the mother's discharge.

Precertification *continued*

Other considerations

An early determination of need for confinement (precertification of the medical necessity of inpatient admission) or specified service, 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 before admission to the hospital (or within two business days following the day 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 otherwise payable on an outpatient basis will be paid.

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 precertification is not obtained for specified services (Hospice Care, Skilled Nursing Facility Care, Home Health Care), disqualification of higher paid benefits will result.

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

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 10 and 34-35)

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 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;
3) The patient (you or a covered family member) is within the first 18 months of eligibility to receive Medicare Part A benefits due to End Stage Renal Disease (ESRD), except when Medicare 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 of the U.S. Code, (b) you are a Tax Court judge who retired under Section 7447 of title 26 of the U.S. Code or (c) you are the covered spouse of a retired judge described in (a) or (b) above;
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 18-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) to 6) 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 coinsurance.
- **Mental Conditions/Substance Abuse Benefits:** If you are enrolled in Medicare Part A, the Plan will waive the inpatient hospital deductible and coinsurance. If you are enrolled in Medicare Part B, the Plan will waive the deductible and coinsurance for inpatient and outpatient visits and outpatient care. Benefits will be paid up to the stated Plan limits.
- **Other Medical Benefits:** If you are enrolled in Part B, the Plan will waive the deductible and any coinsurance for each home and office visit, physician outpatient consultation, and second surgical opinion.
- **Additional Benefits:** If you are enrolled in Medicare Part B, the Plan will waive the coinsurance for mammograms and care in a skilled nursing facility.
- **Dental Benefits:** Deductibles and coinsurance applicable to extended treatment of accidental dental injuries will be waived; benefits for other care will be paid up to the stated Plan amount.

When Medicare is the primary payer, this Plan will limit its payment to an amount that supplements the benefits 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. This is true whether or not Medicare benefits are actually paid. See page 24.

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.

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, charges you 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 Summary Notice. 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. The Carrier has contracted with most Medicare Part B claims processors (also known as carriers) to receive electronic copies of your claims after Medicare has paid their benefits. This means you do not need to submit your Part B claims to the claims processor. Call the Carrier at 1-800/634-0069 to find out if your claims are being filed electronically. If they are not, you should initially submit your claims to Medicare. After Medicare has paid its benefits, the Carrier will consider the balance of any covered expenses. To be sure your claims are processed by this Carrier, 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 MSN.

Enrollment Information

If you are a new member

If you are a new member of this Plan, benefits and rates begin on the effective date of your enrollment, as set by your employing office or retirement system (see Effective date on page 42). 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 except as stated in any cosmetic surgery or dental benefits description in this brochure.

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 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.
- 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 plans. See page 36 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.

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 loses 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 the qualifying event occurs, for example, the date 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 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.

Certificate 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.

Definitions

Accidental injury

An injury caused by an external force such as a blow or a fall that requires immediate medical attention. Also included are animal bites, insect bites and stings, poisonings, and dental care required as a result of an accidental injury to sound natural teeth. An injury to the teeth while eating is not considered an accidental injury.

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.

Confinement

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

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

Congenital anomaly

A condition existing at or from birth that 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, 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 a 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 useful only to a person with an illness or injury;
5) are designed for prolonged use; and
6) serve a specific therapeutic purpose in the treatment of an illness or injury.

Definitions *continued*

Effective date

The date the benefits described in this brochure are effective:

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

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

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

Expense

The cost incurred for a covered service or supply ordered or prescribed by a doctor. An expense is incurred on the date the service or supply is received. Expense does not include any charge:

1) for a service or supply that is not medically necessary, or

2) that is in excess of the reasonable and customary charge for the service or supply. Experimental or investigational drug, device and medical treatment or procedure

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 necessary to determine its maxium tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

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

Group health coverage

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

Home health care agency

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

Home health care plan

A plan of continued care and treatment of an insured person who is under the care of a doctor, and whose doctor certifies that without the home health care, confinement in a hospital or skilled nursing facility would be required.

Hospice care program

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

Medically necessary

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

1) are appropriate to diagnose or treat the patient's condition, illness or injury;

2) are consistent with standards of good medical practice in the United States;

3) are not primarily for the personal comfort 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.

Morbid obesity

A condition in which an individual (1) is the greater of 100 pounds or 100% over his or her normal weight (in accordance with the Plan's underwriting standards) with complicating conditions; and (2) has been so for at least five years, despite documented unsuccessful attempts to reduce under a doctor-monitored diet and exercise program.

Reasonable and customary

Those charges that are comparable to charges made by other providers for similar services and supplies under comparable circumstances in the same geographic area. The Plan's allowances are developed from actual claims received in each Zip Code area throughout the United States, as compiled by the Health Insurance Association of America, and are updated twice a year, at the 90th percentile. This method is used for determining reasonable and customary allowances for surgery, maternity, doctor and other professional services, Other Medical Benefits and Mental Conditions/Substance Abuse Benefits, and accidental injury care. For other categories of benefits, and for certain specific services within each of the above categories, exceptions to this general method for determining the Plan's allowances may exist.

Sound natural tooth

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

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How the Association Benefit Plan Changes January 1999

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

Program-wide Changes

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 psychotherapy will be covered under this Plan's Mental Conditions Benefits. Office visits for the medical aspects of treatment do not count toward the outpatient Mental Conditions visit limit.

If you are enrolled in Medicare, you may be asked by the physician to sign a private contract agreeing that you can be billed directly for services in the amounts exceeding Medicare allowable charges. 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 has been clarified to include biological products.

The States designated as medically underserved have changes for 1999. Idaho and North Dakota have been added, and West Virginia is no longer underserved.

Changes to the Plan

This Plan has added an optional hospital and physician Preferred Provider Organization (PPO) network in the Hampton Roads, Richmond, and Charlottesville, VA areas for 1999. The following counties and cities in Virginia have been added to the PPO Network Area Accomack, Albemarle, Amelia, Charles City, Chesterfield, Cumberland, Dinwiddie, Essex, Fluvanna, Gloucester, Goochland, Greene, Hanover, Henrico, Isle of Wright, James City, King and Queen, King William, Lancaster, Louisa, Lunenburg, Madison, Mathews, Mecklenburg, Middlesex, Nelson, New Kent, Northumberland, Nottoway, Orange, Powhatan, Prince Edward, Prince George, Richmond, Southampton, Surry, Sussex, Westmoreland, York, Charlottesville, Chesapeake, Colonial Heights, Emporia, Franklin, Hampton, Hopewell, Newport News, Norfolk, Petersburg, Portsmouth, Richmond, Suffolk, Virginia Beach, Williamsburg.

One influenza (flu) vaccine will be covered per year regardless of age.

With the exception of enrollees residing overseas, all prescription drugs must be obtained utilizing the prescription drug card and/or mail order program. The copay has increased to $10 for generic drugs or brand name drugs if generic is not available. Brand name drugs when required by the doctor or requested by enrollee when generic is available is now $20 copay.

The routine annual physical benefit has been changed as follows:

(1) For enrollees residing in the PPO Area Network and using participating doctors, PPO benefits apply ($10 copay for services provided in the doctor's office, 90% of covered charges for services provided outside the doctor's office, subject to the $250 deductible.)

(2) For enrollees residing in the PPO Area Network and using non-participating doctors, the Plan pays 80% of the usual and customary (U&C) charges, subject to the $250 deductible.

(3) For enrollees residing outside the PPO Area Network, the Plan pays 85% of the U&C charges, not subject to the deductible.

Summary of Benefits for the Association Benefit 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 Network Area (as defined on page 7):**	
		PPO benefit: 100% of covered charges with no deductible	14
		Non-PPO benefit: 80% of covered charges after a $100 inpatient hospital deductible per admission	14
		Outside the PPO Network Area:	14
		100% of medically necessary days after a $100 inpatient hospital deductible per person per admission, for semiprivate room and other hospital charges	
	Surgical	**PPO benefit: 90%** of covered charges	16
		Non-PPO benefit: 80% of reasonable and customary charges for those residing in the PPO Network Area. **85%** of reasonable and customary charges for those residing outside the PPO Network Area.	16
	Medical	**PPO benefit: 90%*** of covered charges	21
		Non-PPO benefit: 80%* of reasonable and customary charges for those residing in the PPO Network Area. **85%** of reasonable and customary charges for those residing outside the PPO Network Area	21
	Maternity	Same benefits as for illness or injury	18
	Mental Conditions	**PPO benefit: 100%** of covered hospital charges with no deductible.	20
		Non-PPO benefit: 80% of room and board and all other necessary services and supplies after a $100 inpatient hospital deductible per admission; for those residing in the PPO Network Area	20
		After a $100 inpatient hospital deductible, **100%** of room and board and all other necessary services and supplies per admission for up to 60 days per confinement; after 60 days, benefits are payable at **80%** for those residing outside the PPO Network Area.	20
		Up to 50 inpatient and/or outpatient psychiatric treatment sessions are covered at applicable percentage and are subject to the $250 calendar year deductible	
	Substance Abuse	Up to $10,500 per 28-day program per year for inpatient treatment; treatment programs, inpatient or outpatient, are limited to three per lifetime.	20
Outpatient care	**Hospital**	**100%** for all necessary services and supplies rendered at the time of an outpatient surgical operation performed at a hospital, doctor's office or surgi-center; other outpatient services and supplies are subject to the deductible and payable at the applicable percentages.	16
	Surgical	**PPO benefit: 90%** of covered charges	16
		Non-PPO benefit: 80% of reasonable and customary charges for those residing in the PPO Network Area. **85%** of reasonable and customary charges for those residing outside the PPO network area	16

Benefits		Plan pays/provides	Page
	Medical	**PPO benefit:** $10 copay for physician's professional fee and **90%*** of other covered charges	21
		Non-PPO benefit: 80%* of reasonable and customary charges for those residing in the PPO Network Area.	21
		85%* of reasonable and customary charges for those residing outside the PPO network area	21
	Maternity	Same benefits as for illness or injury	18
	Home Health Care	If precertified, the Plan will pay up to $80 per visit for up to 90 home health care visits in a calendar year.	25
		If not precertified, up to $40 per visit for up to 40 home health care visits in a calendar year	
	Mental Conditions	**PPO benefit: 90%*** of covered charges, for up to 50 outpatient and/or inpatient psychiatric treatment sessions per person per calendar year.	20
		Non-PPO benefit: 50%* of reasonable and customary charges for up to 50 outpatient and/or inpatient psychiatric treatment sessions per person per calendar year.	
	Substance Abuse	Up to $4,000 per program per year for outpatient treatment; treatment programs are limited to three per lifetime.	20
Emergency care		**100%** of charges incurred within 96 hours of an accident, and follow-up charges incurred up to 30 days after injury, if initial treatment was received within 96 hours.	25
		Prescription drug program	26-27
Dental care		Routine exams and fillings: fee schedule. **100%** for outpatient treatment of accidental dental injury within 96 hours of injury, then **80%*** for treatment within 24 months of injury.	27
Additional benefits		Accidental injury; Hospice care; Childhood immunizations; Home health care; Ambulance and Skilled nursing facilities.	25
Protection against catastrophic costs		**100%** of reasonable and customary covered charges for the remainder of a calendar year when out-of-pocket expenses for benefits listed on page 32 exceed $2,000 for yourself and/or your family	32