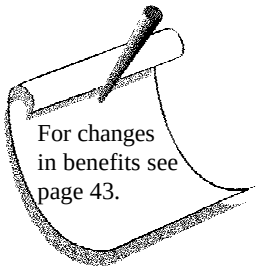
SSEHA Health Benefit Plan 1999

Managed Fee-for-Service Plan



Sponsored by the: U.S. Secret Service Employees Health Association.

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

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

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

Enrollment code for this Plan

Y71 Self Only

Y72 Self Only and Family

:

Authorized for distribution by the:

United States Office of Personnel Management

FEHB
Federal Employees Health Benefits Program

Visit the OPM website at http://www.opm.gov/insure
and
This Plan's website at http://www.bcbsnca.com

RI 72-011

U.S. Secret Service Employees Health Association

The U.S. Secret Service Employees Health Association (SSEHA) (Carrier**)** has entered into Contract No. CS 2276 with the Office of Personnel Management (OPM) to provide a health benefits plan (Plan) authorized by the Federal Employees Health Benefits (FEHB) law. The Plan is underwritten by Blue Cross Blue Shield of the National Capital Area (BCBSNCA) 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 SSEHA Health 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 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 insurance statements carefully. If you find that a provider, such as a doctor, hospital, pharmacy, etc. charged your insurance 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 1-800-424-7474 extension 6039 and explain the situation.
If the matter is not resolved after speaking to your Carrier (and you still suspect fraud has been committed), call or write:

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, N.W., Room 6400
Washington, D.C. 20415

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

When you need help with Plan benefits, or getting your ID card, call 1-800-424-7474 extension 6039. The Fraud Hotline cannot help you with these**.**

Using This Brochure

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

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

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

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

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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 flexible benefits option. Some include managed care options, such as PPO's, to help contain costs.

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

Precertification

Precertification evaluates the medical necessity of proposed admissions and the number of hospital days required to treat your condition. You are responsible for ensuring that the precertification requirement is met. You or your doctor must check with your Carrier before being admitted to the hospital. If that doesn't happen, your Carrier will reduce benefits by $500. Be a responsible consumer. Be aware of your Carrier's cost containment provisions. You can avoid penalties and help keep premiums under control by following the procedures specified on pages 29-30 of this brochure.

Flexible *benefits* option

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

Facilities and Other Providers

What is covered

Benefits under this Plan are available both in facilities, such as hospitals, and from providers, such as pharmacies, doctors and other health care personnel who provide covered services.

Covered facilities

Ambulatory surgical facility

A facility accredited by the Joint Commission on Accreditation of Health Care Organizations or approved by the Carrier, designed for the treatment of minor, elective surgical procedures on an ambulatory basis.

Extended care facility

A facility approved by the Carrier or eligible for payment under Medicare, possessing an organized medical staff providing continuous non-custodial inpatient care for convalescent patients not requiring acute hospital care yet not at a stable stage of illness.

Hospice

A facility which provides short periods of stay for a terminally ill person in a home-like setting for either direct care or respite. This facility may be either free-standing or affiliated with a hospital. It must operate as an integral part of the hospice care program.

Facilities and Other Providers *(continued)*

Hospital

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

Non-participating hospital

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

Participating hospital

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

Cancer research facility

Approved Cancer Research Facility - A facility that is:

1) a National Cooperative Cancer Study Group Institution that is funded by the National Cancer Institute (NCI), and has been approved by a Cooperative Group as a bone marrow transplant center;
2) a NCI-designated Cancer Center; or
3) an Institution that has an NCI-funded, peer-reviewed grant to study allogeneic bone marrow transplants or autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support.

Renal dialysis center

A freestanding facility approved by the Carrier and designed specifically for the treatment of chronic renal disease.

Covered providers

For purposes of this Plan, covered providers include:

1) a licensed doctor of medicine (M.D.) or a licensed doctor of osteopathy (D.O.);

2) a licensed or certified chiropractor, nurse anesthetist, dentist, podiatrist, occupational therapist and speech therapist practicing within the scope of their license or certification; and

3) other covered providers who may render services without the supervision of an M.D. but for whom the Carrier provides benefits include a qualified clinical psychologist, clinical social worker, optometrist, nurse midwife and nurse practitioner/clinical specialist. For purposes of this FEHB brochure, the term "doctor" includes all of these providers when the services are performed within the scope of their license or certification.

Coverage in medically underserved areas

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

Cost Sharing

Deductibles

A deductible is the amount of expense an individual must incur for covered services and supplies before the Carrier starts paying benefits for the expense involved. A deductible is not reimbursable by the Carrier and benefits paid by the Carrier 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 amount of expense an individual must incur for covered services and supplies each calendar year before the Carrier pays certain benefits. The deductible is $200 per person for Surgical, Maternity and Other Medical Benefits and is not reimbursable by the Carrier. Separate deductibles apply to benefits for mental conditions and substance abuse, and to admissions under Inpatient Hospital Benefits, and are not reimbursable by the Carrier.

Other

There is a $100 per admission deductible which applies to inpatient hospital expenses and a separate $200 deductible per person per calendar year which applies to all covered inpatient treatment of mental conditions and substance abuse services.

Carryover

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

Family limit

Under family enrollment, when the expenses applied to the deductible for all family members reach $400, the family deductible is met, and benefits are payable for all family members. The family deductible does not apply to the per admission inpatient hospital deductible.

Coinsurance

Coinsurance is the stated percentage of covered charges you must pay after you have met any applicable deductible. The carrier will base this percentage on either the billed charge or the carrier allowance, whichever is less**.** For instance, when a Carrier pays 80% of Carrier allowance for a covered service, you are responsible for the 20% coinsurance. In addition, you may be responsible for any excess charge over the Carrier's allowance. For example, if the provider ordinarily charges $100 for a service but the Carrier's allowance is $95, the Carrier will pay 80% of the allowance ($76). You must pay the 20% coinsurance ($19), plus the difference between the actual charge and the Carrier allowance ($5), for a total member responsibility of $24.

Copayments

A copayment is the stated amount the Plan may require you to pay for a covered service, such as $5 per prescription for generic and $12 per prescription for brand name drug by mail or from a pharmacy.

If provider waives *your share*

If a provider routinely waives (does not require you to pay) your share for services rendered, the Carrier 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 copayments or deductibles is misstating the actual charge and when doing so may be in violation of the law and subjecting you to a benefit calculated from an amount less than the misstated charge (the lesser amount being the actual charge). The Carrier will only pay the percentage of 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 Carrier will pay $64 (80% of the actual charge of $80).

Cost Sharing *(continued)*

Lifetime maximums

Hospice benefits are limited to 180 days per lifetime with 45 reserve days.

Smoking cessation benefits are limited to one program per member per lifetime.

General Limitations

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

Other sources of benefits

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

Medicare

If you or a covered family member is enrolled in this Plan and Part A, Part B or Parts A and B of Medicare, the provisions on coordination of benefits with Medicare described on pages 31-34 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 allowable expenses. When this Plan pays secondary, it will only make up the difference between the primary plan's coverage and this Plan's coverage. Thus, the combined payments from both plans may not equal the entire amount billed by the provider**.**

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

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

CHAMPUS

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

General Limitations *(continued)*

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 Program (OWCP) to be payable under workers' compensation (under section 8103 of title 5, U.S.C.) or by a similar agency under another Federal or State law. This provision also applies when a third party injury settlement or other similar proceeding provides medical benefits in regard to a claim under workers' compensation or similar laws. If medical benefits provided under such laws are exhausted, medical benefits may be provided for services or supplies covered by this Plan. The Plan is entitled to be reimbursed by OWCP (or the similar agency) for benefits paid by the Plan that were later found to be payable by OWCP (or the agency).

DVA facilities, DoD facilities, and Indian Health Service

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

Other Government agencies

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

Liability insurance and third party actions

Subrogation applies when you are sick or injured as a result of the act or omission of another person or party. Subrogation means the Plan's right to recover any payments made to you or your dependent by a third party's insurer, because of an injury or illness caused by a third party. Third party means another person or organization. If you need more information about subrogation, the Plan will provide you with its subrogation procedures.

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 65 or older and don't have Medicare

The information in these following paragraphs applies to you when 1) you are not covered by either Medicare Part A (hospital insurance) or Part B (medical insurance), or both, 2) 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 services, and you receive care in a Medicare participating hospital, the law (5 U.S.C. 8904(b) requires the Carrier 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**.**

General Limitations *(continued)*

Inpatient hospital care *(continued)*

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 refund call the Plan at 1-800-424-7474 extension 6039 for assistance.

Physician services

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

The Carrier 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 Carrier will base its payment on the lower of these two amounts and you are responsible only for any deductible and copayment or coinsurance.

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

If your physician is not a Carrier doctor but participates with Medicare, the Carrier will base its regular benefit payment on the Medicare-approved amount. For instance, under this Plan's benefit, the Carrier will pay 80% of the Medicare-approved amount. You will only be responsible for any deductible and coinsurance equal to 20% of the Medicare-approved amount.

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

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

The Carrier's explanation of benefits (EOB) will tell you how much the physician can charge you in addition to what the Plan paid. If you are billed more than the physician is allowed to charge, ask the physician to reduce the bill. If you have already paid more than you have to pay, ask for a refund. If you cannot get a reduction or refund, or are not sure how much you owe, call the Carrier at 1-800-424-7474 extension 6039 for assistance.

General Exclusions

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

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

Benefits will not be paid for services and supplies when:

No charge would be made if the covered individual had no health insurance coverage
Furnished without charge (except as described on page 10); while in active military service; or required for illness or injury sustained on or after the effective date of enrollment (1) as a result of an act of war within the United States, its territories, or possessions or (2) during combat
Furnished by immediate relatives or household members, such as spouse, parents, children, brothers or sisters by blood, marriage or adoption
Furnished or billed by a provider or facility that has been barred from the FEHB Program
Furnished or billed by a noncovered facility, except that medically necessary prescription drugs are covered
Procedures, services, drugs and supplies related to sex transformations
Not specifically listed as covered
Investigational or experimental
Not provided in accordance with accepted professional medical standards in the United States.

Benefits will not be paid for:

Any portion of a provider's fee or charge that is ordinarily due from the enrollee but has been waived. If a provider routinely waives (does not require the enrollee to pay) a deductible or coinsurance, the Carrier will calculate the actual provider fee or charge by reducing the fee or charge by the amount waived
Charges the enrollee or Plan has no legal obligation to pay, such as: excess charges for an annuitant age 65 or older who is not covered by Medicare Parts A and/or B (see pages 31-34), doctor charges exceeding the amount specified by the Department of Health and Human Services when benefits are payable under Medicare (limiting charge; see page 33), or State premium taxes however applied
Personal comfort items
Convalescent or custodial care
Rest, institutional, or rehabilitation care not specifically stated as covered
Any portion of a charge which is determined by the Carrier to be in excess of the carrier allowance
Charges for completion of claim forms or similar charges
Claims for services and supplies which are filed later than two years following the date services were rendered or the supplies were provided
Expenses incurred while not covered under this Plan
Services not prescribed by a doctor in accordance with generally accepted professional medical standards in the United States
Charges for services rendered to a patient after the date of death
Travel, even if prescribed by a doctor
Treatment of obesity; weight reduction, except surgery for morbid obesity
Acupuncture, except when used as an anesthesia for covered surgery
Biofeedback
Charges for stand-by services
Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term.

Inpatient Hospital Benefits

What is covered

The Plan pays for inpatient hospital services as shown below.

After a $100 per admission deductible, the Carrier pays 100% of room and board and other covered charges, for covered services and supplies when furnished by a hospital and payable as a regular hospital service in both participating and non-participating hospitals, and 100% of the per diem charge in United States Health Service and Armed Forces hospitals.

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 29-30 for details.

Waiver

This precertification requirement does not apply to persons whose primary coverage is Medicare Part A or another health insurance policy or when the hospital admission is outside the United States and Puerto Rico. For information on when Medicare is primary see pages 31-33.

Room and board

The Plan provides benefits for charges for a semi-private room, meals (including special diets) and general nursing care. Charges for a private room are considered only when there are no semi-private accommodations available or when a private room is medically necessary due to isolation for contagious disease. If a private room is chosen, based upon medical necessity, an allowance will be paid equal to the hospital's average semi-private room rate, as determined by the Carrier. If the hospital has private accommodations only, the Carrier will pay the lesser of the private room charge or the semi-private room charge of the hospital which the Carrier determines to be the most comparable hospital in the area.

Other charges

Administration of blood or plasma.
Ancillary services such as laboratory tests, diagnostic X-rays, electrocardiograms and electroencephalograms.
Dressings, plaster casts and sterile tray service.
Drugs and medicines listed in official formularies.
Intravenous solutions and injections.
Operating, recovery, intensive care, and cystoscopic rooms.
Oxygen, including the use of equipment and administration.
Physical therapy, occupational therapy and inhalation therapy.
Sera (except blood, blood plasma, and blood expanders which are covered under Other Medical Benefits).

Limited benefits

Pre-admission testing

The Plan pays 100% of hospital-billed covered charges, not subject to the per admission deductible, for tests performed in a hospital outpatient department or emergency room when related to and within seven days prior to the admission. Hospital-billed covered charges for tests performed more than seven days prior to an admission are payable under Other Medical Benefits.

Inpatient Hospital Benefits *(continued)*

Related benefits

Professional charges

Doctors' charges are covered under the appropriate benefit provisions (such as Other Medical Benefits).

Take-home items

Take-home items such as prescription drugs, medical supplies and medical equipment are covered under Other Medical Benefits.

Renal dialysis

The Plan pays 100% of covered charges, not subject to the per admission deductible, for inpatient renal dialysis; outpatient renal dialysis rendered in and billed by a renal dialysis center approved by the Carrier is paid under Other Medical Benefits.

Extended care facilities

The Plan pays 100% of facility-billed covered room, board and hospital services and supplies for up to 365 days per confinement in semi-private accommodations. Each day a patient receives benefits in a hospital reduces by two days the number of ECF benefit days available for the confinement. To be covered, ECF confinements must follow and be related to a hospital admission; therefore, ECF admissions are not subject to the per admission inpatient hospital benefits deductible. ECF benefits are not provided for admissions for mental conditions or substance abuse.

What is not covered

Hospital room and board and inpatient doctor care when, in the Carrier's judgement, a hospital admission or portion of an admission 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 the quality of medical care rendered

Admissions primarily for physical therapy

Admissions primarily for diagnostic purposes, convalescence, custodial care, rest, or rehabilitation

Admissions for dental services covered by dental benefits

Surgical Benefits

What is covered

The Plan pays for the following services:

After the $200 calendar year deductible has been met, the Plan pays 80% of the Carrier allowance for the following services received in or out of a hospital:

Doctors' covered surgical services, including pre- and post-operative care.
Treatment of fractures and dislocations.
Surgical sterilization.
Surgical correction of congenital anomalies.

Surgical Benefits *(continued)*

Hospital outpatient surgery

The Plan pays 100% of covered charges (not subject to the calendar year deductible) for hospital billed services and supplies when provided by and in a hospital outpatient department or emergency room in connection with in-and-out surgery, where minor surgery is performed and the patient goes home the same day the surgery is performed. Also covered under this benefit are related facility billed services and supplies when performed in a freestanding ambulatory surgical facility.

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 as follows: the fullallowance for the primary procedure and one half the allowance for secondary procedures. If equal procedures are performed through different incisions or body openings, the Plan pays the full allowance for the first procedure and one half the allowance for the other procedure.

When an office visit is rendered on the same day as a major surgery, benefits are provided for the surgery only. When an office visit is rendered on the same day as surgery, benefits will be provided for either the surgery or the visit by the surgeon, whichever is the greater fee.

Incidental procedures

If primary and incidental procedures are performed, the Plan pays the full allowance for the primary procedure only; there are no additional benefits for incidental procedures.

Assistant surgeon (inpatient)

After the $200 calendar year deductible, the Plan pays 80% of the Carrier allowance for inpatient surgery.

Anesthesia

After the $200 calendar year deductible, the Plan pays 80% of the Carrier allowance for anesthesia and its administration, including acupuncture.

Organ/tissue transplants and donor expenses

Inpatient hospital, surgical, and other medical expenses for covered transplants are limited to a maximum of $150,000 for each listed transplant. The dollar maximums will be applied to the portion of an inpatient hospitalization that is for the transplant, the surgical fees, and all medical care related to the transplant for a period of up to 42 days after the date of surgery. Other services such as maintenance and prescription drugs will be considered under the Plan's Prescription Drug Program.

What is covered

Cornea, heart, kidney, liver, pancreas, heart/lung, single lung and double lung transplants in approved centers for the following end-stage pulmonary diseases: primary fibrosis, primary pulmonary hypertension and emphysema. Double lung transplants for cystic fibrosis.

Bone marrow and stem cell support as follows:

Allogeneic bone marrow transplants, limited to patients with acute leukemia, advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma (limited to children over age one), aplastic anemia, chronic myelogenous leukemia, infantile malignant osteoporosis, severe combined immunodeficiency, thalassemia major, or Wiskott-Aldrich syndrome.

Autologous bone marrow transplants (autologous stem cell support) and autologous peripheral stem cell support, limited to patients with acute lymphocytic, or non-lymphocytic leukemia; advanced Hodgkin's lymphoma, advanced non-Hodgkin's lymphoma, advanced neuroblastoma (limited to children over age one); testicular, mediastinal, retroperitoneal and ovarian germ cell tumors, breast cancer; multiple myeloma, or epithelial ovarian cancer.

What is covered

Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in

(continued)

non-randomized clinical trials. For the transplants covered through clinical trials, the clinical trial must be approved and funded by the National Cancer Institute (NCI) and the procedure must be conducted at an NCI approved Cancer Research Facility, (see page 6). Eligibility for non-randomized clinical trials will be determined according to NCI approved protocols. In the event non-randomized clinical trails are not available for whatever reason, the Plan will provide its regular transplant benefit in a Carrier designated facility, using eligibility criteria for NCI sponsored clinical trials.

Related medical and hospital expenses of the donor are covered 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**.**

Prior approval of the procedure and the facility is required for bone marrow, heart, heart/lung, liver, single or double lung, and pancreas transplants (see Precertification, pages 29-30).

What is not covered

Autologous bone marrow transplants and associated high dose chemotherapy for the treatment of transplants not listed as covered.
Charges in excess of the dollar limitations noted above.

Oral and maxillofacial surgery

The Plan pays 80% of the Carrier allowance (not subject to the calendar year deductible) for a doctor's non-dental oral surgical services for:

Reduction of fractures of the jaws or facial bones
Surgical correction of cleft lip, cleft palate, or protruding mandible
Removal of stones from salivary ducts
Excision of tori, leukoplakia, or malignancies
Excision of cysts and incision of abscesses not involving the teeth
Removal of impacted teeth
Other procedures not involving a tooth structure, alveolar process, periodontal disease, or disease of gingival tissue

Mastectomy surgery

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

Pre-surgical testing

When a covered surgical procedure is performed in an outpatient or inpatient setting, the Carrier pays actual charges for laboratory tests, pathology, radiology and X-rays directly related to the surgery when performed within 10 days prior to the surgery (including the day of the surgery) when an outpatient, or within 10 days prior to admission for inpatient surgery.

What is not covered

Cutting or removal of corns, callouses, or toenails except when necessary because the patient is under active treatment for a peripheral-vascular disease
Subluxations of the joint of the foot
Cosmetic surgeries other than those specifically listed as covered
Services or supplies for or related to transplants other than those listed as covered

Maternity Benefits

What is covered

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

Inpatient hospital

Precertification

The medical necessity of your hospital admission must be precertified for you to receive full Plan benefits. Unscheduled or emergency admissions not precertified must be reported within two business days following the day of admission even if you have been discharged. Newborn confinements that extend beyond the mother's discharge must be precertified. If any of the above are not done, the benefits payable will be reduced by $500. See pages 29-30 for details.

Room and board

After a $100 per admission deductible, 100% of covered charges in both participating and non-participating hospitals, and 100% of the per diem charge in United States Health Service and Armed Forces hospitals.

Bassinet or nursery charges for days on which mother and child are both confined are considered hospital expenses of the mother and not expenses of the child. All other expenses of the newborn child are considered the child's own expenses and are covered only if the child is covered as a family member. Routine newborn care is covered as part of Well Child Care (see page 20).

Other charges

Charges for covered services shown on page 12 when appropriate to maternity care.

Obstetrical care

After the $200 calendar year deductible, the Plan pays:

80% of the Carrier allowance for maternity care such as the delivery of a child (or miscarriage)
80% of the Carrier allowance for prenatal care, postnatal care, sonograms, amniocentesis and other related tests of the unborn child
80% of the Carrier allowance for services of a licensed midwife when those services are within the scope of the license and rendered in lieu of doctor's services
80% of the Carrier allowance for Pregnancy Risk Management Programs

Related benefits

Diagnostic and treatment of infertility

Infertility services, including diagnostic testing and treatment, are covered under Other Medical Benefits (see pages 18-19).

Voluntary sterilization

Voluntary sterilization is covered under surgical benefits (see pages 13-15).

For whom

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

Maternity Benefits *(continued)*

What is not covered

Procedures, services, drugs and supplies related to abortions except when the life of the mother would be endangered if the fetus were carried to term
Implanted contraceptive drugs, such as Norplant, and contraceptive devices
Services related to conception by artificial means, including artificial insemination, in vitro fertilization, and embryo transplants
Reversal of voluntary surgical sterilization
Charges incurred after enrollment in this Plan ends
Assisted Reproductive Technology (ART) procedures such as artificial insemination, in-vitro fertilization, embryo transfer and Gamete Intrafallopian Transfer (GIFT) as well as services and supplies related to ART procedures, are not covered.

Mental Conditions/Substance Abuse Benefits

What is covered

The Plan pays for the following services:

Inpatient care

After a separate inpatient deductible of $200 per person per calendar year for treatment of mental conditions and substance abuse, the Plan pays 80% of inpatient room and board, and other inpatient services and supplies furnished, and billed for, by a hospital, including a mental hospital or licensed substance abuse facility.

Precertification

The medical necessity of your admission to a hospital or other 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 pages 29-30 for details.

Inpatient visits

The Plan pays 80% of the Carrier allowance for non-surgical inpatient services rendered during a covered confinement for treatment of mental conditions or substance abuse.

Catastrophic protection

When a member's share of the above covered inpatient charges reaches $4,000 in a calendar year, in addition to the separate deductible, the Plan pays 100% of covered charges up to $50,000 per calendar year per person.

Outpatient care

After the $200 calendar year deductible, the Plan pays 50% of covered charges per person per calendar year for doctor and hospital outpatient treatment rendered for mental conditions, and up to $2,000 per person per calendar year for doctor and hospital outpatient treatment rendered for substance abuse. Covered services include:

Individual and group therapy
Collateral visits
Day-night psychiatric services, when provided by a doctor, clinical psychologist, clinical social worker or psychiatric nurse
Psychological testing

Calendar year maximum

There is a $50,000 per calendar year maximum per person for inpatient treatment of substance abuse.

What is not covered

Marriage or family counseling and related therapy

Other Medical Benefits

What is covered

After the $200 deductible has been met, the Plan pays 80% of the Carrier allowance for the following:

Allergy tests, injections and serum
Artificial limbs or eyes
Blood transfusions, including the cost of blood if not donated or replaced, blood plasma, and blood plasma expanders
Casts, splints, braces (except corrective shoes and related devices), crutches and trusses
Chiropractic services
Dental care, dental surgery or dental appliances required as a result of and directly related to an accidental bodily injury occurring while the participant was covered by a FEHB Plan
Diagnostic laboratory tests and x-rays
Doctor's office, home and hospital visits
Doctor-billed services for a medical emergency or accidental injury other than initial care rendered within 72 hours
Dressings
Group B streptococcus screening for pregnant women
Growth hormone therapy
Infertility services, including diagnostic testing and treatment
Pre-admission testing performed more than seven days prior to admission
Occupational therapy when rendered by a registered or licensed professional occupational therapist
Oxygen and equipment for its administration
Physical therapy rendered by a registered or licensed professional therapist
Professional ambulance services within the subscriber’s local area for medical emergencies
Radiation therapy, chemotherapy, respiration therapy, and speech therapy
Renal dialysis treatment on an outpatient basis
Rental or, at the Carrier’s option, purchase of durable medical equipment
Take-home items billed by a hospital

Limited benefits

Cardiac rehabilitation program

The Plan provides benefits, subject to the $200 calendar year deductible and 20% coinsurance, for up to 90 outpatient visits during the course of a cardiac rehabilitative treatment plan, when those visits consist of outpatient cardiac rehabilitation exercise, education, and counseling.

Members must be diagnosed as having angina pectoris (chest pain) or must have been hospitalized for a diagnosed myocardial infarction (heart attack) or coronary surgery to be eligible for cardiac rehabilitation benefits.

Services must be provided by an approved hospital-based or hospital-coordinated cardiac rehabilitation program. Cardiac rehabilitation benefits are renewed after subsequent hospital admissions for a diagnosed myocardial infarction or coronary surgery.

Smoking cessation benefit

After satisfaction of the $200 calendar year deductible, the Plan will pay up to $100 for enrollment in one smoking cessation program per member per lifetime.

Other Medical Benefits *(continued)*

Other

One pair of eyeglasses or contact lenses, and examinations therefor, if required to correct an impairment directly caused by accidental ocular injury or intraocular surgery
Private duty nursing care by a registered private duty nurse (R.N.) or a licensed practical nurse (L.P.N.) rendered to a subscriber who is not confined in the hospital; Plan payment is limited to $10,000 per person per calendar year
Up to $6 per day toward the cost of a private room above the average semi-private room rate, when a private room is medically necessary

What is not covered

Air conditioners, humidifiers, dehumidifiers and purifiers
Hearing aids unless required because of an accidental injury
Medical examinations or tests not incidental or necessary to the diagnosis or treatment of an illness, injury, or condition
Nutritional supplements and vitamins (except injectable B-12 for treatment of pernicious anemia)
Routine physical exams and all related expenses and immunizations beyond those covered under the Well Child Care provision and childhood immunization provision
Private duty nursing care when requested by, or for the convenience of, the patient or the patient's family; or when it consists primarily of custodial care (see Definitions)
Acupuncture, except when used as an anesthetic agent for covered surgery
Orthotics, orthopedic shoes, arch supports, and other devices to support the feet

Additional Benefits

Accidental injury and medical emergency

The Plan pays 100% of covered charges for the initial care other than surgery rendered for and within 72 hours of an accidental injury of the onset of a medical emergency by a doctor and by the outpatient department of a hospital. Other Medical Benefits are available for covered services and supplies provided for follow-up care provided after 72 hours. Surgery required in the event of an accidental injury is covered under Surgical Benefits.

Ambulance service special benefit

The Plan pays a maximum of $50 per illness for professional ambulance services for medical emergencies outside of the subscriber's local area.

Home health care

The Plan pays 100% of covered charges for up to 90 visits by members of an approved home health care team during the course of a home health care treatment plan. A visit is any continuous care rendered by a member of a home health care team for up to four continuous hours or any portion of four continuous hours. Benefits are renewed when the patient receives no home health care for 60 consecutive days or following readmission to a hospital.

Hospice care

What is covered

The Plan pays 100% of covered charges for services provided to terminally ill patients with a life expectancy of 6 months or less for whom no further curative therapy is indicated.

Benefits are provided for condition management services rendered at home or as an inpatient. Benefits are provided for palliative care delivered by a team of hospice professionals and volunteers with family members participating as active members of that team. Inpatient hospice care is covered when the patient requires 24-hour-a-day care or when the proper care cannot be provided in the home.

Additional Benefits *(continued)*

What is covered *(continued)*

The Plan pays for up to 180 days per lifetime, 60 of which can be used for inpatient hospital care. If a patient requires hospice care benefits beyond the six month life expectancy period and has exhausted 180 hospice benefit days, 45 reserve days are available.

What is not covered

Bereavement benefits and remission benefits
Benefits provided in excess of the limitations listed above.

Flexible *benefits* option

Flexible benefits option is part of the Plan's cost containment program with BCBSNCA. Flexible benefits option is a health care service that identifies patients with potentially high cost illnesses as early as possible and is designed to both contain costs and to help patients, their families, and their providers to cope with the difficult financial issues involved in caring for the chronically ill. Flexible benefits option helps to identify medically appropriate alternatives to traditional care and coordinates the provision of the Plan's benefits for that care in place of the more costly benefits of the Plan.

International medical transportation

The Plan pays 100% of charges for medically necessary transportation rendered overseas, including medical transportation back to the U.S. when such medical transportation is coordinated and arranged for by World Access, Inc. If such service is needed contact World Access, Inc., with the assistance of the international operator when overseas, either by calling 202/861-3800 collect or, via telex, by using the telex number 706305.

Routine services

The Plan pays 100% of the following routine (screening) services as preventive care:

Colorectal cancer screening

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

Prostate cancer screening

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

Breast cancer screening

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

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

Cervical cancer screening

Annual coverage of one pap smear and related office visit for women age 18 and older.

Lead screening

One routine annual lead screening for children up to age 12.

Well child care

The Plan pays 100% of covered charges for routine newborn care, routine physical examinations and immunizations, for babies up to one year of age who are covered subscribers under a Self and Family enrollment in this Plan.

Childhood immunizations

Childhood immunizations recommended by the American Academy of Pediatrics are covered at 100% of covered charges (not subject to the deductible or coinsurance) for dependent children under age 22. Benefits for associated office visits are subject to the deductible and coinsurance under Other Medical Benefits.

Prescription Drug Benefits *(continued)*

What is covered

This program enables you to purchase medication prescribed for immediate use that requires a prescription by Federal law and is prescribed by your doctor and obtained from a local pharmacy for the initial 30-day supply and one refill only. You may receive up to a 90-day supply of maintenance medication through the Mail Order Drug Program. Prescription drugs are not subject to the calendar year deductible and any coinsurance or copays by you do not count toward the catastrophic protection benefit.

Covered medications and accessories include:

Drugs for which a prescription is required by Federal law
Oral contraceptive drugs; diaphragms
Insulin and the following injectables; Heparin, Glucagon, Initrex, EpiPen and Anakit
Disposable needles and syringes needed to inject covered prescribed medication
Smoking deterrents, limited to one series per member per lifetime
Diabetic supplies, including insulin syringes, needles, glucose test strips, lancets and alcohol swabs
Implantable drugs (such as Norplant), some injectable drugs (such as Depo Provera), and IUDs are covered under Medical and Surgical Benefits
Drugs to treat sexual dysfunction are limited to drugs for male impotence (i.e., viagra) viagra limited to 6 pills per 30 days
Allergy serum and intravenous fluids and medication for home use under Other Medical Benefits

What is not covered

Drugs to aid in smoking cessation except those limited to the $100 lifetime maximum as part of the smoking cessation benefit (see page 18).
Nutritional supplements and vitamins (except injectable B-12 for treatment of pernicious anemia).
Drugs available without a prescription.

From a pharmacy

You will be provided with a PAID Prescription identification card. In most cases, you simply present the card together with the prescription to the pharmacist. Under the Prescription Drug Card Program, you may only obtain a 30-day supply and one refill. For the initial 30-day supply and the one refill, you pay $12 for brand name and $5 for generic drugs. You may fill your prescription at any pharmacy participating in the PAID TelePAID system. You may obtain the names of participating pharmacies by calling 1-800/272-PAID.

If a participating pharmacy is not available where you reside or you do not use your identification card, you must submit your claim to:

PAID Prescriptions, Inc.
P.O. Box 6121
Fair Lawn, NJ 07410-0999

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

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

Drug Formularies Medications that are not on the formulary are still covered through the prescription drug program and members do not have to pay any additional copayments. Enrollees are not held accountable for departures from formulary prescriptions.

Prescription Drug Benefits *(continued)*

To claim benefits

Use a claim form to claim benefits for prescription drugs and supplies you purchased (without your PAID drug card). You may obtain these forms by calling 1-800/272-PAID. Follow the instructions on the form and mail it to the address referenced on this page.

By mail

Through the Mail Order Program you may receive up to a 90-day supply of maintenance medications for drugs which require a prescription, diabetic supplies, and insulin (including syringes) and oral contraceptives. You may receive refills of the original prescription for up to one year. You must pay a copayment of $12 for brand name drugs and $5 for generic drugs.

Each enrollee will receive an enrollment kit which includes a brochure describing the Mail Order Program, including a Patient Profile Questionnaire, and a pre-addressed reply envelope.

Waiver

If you are enrolled in Medicare Part B, the Plan will waive the $5 or $12 copayment ONLY through the Mail Order Drug Program. The copayment WILL NOT be waived under the Prescription Drug Card Program. Any copayment or coinsurance for drugs purchased at retail are not waived.

To claim benefits

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

1) Complete the Patient Profile Questionnaire Kit the first time you order under this program. Complete the information on the back of the pre-addressed envelope.
2) Enclose your prescription and your $12 or $5 copayment.
3) Mail your order to National RX Services, Inc. of Pennsylvania, P.O. Box 8385, Harrisburg, PA 17105-8385.
4) Allow approximately two weeks for delivery.

You will receive forms for refills and future prescription orders each time you receive drugs or supplies under this program. In the meantime, if you have any questions about a particular drug or a prescription, and to request your first order forms, you may call toll free: 1-800/950-5070 from 8 a.m. to 8 p.m. Monday through Friday, and 8 a.m. through 12 noon on Saturday, EST. Emergency consultation is available seven days a week, 24 hours per day.

Purchasing drugs when you are overseas

When purchasing mail order drugs while you are overseas, you must provide an APO address. The mail order company is unable to mail prescription drugs if you do not have an APO address. If you do not have an APO address, you may request that the drugs be sent to a friend with an APO address who can then ensure that you get them.

For the prescription card benefit (short term medications or the first two times you fill a long term medication, or if you don't have an APO address), you should have the pharmacist complete the blue portions of the claim form as completely as possible, and sign it in the bottom right corner (you may have to translate it for him/her). You should complete the white areas. Attach the bill and include a short note notifying the Plan that you are overseas. Also, please have the total on the bill converted to U.S. dollars, or if that is not possible, indicate what currency the bill is in.

As with all claims, keep a copy of your documents. Send the originals to:
PAID Prescriptions
1900 Pollitt Dr.
Fair Lawn, NJ 07410
ATTN: Correspondence

You will be reimbursed the average wholesale price of the drug, minus your copayment ($5 for generic and $12 for brand name).

Dental Benefits

What is covered

The Plan pays 100% of the Carrier's allowance up to $1,000 per person per calendar year for covered dental services and supplies, when provided by a licensed dentist. Services and supplies covered under dental benefits are not covered under any other provision of this Plan. The following is a complete list of covered services:

Routine cleaning, including scaling and polishing, twice in a calendar year
Two oral examinations per person per calendar year
Two topical fluoride applications per calendar year for children under age 16
Regular X-rays
Palliative emergency services
Space maintainers for maintenance of space created by premature loss of deciduous teeth from cuspid to posterior
Diagnostic models
Panoramic X-rays in lieu of full mouth X-rays, not to exceed one in three consecutive calendar years
Pulp vitality tests
One consultation by any dental consultant per calendar year. Such consultation must be requested by the attending dentist, rendered to a subscriber and supported by a written report from the consultant

Related benefits

Oral surgery

For covered oral surgery, see page 15.

What is not covered

Charges for services or supplies not meeting accepted standards of dental practice as determined by the Plan
Dental preventive counseling, including plaque control
Endodontic services
Orthodontic treatment and appliances
Periodontic services
Prosthodontic services
Restorative services
Sealants
Service or supplies to diagnose or treat conditions or dysfunctions of the temporomandibular joint
Services, treatments, or supplies provided by a non-covered dental provider except for prophylaxis performed by a licensed dental hygienist working under the supervision of a dentist.

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 you may call the Carrier at [1-800/424-7474 extension 6039 toll-free outside the Washington, D.C. area; 202/479-6039 in the Washington, D.C. area; or 1-202/479-3546 TDD Telecommunications Device for the Deaf] 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.

How to Claim Benefits *(continued)*

Claim forms, identification cards and questions *(continued)*

If you have a question concerning Plan benefits, contact the Carrier at 1 800/424-7474 extension 6039 or 202-479-6039 or you may write to the carrier at BCBSNCA, 550 12th St, S.W., Washington, D.C. 20065. (You may also contact the Carrier by fax at 202-479-1544, at its web site at http://www.bcbsnca.com.

Claim forms and detailed instructions for filing claims will be furnished with your identification card. You may obtain additional claim forms, duplicate identification cards and information about benefits from Blue Cross and Blue Shield of the National Capital Area.

When writing: Blue Cross and Blue Shield of the National Capital Area
SSEHA Health Benefit Plan
550 12th Street, SW
Washington, D.C. 20065

In all correspondence, please include your full name, address and identification number, including the three-letter prefix, SSA.

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

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

In addition:

A copy of the explanation of benefits (EOB) from any primary payer (such as Medicare) must be sent with your claim.
If benefits are assigned directly to the provider of care, the bill must show the provider's Tax ID Number.
Bills for psychotherapy must show the length and type of each session.
Bills for private duty nurses must show that the nurse is a registered or licensed practical nurse.
Claims for rental or purchase of durable medical equipment, private duty nursing, and physical, occupational and speech therapy require a written statement from the doctor specifying the medical necessity for the service or supply and the length of time needed.
Dental claims must be submitted with a Dental Health Plan Claim Form. Complete and sign the top portion of the form and either have the dentist fill out the bottom portion or attach the itemized bill (including the tooth number treated) to the claim form.

How to Claim Benefits *(continued)*

How to file claims *(continued)*

Claims for surgical benefits, other medical benefits and additional benefits must be submitted with a SSEHA Health Benefit Plan Claim Form.
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.

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

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

Blue Cross and Blue Shield of the National Capital Area
SSEHA Health Benefit Plan
550 12th Street, SW
Washington, D.C. 20065

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 copies of medical bills including those you 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

You are strongly encouraged to file your claims within 12 months of the date the service was rendered. All claims must be received by the Carrier no later than 24 months after the services were provided. No claims will be considered if received more than 24 months after the date of service, unless timely filing was prevented by administrative operations of government or legal incapacitation, provided the claim was submitted as soon as reasonably possible. Once benefits have been paid, there is a three year limitation on the reissuance of uncashed checks.

If the Carrier returns a claim or part of a claim for additional information, it must be resubmitted within 90 days, or before the timely filing period expires, whichever is later.

Direct payment to hospital or provider of care

Bills from a participating hospital

If you are admitted to or receive services in a participating hospital, your claim will be filed for you; however, you must show your identification card when you are admitted to assure that the hospital files its charges with the Blue Cross Plan with which it participates.

The three-letter prefix "SSA" with your identification number identifies you as an SSEHA Health Benefit Plan subscriber, and advises the Blue Cross Plan in your area to contact Blue Cross and Blue Shield of the National Capital Area to determine what benefits should be provided. The hospital must include the three-letter prefix with your identification number when filing claims. If the services are for pre-admission testing or are related to outpatient surgery, an accidental injury or a medical emergency, please advise the hospital to include that information on the bill so that you can receive the benefits to which you are entitled. If the services rendered are in relation to mental conditions or substance abuse, an SSEHA Health Benefit Plan Claim Form must be filed as described under How to File Claims (see pages 24-25).

How to Claim Benefits *(continued)*

Bills from a non-participating hospital

If you are admitted to a non-participating hospital or receive services for pre-admission testing or services related to outpatient surgery, an accidental injury, or a medical emergency in a non-participating hospital, you must complete and file a claim form. Complete a SSEHA claim form, and send it to BCBSNCA (see address on the back of the claim form) with the itemized bill. It is good practice to keep a copy of the itemized bill for your records. You should arrange to pay the hospital and then file a claim with the Blue Cross Plan for reimbursement. Payments will usually be made directly to you.

Other facilities

For the following charges: hospice care, home health care, ambulatory surgical facility, extended care facility, overseas facilities or renal dialysis center; if the organization participates with the Blue Cross Plan in the area where the services were rendered, the organization completes and files your claim for you. If the organization does not participate, you must complete and file a claim form, as described above, for obtaining benefits from a non-participating hospital.

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

Disputed claims review

Reconsideration

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

How to Claim Benefits *(continued)*

Reconsideration *(continued)*

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

OPM review

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

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

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

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

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

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

OPM review
(continued)

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 Plan 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 the Carrier allowance charges for the remainder of the calendar year after the calendar year deductible is met, if out-of-pocket expenses for the deductible and coinsurance in that calendar year exceed $1,000 per member or $2,000 per family enrollment.

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

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

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

Expenses for Inpatient Hospital Benefits;
Expenses in excess of the Carrier allowance or maximum benefit limitations;
Expenses for mental conditions, substance abuse or dental care;
Any amounts you pay if benefits have been reduced because of non-compliance with this Plan's cost containment requirements (see pages 5 and 29-30);
Expenses for prescription drugs purchased through retail or mail order program.

Mental conditions/substance abuse

The Plan pays 100% of the Carrier allowance for inpatient hospital care up to $50,000 per calendar year per person after the separate $200 deductible is met, if out-of-pocket expenses for your 20% of covered inpatient charges for mental conditions/substance abuse treatment total $4,000 for the covered person in that calendar year.

Carryover

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

Other Information

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 1 800/424-7474 extension 6039 or you may write the Carrier at BCBSNCA. You may also contact the Carrier by fax at 202-479-1544, at its website at http://www/bcbsnca.com or by mail at 550 12th Street, S.W., Washington, D.C. 20065.

Information that must be made available to you include:

Disenrollment rates for 1997.
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 existence.
Whether the carrier meets State, Federal and accreditation requirements for fiscal solvency, confidentiality and transfer of medical records.

Precertification

Precertify before admission.

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

To precertify a scheduled admission:

You, your representative, your doctor, or your hospital must call BCBSNCA for medical admissions, at least two days prior to admission. The toll-free number is 1-800/999-9849 or 202/479-6718 in the Washington, D.C. area. For mental health and substance abuse admissions call Health Management Strategies International, Inc. (HMS) at 1-800/553-8700 or 703/836-6365.
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.

HMS will then tell the doctor and hospital the number of approved days of confinement for the care of the patient's condition. Written confirmation 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 not be medically necessary by the Carrier during the claim review.

Precertification *(continued)*

Need additional days? *(continued)*

You don't need to certify an admission when:

Medicare Part A, or another group health insurance policy, is the primary payer for the hospital confinement (see page 13). 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 1-800/999-9849 or 202/479-6718 in the Washington, D.C. area, 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.

Other considerations

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

If you do not precertify

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

This Plan and Medicare

Coordinating benefits

The following information applies only to enrollees and covered family members 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 31-33).

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

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

This Plan is primary if:

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

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

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

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

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

Medicare is primary if:

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

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

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

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

Medicare is primary if: *(continued)*

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

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

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

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

9) The patient (you or a covered family member) becomes eligible for Medicare due to ESRD after Medicare assumed primary 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 applicable to inpatient hospital care covered by Medicare Part A and this Plan.

Surgical benefits: If you are enrolled in Medicare Part B (medical insurance), and Medicare is the primary payer, you do not have to meet the Plan's calendar year deductible and all of your balances for covered services are paid up to 100% of the Carrier's Plan allowance.

Maternity benefits: If you are enrolled in Medicare Part A (inpatient hospital), and Medicare is the primary payer, this Plan will waive the deductible applicable to inpatient maternity benefits. If you are enrolled in Medicare Part B (medical insurance), and Medicare is the primary payer, you do not have to meet this Plan's calendar year deductible and all of your balances are paid up to 100% of the Carrier's Plan allowance. This provision applies solely to services covered by both Medicare and the Plan.

Mental conditions/substance abuse benefits: If you are enrolled in Medicare Part A (inpatient hospital), expenses for covered hospital inpatient care for the treatment of mental conditions and substance abuse are paid at 100% up to the calendar year maximum.

Other medical benefits: If you are enrolled in Medicare Part B (medical insurance), and Medicare is the primary payer, you do not have to meet this Plan's calendar year deductible and all of your balances are paid up to 100% of the Carrier's Plan allowance. This provision applies solely to services and supplies covered by both Medicare Part B and the Plan. Note: prescription drugs are not covered by Medicare; therefore, the coinsurance for prescription drugs is not waived except for as noted below.

Additional Benefits (Prescription Drugs): If you are enrolled in Medicare Part B, the Plan will waive the $5 or $12 copayment ONLY through the Mail Order Drug Program. The copayment WILL NOT be waived under the Prescription Drug Card Program. Any copayment or coinsurance for drugs purchased at retail are not waived.

When Medicare is primary *(continued)*

Dental Benefits: If you are enrolled in Medicare Part A (inpatient hospital) or Medicare Part B (medical insurance) and Medicare is the primary payer, this Plan will continue to provide benefits for covered dental care up to the annual Plan maximum benefit.

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.

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 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 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 Explanation of Benefits (EOB) 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 EOB form. In any case, a doctor who does not participate with Medicare is not entitled to payment of more than 115 percent of the Medicare-approved amount.

This Plan and Medicare *(continued)*

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 some Medicare Part B carriers to receive electronic copies of your claims after Medicare has paid their benefits. This eliminates the need for you to submit your Part B claims to this Carrier. You may call the Carrier at 1-800-638-8432 to find out if your claims are being electronically filed. If they are not, you should initially submit your claims to Medicare and, after Medicare has paid its benefits, this Plan will consider the balance of any covered expenses upon receipt of the itemized bill and Medicare EOB statement. This Carrier will not process your claim without knowing whether you have Medicare and, if you do, without receiving the Medicare EOB. Once benefits have been paid, there is a three year limitation on the reissurance of uncashed checks.

Enrollment Information

If you are a new member

Use this brochure as a guide to coverage and obtaining benefits. There may be a delay before you receive your identification card and member information from the Carrier. Until you receive your ID card, you may show your copy of the SF 2809 enrollment form or your annuitant confirmation letter from OPM to a provider as proof of enrollment in this Plan. If you do not receive your ID card within 60 days after the effective date of your enrollment, you should contact the Carrier. See "How to claim benefits" on pages 23-28.

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

If you are a new member of this Plan, benefits begin on the effective date of your enrollment, as set by your employing office or retirement system (see Effective date on page 40). 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” on the next page.

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.

Enrollment Information *(continued)*

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" on page 34. 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 Plan when a family member loses eligibility.

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

Things to keep in mind *(continued)*

An employee, annuitant, or family member enrolled in one FEHB plan is not entitled to receive benefits under any other FEHB plan.

Report additions and deletions (including divorces) of covered family members to the Carrier promptly.

If you are an annuitant or former spouse with FEHB coverage and you are also covered by Medicare Part B, you may drop your FEHB coverage and enroll in a Medicare prepaid plan when one is available in your area. If you later change your mind and want to re-enroll 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 plan. See page 33 for how this Plan's benefits are affected when you are enrolled in a Medicare prepaid plan.

Contact your local Social Security Administration (SSA) office for information on local Medicare plans (also known as Coordinated Care Plans or Medicare HMOs) or request it from SSA at 1-800-638-6833. Contact your retirement system for information on dropping your FEHB enrollment and changing to a Medicare prepaid plan.

Federal annuitants are not required to enroll in Medicare Part B (or Part A) in order to be covered under the FEHB Program nor are their FEHB benefits reduced if they do not have Medicare Part B (or Part A).

Coverage after enrollment ends

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

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.

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.

Enrollment Information *(continued)*

Temporary continuation of coverage

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 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 non-group 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 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 non-group 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**.**

Enrollment Information *(continued)*

Temporary continuation of coverage *(continued)*

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

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

Conversion to individual coverage

When none of the above choices is available - or chosen - when coverage as an employee or family member ends, or when TCC coverage ends (except by cancellation or nonpayment of premium), you may be eligible to convert to an individual, non-group 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, for example divorce or reaching age 22. Benefits and rates under the individual contract may differ from those under the FEHB Program.

Definitions

Accidental injury

An injury caused by an external force such as a blow or fall and which requires immediate medical attention. Also included are animal bites, 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

The period of time beginning when a subscriber is admitted into a hospital or extended care facility as an inpatient and ending when the subscriber has been out of a hospital or extended care facility for 60 consecutive days.

Congenital anomaly

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

Cosmetic surgery

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

Covered charges

The actual charges or expenses, allowed by the Carrier for medically necessary covered services and supplies.

Custodial care

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

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

The Carrier determines which services are custodial care.

Definitions *(Continued)*

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.

Effective Date

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

Experimental or investigational

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

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

Group health coverage

Health care coverage that a member is eligible for because of employment, membership in, or connection with, a particular organization or group that provides payment for hospital, medical, or other health care services or supplies, including extension of any of these benefits through COBRA. Group health coverage also includes coverage that pays a specific amount for each day or period of hospitalization if the specified amount exceeds $100 per day; the Carrier will coordinate benefits against the amount that exceeds $100 per day.

Home health care agency

An agency that provides care that is ordered and supervised by a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.), rendered in the patient's place of residence on a visiting or part-time basis by a home health care agency, providing skilled and non-skilled personal care to the patient, including assisting with self-administered medication, caring for the nutritional needs of the patient, and helping the patient with exercises and other personal needs.

Definitions *(Continued)*

Hospice care program

Professional care rendered by a licensed or certified hospice to terminally ill patients for the personal care and relief of pain using technical and related medical procedures.

Maternity care

Care rendered resulting in childbirth or miscarriage.

Medical emergency

The sudden and unexpected onset of a condition requiring immediate non-surgical medical care, which the covered person secures within 72 hours of the onset. The severity of the condition as revealed by the doctor's diagnosis must be such as would normally require emergency care. Medical emergencies include heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, and such other acute conditions as may be determined by the Carrier to be medical emergencies.

Medically necessary

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

1) are appropriate to diagnose or treat the patient's condition, illness, or injury;
2) are consistent with standards of good medical practice in the United States;
3) are not primarily for the personal comfort or convenience of the patient, the family, or the provider;
4) are not a part of or associated with the scholastic education or vocational training of the patient; and
5) in 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 or equipment does not, in itself, make it medically necessary.

Mental conditions/substance abuse

Conditions and diseases listed in the most recent edition of 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 Carrier's Medical policy); and (2) has been so for at least five years, despite documented unsuccessful attempts to reduce weight under a doctor-monitored diet and exercise program.

Reasonable and customary

The basis the Carrier uses to determine your claim payment.

In developing its customary charge, the Carrier sets aside those charges at the high end of the scale by setting a point it considers acceptable or "customary". This cutoff point is known as a percentile. For example, if the Carrier uses the 90th percentile, it bases its payments on a charge at or below ninety percent of local providers' claims for the particular service or supply. Payments for this Carrier are generally based on the 90th percentile or higher.

A charge is reasonable if it is customary or if, in the opinion of the Carrier, it is justified because of unusual circumstances such as medical complications.

Definitions *(Continued)*

Reasonable and customary *(continued)*

The Carrier applies its coinsurance percentage to the provider's charge, up to the reasonable and customary (R&C) amount. For example, the Carrier will pay 80 percent of your surgeon's charge or 80 percent of the R&C amount, whichever is less.

The R&C allowances are adjusted upwards or downwards as appropriate, to reflect charge patterns in the providers' area.

Resource Based Relative Value Scale

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

For services rendered outside the United States, RBRVS is determined based upon the charges and services and supplies in Washington, D.C. Any difference between the actual charges and RBRVS is not covered.

How SSEHA Health Benefit Plan Changes January 1999

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

Program-wide Changes:

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

- The medical management of mental conditions will be covered under this Plan's Other Medical Benefits provisions. Related drug costs will be covered under this Plan's Prescriptions Drug Benefits, and any costs for psychological testing or psychotherapy will be covered under this Plan's Mental Conditions Benefits.

  The definition of experimental or investigational (see page 40) has been clarified to include biological products.

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

  The States designated as medically underserved have changed for 1999. Idaho and North Dakota have been added, and West Virginia is no longer underserved. See page 6 for information on medically underserved areas.

Changes to this Plan:

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

Summary of Benefits for SSEHA Health Benefit Plan - 1999

Do not rely on this chart alone. All benefits are subject to the definition, 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 with an asterisk (*) are subject to the $200 calendar year deductible.

Benefits	Plan pays/provide	Page
Inpatient Hospital Care	100% of covered services and supplies subject to a $100 per admission deductible	12-13
Surgical	80% of covered charges*	13-15
Medical	80% of covered charges*..	18-19
Maternity	Same as for illness or injury*	16-17
Mental Conditions/ Substance Abuse	After the separate $200 deductible per person per calendar year; 80% of covered charges after certain out-of-pocket costs for covered expenses, reach $4,000 additional covered charges are paid at 100% for the remainder of the calendar year; inpatient benefits for substance abuse are subject to a $50,000 per calendar year per person maximum	18-19
Outpatient Hospital Care	100% of covered services and supplies for accidental injury (initial care), same day surgery and pre-admission testing; 80% of other covered hospital-billed services and supplies*	14-19
Surgical	80% of covered charges*	13-15
Medical	80% of covered charges*	18-19
Maternity	Same as for illness or injury*	16-17
Home Health Care	100% of covered charges for up to 90 visits; benefits renew after 60 consecutive days without home health care or following readmission to a hospital	19

Summary of Benefits for SSEHA Health Benefit Plan - 1999

Mental Conditions/ Substance Abuse	50% of covered charges per person per calendar year up to $2,000 per person per calendar year for substance abuse 17
Emergency Care (accidental injury)	100% of covered charges for initial care rendered within 72 hours (see page 18 for coverage of follow-up care) 19
Prescription drugs	
Retail Card Program	Member pays $5 for generic drugs, $12 for brand name drugs for initial prescription and one refill 21-22
Mail Order Program	Member pays $5 for generic, $12 for brand name drugs up to a 90 day supply . . . 22
Dental Care	100% of covered preventive and diagnostic services, up to $1,000 per person per calendar year 23
Additional Benefits	Ambulance service special benefit, home health care, hospice care, well child care, flexible benefits option and international medical transportation 19-20
Protection against catastrophic costs	100% of covered surgical, maternity and other medical benefits charges after a subscriber's cumulative coinsurance (inclusive of the deductible) reaches $1,000 per person or $2,000 per family for a calendar year . . . . . 28 100% of additional covered inpatient services for mental conditions/substance abuse after covered charges other than separate deductible reach $4,000 in the same calendar year; subject to $50,000 per calendar year per person maximum 28

Notes

1999 Rate Information for Secret Service

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

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

		Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
Type of Enrollment	Code	Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share
High Option Self Only	Y71	$66.31	$22.10	$143.67	$47.89	n/a	n/a
High Option Self and Family	Y72	$157.14	$52.38	$340.47	$113.49	n/a	n/a